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

A COMPREHENSIVE LEGISLATIVE FRAMEWORK

CONSULTATION REPORT

February 2007

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FOREWORD

The Bamford Review of Mental Health and Learning Disability (Northern Ireland) consists of a number of interlinked reviews under one overarching title, and comprises policy, services and legislation.

The Review's Steering Committee oversees the work of 10 major Expert Working Committees, 4 of which commenced their work by April 2003, with the remaining 6 by November 2003.

In consultation with Government, we have agreed to produce our reports separately in a phased manner, as the work has been completed. This is the final report from the Review and deals with the reform of law.

As with all of the other Expert Working Committees, the Legal Issues Committee has adopted an evidence-based approach to its work, drawing especially on recent developments in law and practice and taking account of the experience in the rest of the United Kingdom, in the Republic of Ireland and internationally on the introduction of mental health and related capacity legislation.

The Review is grateful to the many external contributors who have helped us develop our thinking on this important and complex subject; and I particularly want to thank Master Brian Hall who has chaired the Legal Issues Working Committee and has brought its work to this crucial stage of consultation.

The Review's proposals for law reform are quite radical. I commend the Report to you and look forward to receiving your comments.

Roy J McClelland (Professor)
Chairman

February 2007

PREFACE

The Minister for Health, Social Services and Public Safety established the Review under the Chairmanship of the late Professor David Bamford in October 2002. The Terms of Reference for the Review, set out in Annex 1, focused on the existing provisions of the Mental Health (Northern Ireland) Order (the 1986 Order) and directed that particular account be taken of issues relating to incapacity, human rights, discrimination and equality of opportunity.

The Legal Issues Working Committee (the Committee), together with its sub-groups, whose membership is set out in Annex 2, has examined all the provisions of the 1986 Order and has taken account of continuing developments in law and practice in neighbouring jurisdictions. The Committee has also taken careful account of the contributions of stakeholders and the service users' and carers' Reference Groups within the Review. These Groups have examined critically both the current level of service provision and the suitability of existing statutory powers to serve the needs of people with mental health difficulties or a learning disability.

This Report represents the distillation of a great volume of work. In order to produce a concise document, the text is confined to the most significant aspects of each topic scrutinised, leading to specific recommendations. The more detailed consideration of particular topics provided by the Committee's sub groups is available on the Review's website www.rmhldni.gov.uk

An easy-read summary version of this Report has also been produced. This can be obtained from the Review's Support Team, Annexe 6, Castle Buildings, BT4 3PP (tel: 028 90 522067) and is posted on the Review's website (above).

In addition, for ease of reference in reading this Report, a number of short terms or abbreviations have been used, a list of which appears in the Glossary.

GLOSSARY OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

ENACTMENTS

The 1983 Act	The Mental Health Act 1983
The 1986 Order	The Mental Health (Northern Ireland) Order 1986
The AWI Act 2000	The Adults with Incapacity (Scotland) Act 2000
The MHCT Act 2003	The Mental Health (Care and Treatment) (Scotland) Act 2003
The 2005 Act	The Mental Capacity Act 2005
The MH Bill 2006	The draft Mental Health Bill 2006

REPORTS

The Richardson Report	The Report of the Expert Committee: Review of the Mental Health Act 1983 (submitted in December 1999)
The Joint Committee Report	The Report of the Joint Committee on the draft Mental Health Bill 2004 (March 2005)
The draft Code of Practice	The draft Code of Practice (issued by the Department of Constitutional Affairs) setting out guidance on the 2005 Act
The MacLean Report	The Report of the Committee on Serious Violent and Sexual Offenders (submitted to the Scottish Executive, 2000)
The Millan Report	The Report on the Review of the Mental Health (Scotland) Act 1984 “New Directions” laid before the Scottish Parliament in January 2001

OTHER TERMS USED

The Review	The Bamford Review of Mental Health and Learning Disability (Northern Ireland)
The Tribunal	The Mental Health Review Tribunal for Northern Ireland
The Commission	The Mental Health Commission for Northern Ireland
The RQIA	The Regulation and Quality Improvement Authority
The Court	The High Court of Justice (Family Division)
User of Services	A person who is receiving or may require health care services or treatment or who lacks capacity and who is receiving or may require protection or support under any statutory provision relating to the Review
Advocate	A person appointed to provide advocacy services (whether statutorily defined or otherwise)
Attorney	A person appointed by a user of services to act on behalf of him or her under a Lasting Power of Attorney
Nominated person	A person nominated to represent the interests of the user of services
RMO	Responsible Medical Officer

INTRODUCTION

1. The values base of the Review, articulated systematically in the Human Rights and Equality of Opportunity Report, has underpinned our consideration of legislative reform. We have sought to specify a framework (hereafter referred to as the "Framework" for future legislation) which reflects the need to respect the rights of all citizens, to provide rights for those whose freedoms may need to be interfered with on healthcare grounds, where appropriate, to protect public safety and the need to encourage best practice generally.

2. The Framework proposals are not an attempt at legislative drafting, but a description and an explanation of what is considered necessary for reforming existing legislation, applying a principles-based approach.

3. The values base on which modern Mental Health legislation should rest (Chapter 1) and the need for changes to existing provision (Chapter 2) have been informed by a review of developments in human rights and Mental Health law (national and international) and by a review of the Mental Health (Northern Ireland) Order 1986 (Chapter 3). Detailed consideration has been given to the principles which should underpin future legislation (Chapter 4) and to how a principles-based approach should inform provision (Chapter 5). Based on these considerations, a new legislative Framework has been formulated (Chapter 6) and a model example presented to demonstrate how such a Framework might operate in practice (Chapter 7). The next steps in this proposed reform process, including the principal recommendations from this review of legislation, are then set out (Chapter 8).

4. A major advantage of the present Review has been the opportunity for a joined-up approach to service modernisation and reform of legislation. The legislative proposals within this Report will only be fully effective if there is a full range of appropriate community and hospital services. The specifics of such service provision are the subject of other Reports from the Bamford Review.

5. In the course of the Review, the Office of Law Reform (OLR) indicated its intention to bring forward proposals for Capacity legislation, in line with recent developments in Scotland, England and Wales. The proposal to introduce Capacity legislation in Northern Ireland is welcomed by the Review and OLR is awaiting the Review's proposals for legislative reform before proceeding further.

CHAPTER 1

VALUES AND PRINCIPLES

1.1 The Review has recognised from the outset that new legislative proposals for Northern Ireland should be based on agreed principles. They should have regard to human rights and the dignity of the individual and should provide equally for all circumstances in which an individual's autonomy might be compromised on health grounds.

1.2 Issues of compulsory detention raise a number of particularly difficult legal problems. The international and European evidence base, "suggests that a complex set of still poorly understood legal, political, economic, social, medical and multiple other factors seems to interact in the process of involuntary placement" (Faulkner, 1989). The local evidence base is limited. For these reasons, it is particularly important that the values and principles underlying any new legislation are clearly stated.

1.3 Our present concepts of human rights have developed from common law, the Universal Declaration of Human Rights in 1948 and the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care in 1991. Principles reflecting these are increasingly being included in legislation as the basis of law where they can have even broader impact in shaping public attitudes and developing person-centred services, rather than separately specifying civil liberties and political freedom. This is in keeping with the European Convention on Human Rights and the spirit of the Human Rights Act 1998.

1.4 The comprehensive nature of this Review allows the same core values to run throughout its deliberations. This ensures an integrated and co-ordinated approach to its work.

1.5 The vision underpinning the Review is a valuing of those with mental health needs or a learning disability, including their rights to full citizenship, equality

of opportunity and self determination. The vision also looks to a reform and modernisation of services that will make a real and meaningful difference to the lives of people with mental health needs or a learning disability, to their carers and families. It emphasises promoting the mental health of the whole community and addressing mental health through preventative action; and acknowledges the essential role of carers.

1.6 The commitment to a principled approach was promoted in the Review's Human Rights and Equality of Opportunity Report (2006) which states "Because a person has a mental health problem or a learning disability does not of itself mean that he or she is incapable of exercising his or her rights" (paragraph 4.5). That Report highlights (at paragraph 3.1) particular barriers preventing people from exercising their rights including:

- assumptions made about a person's capacity;
- lack of knowledge and/or support to exercise rights;
- unequal access to services and opportunities in employment, education, transport and access to and participation in the criminal justice system;
- stigma and prejudice; and
- staff attitudes.

1.7 The Report makes recommendations regarding:

- citizenship;
- involuntary detention;
- capacity;
- representation at Mental Health Review Tribunals; and
- advocacy.

These recommendations have informed the work of the Review and should be read in conjunction with this Report to provide the context of the principles described below.

The Principles Base

1.8 A sound ethical base for legislation is the cornerstone around which specific proposals should be formed. The following overarching principles, which are elaborated on in Chapter 5, recognise and support the dignity of the person. They form the basis of the Review's proposals for legislative reform:

i **Autonomy - respecting the individual's capacity to decide and act on his own and his right not to be subject to restraint by others.**

ii **Justice - applying the law fairly and equally**

iii **Benefit - acting in the individual's best interests**

iv **Least Harm - acting in a way that does not harm the individual**

1.9 While the principles necessarily refer to the individual concerned, those persons who provide informal care to users of services (such as family or friends) should be accorded due respect for their role and experience, be given appropriate and timely information and advice and have their views and their own needs taken into account.

1.10 Having a recognition and acceptance of principles does not provide a means of choosing between them. There remain fundamental tensions between autonomy and benefit, for example where emphasis on benefit can lead to paternalism. However the need to have regard to all the principles provides a balance in the process.

1.11 A principles base which respects the dignity of the person whose decision-making capacity is impaired will also respect the dignity and safety of others in the rare cases where that person's behaviour poses a risk. A balance must also be struck between private rights and public safety.

1.12 Principles underpinning legislation will only have effect if they are translated into clear provisions, if there are adequate services to provide good quality

treatment and care to allow them to act as intended and when all those operating the legislation have adequate education and training. The impact of the principles in the Code of Practice for the 1986 Order was reduced because of delay in publication and a failure to deliver an associated training programme. Principles must be incorporated into the new law and elaborated on in a Code of Practice. The new legislation, the Code of Practice and related training programmes must be introduced at the same time.

CHAPTER 2

THE NEED FOR CHANGE

Legislation in Northern Ireland

2.1 The purposes of Mental Health legislation in Northern Ireland, as elsewhere, are:

- to provide the legal authority and basis for the delivery of mental health services;

- to protect people who are vulnerable by virtue of mental disorder or learning disability from abuse and exploitation; and

- to regulate the circumstances in which people with a mental disorder can be detained, and, if necessary, treated against their will, for their own protection and/or the protection of others.

2.2 Rooted in nineteenth century legislation that was primarily concerned with safety issues (public and private), the current law has moved towards a growing recognition of the rights of those most affected by the law – users of mental health and learning disability services.

2.3 Some of the major developments can be summarised by referring to the laws that made them possible, outlined below:

- The Mental Treatment Act (Northern Ireland) 1932;
- The Mental Health Act (Northern Ireland) 1948;
- The Mental Health Act (Northern Ireland) 1961; and
- The Mental Health (Northern Ireland) Order 1986.

2.4 Informal treatment for mental disorder became possible under the 1932 legislation and then became the norm after 1961. The 1961 Act also established a Mental Health Review Tribunal, which gave legal protection and a right of appeal to persons subject to compulsory detention and treatment.

2.5 A Mental Health Commission was introduced after 1986 to protect the individual's rights to care and treatment, and a revised power of Guardianship was created to protect and support patients in the community.

2.6 Legislation also made possible the establishment of new specialist services for people with learning disability and substance misuse (1948), the promotion of mental health (1961), the introduction of new approaches to assessment for hospitalisation, including special training for Approved Social Workers (1986) and, finally, a guaranteed right to information for users of services (1986).

2.7 The impetus for change at each of these stages of law reform came from changes in society and the professions, influenced by developments in other jurisdictions and by innovative practice at local level. Since 1986, new opinions have been articulated by health and welfare professionals (reflecting changes in scientific knowledge); by the public (reflecting changes in views on health, illness, safety, and risk); by lawyers (reflecting changes in mental health law elsewhere); and, most importantly, by users of mental health and learning disability services and their carers (reflecting their experiences with the current mental health system). The most important drivers of the current review can be summarised as follows:

- the voice of users of services and their carers;
- changes in society and professional practice;
- the Human Rights agenda;
- changes in Mental Health law in other jurisdictions; and
- the introduction of Capacity legislation in other jurisdictions.

Users of Mental Health Services and their Carers

2.8 Because of the importance of the opinion of those most affected by any change in Mental Health legislation, the perspective of this constituency is given priority here. On models of care, users of services and their carers told the Review:

- emphasis must be given to a holistic person-centred approach, which is respectful of the individual and delivered in a way that avoids stigma;

- services should be 'Recovery' focused, promoting a mutual connection between the clinician and service user, and involving a wide range of approaches to empower people to achieve their potential and lead a fulfilling life;

- advocacy services need to be developed (especially peer advocacy) as a valuable contribution to empowerment by assisting the individual to exercise choice in relation to care and treatment;

- responses to mental health crises need to be open, respectful and just, demonstrating accountability and transparency;

- policies and services need to be based on human rights, equality and assessment of need;

- community service responses should be the norm as there is still a fear of institutionalisation among users of services; and

- mental health services need to be adequately resourced.

2.9 In relation to possible changes in the law, users of services and their carers highlighted the following points:

- a welcome for the shift in focus towards a capacity-based approach;

- adequate legal protection must be in place for people subject to compulsory powers of any kind, whether in hospital or in the community;

- people with personality disorders should not be discriminated against, either directly or indirectly. They should have access to services which may be of benefit to them; and

- some users of services expressed concern about proposals to broaden the current criteria for compulsory admission to hospital by including psychological as well as physical harm as a risk.

2.10 Users of services have a significant contribution to make to staff education and training and service planning and delivery.

2.11 Concerns about treatment approaches centre around the perceived emphasis on medication with insufficient choice in both the relative importance of medication and its type. The need for more therapies guided by psychological and social approaches was emphasised, echoing the holistic approach above.

2.12 Users of services recommend the introduction of Living Wills or Advance Directives for mental health treatment so that their views can be known and respected.

2.13 Carers acknowledge the complex and sensitive relationships issues that can arise with mental health services users and their families. Carers also emphasise the contribution they can and wish to make to the development of care plans and the delivery of appropriate support packages to users of services.

2.14 Carers seek respect for their role and an obligation for them to be consulted and involved in service planning and delivery.

Changes in Society and Professional Practice

2.15 There have been significant developments in community-based care. These have extended alternatives to hospital care and treatment and should result in more local options in less restrictive forms of care. These include Home Based Treatment and Assertive Outreach teams and the further development of social and psychological therapies, as described in the Review's Report, A Strategic Framework for Adult Mental Health Services (2005).

2.16 For people with learning disability it is accepted that community living with appropriate support and care is the norm, with specialist treatment needs met using the same standards and, where possible, the same services as others (Equal Lives Report (2005)). There have been developments in diagnostic practice to improve the identification of mental illness affecting people with a learning disability (Diagnostic Criteria – Learning Disability (2001)) and, in turn, more appropriate treatment and services have been developed.

2.17 Issues of stigma continue to be identified. Despite advances in practice, the use of Mental Health legislation in situations of care and treatment continues to be experienced as stigmatising to many individuals, including those with a learning disability.

2.18 The advocacy movement continues to grow and gain recognition. This has enabled more effective participation of users of services and their carers in the planning, delivery and monitoring of services.

2.19 There is a general acknowledgment among mental health professionals that social and environmental factors impact on mental health and illness. Therefore, in more complex cases, single solutions based on medicine alone need to be replaced by multi-disciplinary approaches to care that address the relevant biological, psychological and social factors.

Human Rights Requirements

2.20 Although the European Convention on Human Rights (the ECHR) had been in existence for decades and, with it, the European Court of Human Rights, a series of cases focusing on possible infringements of rights in the provision of mental health care led to an increasing concern about gaps in the existing statutory provisions throughout the United Kingdom. While some of these cases have focused on people who lack decision-making capacity, others have highlighted the rights of people with a psychiatric diagnosis (regardless of their legal status) to a full assessment of their situation, a fair hearing if they object to treatment, and to representation and advice in relation to decisions that will affect their lives and those of their children.

2.21 The passing of the Human Rights Act 1998 resulted in the incorporation of the ECHR into United Kingdom domestic law and highlighted the need for Mental Health law to be revised to ensure compliance with the ECHR. This reinforced the importance of individual rights and freedoms and made more explicit the duties and obligations of those who are responsible for implementing and monitoring legislation that impacts on vulnerable people.

2.22 The Northern Ireland Human Rights Commission, having considered the1986 Order in the light of the new human rights agenda, produced Connecting Mental Health and Human Rights (NIHRC, 2003).

2.23 The NIHRC report has served as a valuable source of comment to the Review, whose own Report, Human Rights and Equality of Opportunity, has confirmed the need for Mental Health legislation in Northern Ireland not only to take account of international concerns but also to comply with the equality obligations of Section 75 of the Northern Ireland Act 1998.

Changes in Mental Health Law in Other Jurisdictions

Scotland

2.24 In relation to the reform of Mental Health law, Scotland is ahead of other jurisdictions within the United Kingdom, with the Mental Health (Care and Treatment) (Scotland) Act 2003 (the MHCT Act 2003). The 2001 report, New Directions, of the committee established under the chairmanship of Rt. Hon. Bruce Millan to review the Mental Health (Scotland) Act 1984, formed the basis for this Act.

2.25 For the first time in the United Kingdom, Mental Health legislation begins with a statement of principles on which all interventions must be based. Informal treatment is regarded as the norm. The ethical and practical basis for compulsory detention and treatment was revisited by the committee and it was recommended that it should be the combination of impaired judgement, risk, and benefit to the individual with mental disorder.

2.26 There is a significant strengthening of the rights of users of services in the MHCT Act 2003, including new rights for voluntary patients; rights to assessment and to services (under the principle of reciprocity); the introduction of Advocacy support; and the encouragement of the use of Advance Statements for mental health care and treatment.

2.27 This legislation was implemented in October 2005 and its operation is being carefully monitored by the Scottish Mental Welfare Commission. Scotland also had the advantage of having a parallel process examining the assessment and risk management of high risk offenders through the MacLean Committee (Report of the Committee on Serious Violent and Sexual Offenders, Scottish Executive, 2000). Emphasis is on the risk posed rather than the cause of it and, since 2003, risk is managed in the same way for all such offenders, whether or not they have a mental disorder.

England and Wales

2.28 In England and Wales, the Department of Health established an Expert Committee under the chairmanship of Professor Genevra Richardson to review the Mental Health Act 1983 (Richardson Report, 1999). The Committee re-examined the ethical basis for the use of compulsion for people with a mental disorder and highlighted the pivotal importance of the effect of the mental disorder on the individual's decision-making, by suggesting that impaired decision-making be considered as the basis of interventions in Mental Health legislation. Although the Joint Committee of both Houses of Parliament set up to scrutinise the Mental Health Bill 2004 supported this view, the Government rejected this and other proposals and the Bill was subsequently withdrawn.

2.29 A decision was then made by the Government in November 2006 to amend the 1983 Act rather than introduce a comprehensive new statute. The main proposals in the MH Bill 2006 are more limited in their modernising objectives. The Bill seeks to introduce supervised community treatment, to simplify the definitions and exclusions, change the treatability criterion for compulsory treatment and extend professional roles. While strengthening some patient protections and addressing Human Rights incompatibilities it does not include patients' rights to Advocacy services. Advance Statements about treatment may be included in the draft Code of Practice but not in the legislation. Principles should be set out in a Code of Practice but not on the face of the legislation.

The Republic of Ireland

2.30 In the Republic of Ireland, the most recent Mental Health law is the Mental Health Act 2001, significant elements of which were implemented on 1 November 2006. It is an easily-read statute which strengthens the rights of users of service by introducing a Mental Health Commission and gives early automatic reviews of detention for every patient by a Mental Health Tribunal. Initiatives in relation to care of older people, vulnerable adults and individuals

who lack capacity will also have an impact on mental health services. The land border between Northern Ireland and the Republic gives particular significance to this legal interface between these jurisdictions.

The Introduction of Capacity Legislation in Other Jurisdictions

2.31 Extensive debates took place in England and Wales throughout the 1990s on the need for legislation to underpin common law in situations where decisions have to be made for persons who lack the capacity to make those decisions themselves (often because of mental disorder or disability). These debates led to the Law Commission's Report on Mental Incapacity in 1995, the Green Paper "Who Decides? Making Decisions on behalf of Mentally Incapacitated Adults" in 1997 and Government proposals for legislation outlined in a White Paper "Making Decisions" in 1999.

2.32 It was clear that, with the exception of some provisions for the protection of the property and finances of certain individuals under existing Mental Health legislation, there were very few legal protections in these situations. The Human Rights Act 1998 highlighted the need for legal justification for any interference with the rights of another person and legal protection for those who do so.

2.33 Scotland was first to pass a statute to meet the concerns articulated by these debates - the Adults with Incapacity (Scotland) Act 2000 (the AWI Act 2000). This Act includes all the provisions for welfare Guardianship which originally fell under Mental Health legislation. Significantly for the work of the Northern Ireland Review, the Millan Committee recommended that Mental Health law and Capacity provisions should, in due course, be consolidated into a single Act.

2.34 In England, the progress of the case commonly referred to as the Bournewood Case through the House of Lords to the European Court of Human Rights (HL v UK, 2004) highlighted the lack of legal protections for compliant persons

who are deprived of their liberty at a time when they lack the capacity to object.

2.35 The Government originally published a draft Mental Incapacity Bill for England and Wales which was examined in detail by a Joint Scrutiny Committee of both Houses of Parliament. Many suggestions made by that Committee led to the promotion of a revised Bill which, with further amendments made during its Parliamentary stages, was passed as the Mental Capacity Act 2005 (the 2005 Act).

2.36 The Irish Law Reform Commission in Dublin has recently published a report on Vulnerable Adults and the Law, setting out clear proposals for statutory provisions in relation to mental capacity and Guardianship. The report includes a Draft Scheme for a Bill to implement its key recommendations.

2.37 Northern Ireland stands alone within the United Kingdom in not having a statute dealing with Capacity. The OLR originally carried out a consultation exercise in Northern Ireland on the Lord Chancellor's Green Paper (of 1997) and began a preliminary examination of the Mental Capacity Bill 2004 during its Parliamentary stages in 2005. In acknowledgement of the emerging interface with other related legislation, however, the OLR is waiting for the conclusions of the Bamford Review before proceeding with this work.

2.38 The experience gained from the introduction of Capacity legislation in England and Wales and in Scotland and the proposals for law reform in the Republic of Ireland point to the importance of considering carefully the interface between the two types of legislation, Mental Health statutes and Capacity law, and provide valuable information for proposed legislation in Northern Ireland.

The Convention on the International Protection of Adults

2.39 The International Convention signed at The Hague on 13 January 2000 makes essential provision for the recognition and enforcement of protective measures made in respect of the person or property of an incapacitated adult in other Convention countries. The Convention has been ratified in Scotland by the AWI Act 2000 and in England and Wales by the 2005 Act. The implementation of the Convention in Northern Ireland would be welcome.

CHAPTER 3

AN APPRAISAL OF THE 1986 ORDER

3.1 In formulating proposals for changes in legislation it has been essential to make a fresh appraisal of the 1986 Order, its strengths and weaknesses, against the background of significant changes in Mental Health and Capacity legislation introduced or proposed in neighbouring jurisdictions. Account has been taken of the submissions made to the Review by users of services, carers and other stakeholders. The Committee and its sub groups have also had the benefit of considering the detailed analyses contained in the reports of committees and other commentaries relating to recent developments in Scotland, England and Wales, and in the Republic of Ireland.

General Comments

3.2 The 1986 Order incorporated many of the recommendations contained in the Report of the Northern Ireland Review Committee on Mental Health Legislation (October 1981) (the MacDermott Report) and also took account of the provisions then enacted in the English 1983 Act and the Mental Health (Scotland) Act 1984 – both of which had been subjected to detailed scrutiny and amendment during their passage through Parliament. The overall purpose of the Order was to provide for care, treatment and protection of people suffering from mental disorder. The measure is a combination of powers and protections including compulsory hospital-based detention and treatment, involuntary community care without treatment provisions (Part II), provision for those involved in criminal proceedings (Part III), separate consideration of capacity to consent to treatment for mental disorder (Part IV), protections for all those with mental disorder through the Mental Health Commission (the Commission) (Part VI), legal protections for those detained through the Mental Health Review Tribunal (the Tribunal) (Part V), "capacity type" protections for people with mental disorder who are unable to manage their financial affairs (Part VIII), and protections from sexual and other abuse through defining specific offences (Part X).

3.3 Significant features of the Order have been the provision of Guardianship as a less restrictive alternative to detention in hospital, establishment of a Mental Health Commission, increased access to the Mental Health Review Tribunal, more stringent criteria for compulsory admission to hospital, an assessment period before detention for treatment, consent to treatment provisions and arrangements to keep patients and their nearest relatives fully informed of their rights. The Order also provided for management and administration of the financial affairs and property of people deemed incapable by reason of mental disorder. To ensure the proper implementation of the legislation a Code of Practice was to be introduced and revised from time to time and, in recognition of the importance of social factors and circumstances, a duty was imposed on Health and Social Services Trusts to appoint adequate numbers of competent Approved Social Workers.

3.4 However, the use of compulsory powers was based on "substantial likelihood of serious physical harm", with narrower criteria than anywhere else in the United Kingdom, thereby excluding some people with severely deteriorating conditions by disregarding psychological harm. The specific exclusion of persons disabled "by reason only of personality disorder" may have disadvantaged such persons in accessing assessment and treatment.

3.5 The Code of Practice was not issued until five years after the Order came into operation and the introduction of the Order was not supported by a comprehensive education or awareness strategy. The Commission was not adequately resourced and as a consequence it could not satisfactorily fulfill its function to monitor and protect those outside hospital. Experience of the use of the Order has shown difficulties with the application of terms used - for example, "severe mental impairment". There are many aspects of its operation which users of services and carers find paternalistic.

3.6 A range of submissions from stakeholders also highlighted widespread concerns about the absence of a statutory basis for decision making on behalf of adults, the need for services to be adequately resourced to allow informal

access to care and treatment where possible, the limited usefulness of the powers of Guardianship and the role of a nearest relative as applicant for compulsory admission.

Compulsory Admission to Hospital

3.7 Part II of the 1986 Order, reflecting equivalent provisions in the English 1983 Act and giving effect to key recommendations in the MacDermott Report, sets out the procedures relating to the compulsory admission of patients to hospital – initially for assessment and, if necessary, for treatment. The principle of having a period of assessment with broader entry criteria has worked well and may serve as the basis for future practice subject to essential amendments. However, there is a need for re-definition of the grounds upon which an application for assessment should be founded and of the essential roles to be discharged by professionals involved.

Admission Procedures

3.8 The Review's Report on Human Rights and Equality of Opportunity (2006), identified a concern about the second ground upon which an application must be founded – which appears in Article 4(2)(b) that there is a substantial likelihood of serious physical harm to himself or to other persons and it is noted that in the MHCT Act 2003 in Scotland this statutory requirement has been expressed as "a significant risk to the health, safety or welfare of the patient or to the safety of any other person."

3.9 It is the general view that the special status accorded to the nearest relative of a patient in the 1986 Order and, in particular, the right of that person to make an application for assessment, defined in Article 5(1)(a), should be repealed. On the other hand it is essential that full recognition be given to relevant views expressed by attorneys, nominated persons, carers and, where appropriate, the nearest relative. If no such representative of the patient is available to be consulted and informed of proposals to have the patient admitted to hospital

for assessment and treatment it should be essential to engage the service of an independent (accredited) advocate.

3.10 The current requirements of Article 4(3) of the Order envisage that the medical recommendation required in support of an application may be supplied by the patient's own GP or another doctor who has recently been involved in his/her care or treatment. Following the introduction of the General Medical Service contract it has become increasingly difficult to ensure that the first choice sources of supporting recommendations should be knowledgeable and experienced practitioners – as contemplated in the general provisions prescribed in Article 6 of the Order. In practice it has been increasingly apparent that recommendations are being sought from another doctor in general practice or a doctor in hospital who may have limited knowledge of the statutory procedures or diagnostic issues involved and no previous connection with the patient. There is an incontrovertible case for insisting that all professionally qualified persons engaged in the initial stages of an application should be trained and approved for the purpose. Appropriate facilities should be provided to enable such sensitive and stressful interventions to be undertaken with dignity and in privacy.

3.11 While the preliminary recommendation for admission and the initial confirmatory assessment made by the hospital doctor formally admitting the patient may be undertaken by professionals trained and accredited for those purposes it is essential that a more detailed assessment be undertaken by a responsible medical officer of consultant status, as soon as possible. It will be essential to review the present arrangements for the appointment of appropriate practitioners for the purposes of Part II by the Mental Health Commission so that accredited training is a pre-requisite. It is also been submitted that in order to make a satisfactory comprehensive assessment in complex cases the periods permitted by Article 9(7) and (8) – up to 14 days, is not sufficient and should be extended with appropriate protections.

Guardianship

3.12 Guardianship, as now defined in Articles 18-26 of the 1986 Order, is intended to provide a means of caring for certain mentally disordered people who require formal supervision in the interests of their welfare but who do not need to be detained in hospital. The care provided may relate to more effective protection of their welfare or living arrangements, require the person to attend for medical treatment, occupation, education or training and to allow access to specified professionals.

3.13 Guardianship has been used successfully to protect persons with severe mental handicap and increasingly with persons with dementia and with chronic mental illness. The optimum benefit of Guardianship can only be achieved by the willingness of all the parties involved to work together and concerns have arisen regarding lack of clarity around issues of compulsion, for example to return the person to the designated residence. There is, in addition, a need to clarify the procedures which may lead to emergency applications for the protection of a patient and to ensure that short term welfare arrangements are accessible immediately.

Patients Concerned in Criminal Proceedings or Under Sentence

3.14 Part III of the Order contains provisions for patients concerned in criminal proceedings or under sentence. These include powers that enable Courts to remand an accused person to hospital for a report on his mental condition (Article 42), to remand a person to hospital for treatment (Article 43), to make a person the subject of a hospital order or guardianship order (Article 44) or an interim hospital order (Article 45). Part III of the Order also contains provisions for transfer direction orders which enable the transfer of prisoners to hospital for treatment and it contains arrangements in relation to individuals who are found legally insane or unfit to stand trial. In certain situations, where it is necessary to protect the public from serious harm, individuals may be made the subject of a restriction order which restricts their leave, transfer or discharge from hospital.

3.15 Thus the Order contains many useful provisions that form a solid legislative foundation for the assessment, treatment and care of mentally disordered offenders and others with similar needs. The Review's Report on Forensic Services (2006) has made wide-ranging recommendations for the future development of forensic services. In order to support these proposals and to update the current legislation a number of issues require to be addressed, for example:

- The powers to remand individuals to hospital do not extend to the Court of Appeal and do not make provision for the granting of temporary leave in appropriate circumstances.

- When recommendations are made to the Court for disposals such as a hospital order there are no specified time periods within which the individual should have been assessed.

- Where there are recommendations to the Court that an individual should be admitted to hospital but the individual is acquitted at Court there are no arrangements to provide for appropriate assessment, treatment and care.

- There are no legal mechanisms to ensure that certain types of prisoners, such as those on remand or those who may require an interim hospital order, can be transferred to conditions of high security for assessment, treatment and care.

- Prisoners who are transferred to hospital for treatment under the current Mental Health legislation are treated on a compulsory basis even when they have the capacity to accept their treatment on a voluntary basis.

- Prisoners can be transferred to hospital for treatment while the subject of a transfer direction order, but the current arrangements do not provide for transfer for assessment followed by treatment.

- The current arrangements could be improved to ensure that the Court makes its decisions on disposal after the individual has undergone detailed assessment.

- The range of disposal options for mentally disordered offenders could be increased in line with experience in other jurisdictions.

- Additional rights of appeal should be introduced in certain circumstances, including a right of appeal against detention in conditions of excessive security or restriction.

- Outmoded or pejorative terminology should be replaced, for example in relation to the legal term “insanity”.

- Measures under the Mental Health legislation which aim to protect the public from serious harm should be placed within a wider risk management framework so that they do not discriminate unjustifiably against people suffering from certain types of mental disorder.

Consent to Treatment

3.16 Part IV of the 1986 Order introduced new statutory provisions to clarify the circumstances in which detained patients (including patients admitted for assessment) may be given specified treatments for mental disorder without their consent and extended protections to all patients for some of the most serious treatments.

3.17 Services users’ and carers’ representatives have also been concerned to ensure that full protection will be afforded to a patient in establishing his/her known wishes in relation to particular forms of treatment.

3.18 Particular concern was expressed about the provision to allow the use of electro-convulsive therapy (ECT) for those who retain decision-making capacity and also the extent to which advance decisions indicating the refusal of certain treatments might be ignored by doctors proposing particular treatments.

3.19 There is a need to revisit the circumstances in which decisions might be made about treatment on behalf of other people and to revise the classification of specified treatments taking account of the re-appraisal of such treatments in England and Wales and the new definition of treatments and additional safeguards found in the MHCT 2003 Act in Scotland.

The Mental Health Review Tribunal for Northern Ireland

3.20 The Tribunal was established in Northern Ireland by the 1961 Act to provide a safeguard for detained patients specifically against unjustified detention by means of a review of the detention from medical, legal and lay points of view. Part V of the 1986 Order sought to strengthen the Tribunal (by increasing its membership and widening its powers) and also extended the rights of access to it. The patient is prima facie entitled to be at liberty and the burden of proof is on the detaining Authority as clarified by the Mental Health (Amendment) (Northern Ireland) Order 2004 to ensure compliance with the Human Rights Act.

3.21 Stakeholders generally support the existence of a Tribunal system. However, the following concerns have been expressed by users of services: a patient is often regraded to voluntary status just before a Tribunal hearing, which leads to lack of accountability for the preceding period of detention; the choice of venue where hearings are held may not be appropriate patients are often unwilling to ask for Tribunal hearings; and patients would welcome the support of skilled advocacy services.

3.22 Professionals expressed concern about adequate hearings for those patients who refuse legal representation and about the potential detrimental effect of a full hearing against the patient's wishes in those cases referred for automatic review. The Review's Human Rights and Equality of Opportunity Report makes specific recommendations in relation to the entitlement of patients to have specialist legal representation before the Tribunal without charge; to appoint a representative of his/her choice; and to have the assistance of an advocate, when appropriate.

The Mental Health Commission for Northern Ireland

3.23 Part VI of the 1986 Order established the Commission as an independent multi-disciplinary body with regulatory, investigative, inspectorial and advisory functions. The primary function of the Commission, defined in Article 86(1), is to "to keep under review the care and treatment of patients", to protect the interests of mentally disordered individuals and to safeguard staff involved in their care and treatment. For this purpose such individuals may be patients – both voluntary and detained, persons placed in Guardianship, persons receiving out-patient care and those residing in nursing or residential care accommodation (and anyone else suffering from mental disorder). The discharge of that wide ranging responsibility has been constrained from the outset by the lack of resources and the lack of an agreed operational plan.

3.24 In the period since the initial submissions were made to the Bamford Review there has been a fundamental Review of Public Administration throughout Northern Ireland. As part of that initiative the Secretary of State made a formal announcement on 21 March 2006 of his intention to proceed with a transfer of the functions of the Commission to the Regulation and Quality Improvement Authority (the RQIA) to be achieved by April 2008.

3.25 It will be essential to establish a comprehensive range of functions to be defined in new legislation – supplementing the present range of responsibilities of the RQIA set out in the Health and Personal Social Services

(Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The RQIA should monitor and regulate the services provided to people with mental disorder or learning disability irrespective of where they may receive care or treatment – in the community, in hospital or in prison. The new arrangements must guarantee the delivery of an effective service replacing and extending the role of the present Commission.

Management of Property and Affairs of Patients

3.26 The provisions set out in Part VIII of the 1986 Order, based upon the equivalent sections of the English 1983 Act, define the circumstances in which the Court may exercise jurisdiction in relation to the property and affairs of a person who lacks capacity to manage such matters as a result of mental disorder. The current arrangements must therefore be reviewed in the light of the 2005 Act. It will be necessary to consider the replacement of the present provisions of Part VIII in conjunction with recommendations which cover the enlargement of the jurisdiction of the Court and related procedures including the creation of Lasting Powers of Attorney which should be introduced in Northern Ireland.

The Court

3.27 All jurisdiction relating to persons with impaired decision-making capacity in Northern Ireland is vested in the High Court and judicial responsibility lies with the Family Judge (or another Judge assigned by the Lord Chief Justice) and with the Master (Care and Protection). In this respect the position in Northern Ireland differs from that in England and Wales where the Court of Protection is established outside the High Court. The Review does not consider that the creation of a separate Court of Protection would be necessary or appropriate for Northern Ireland and there is adequate provision in the Judicature (Northern Ireland) Act 1978, as amended, to assign responsibility to Judges and statutory officers and to deal with the arrangement of Court business at specified venues.

The Office of Care and Protection

3.28 The current responsibilities of the Office of Care and Protection (the OCP), which is a department of the High Court, will have to be critically re-examined in the light of new arrangements for the discharge of equivalent functions in Scotland and in England and Wales. The creation of a separate statutory office of the Public Guardian has recently been recommended by the Law Reform Commission in the Republic of Ireland. The specific management and supervisory role of the post of Public Guardian in each of these jurisdictions is seen to be quite distinct and separate from the judicial functions of the Court.

3.29 The range of functions currently undertaken in the OCP is significantly greater (and arguably more effective) than is found in neighbouring jurisdictions. The availability of legal services to assist the OCP has been an essential component in the present system – providing valuable guidance in the initial stages of a case.

3.30 Having regard to the developing trends in neighbouring jurisdictions to restrict, as far as possible, official involvement in the financial affairs and welfare needs of an individual it will be necessary, in particular, to distinguish between office functions relating to formal applications to the Court and the current investigative and case management roles of the OCP considered in the next paragraph. The latter (purely executive) tasks should be critically reviewed and specific responsibilities re-assigned.

The Duty to Notify the Office

3.31 It is apparent from the terms of the 2005 Act and the draft Code of Practice in England that an application to the Court is intended to serve as a remedy of last resort and so far as possible, the affairs of an incapacitated adult should be resolved without recourse to formal legal proceedings. In contrast there has been a statutory duty imposed on local Health and Social Services Trusts (which is unique to Northern Ireland) to notify the OCP of cases where any of the powers of the Court ought to be exercised. While these arrangements have

worked well and have provided a valuable level of protection to individuals and to social work staff, there is a need to define more precisely the circumstances in which formal intervention (or "whistle blowing") would be justified in future.

3.32 If it is assumed that responsibility to make provision for an adult's welfare arrangements and personal needs should, in the first instance, lie with the person himself, his family, carers or nominated persons, the involvement of any outside agency should only arise where there is apparent neglect or risk to the adult. The local system of "early warning" of difficulties involving an adult has hitherto provided a higher level of protection than is found in other jurisdictions.

Offences

3.33 There is a need to review the range of offences and penalties now prescribed in Part X of the 1986 Order. The majority of those offences and of other new offences relating to incapacitated adults in the AWI Act 2000 and in the 2005 Act should be included in new legislation resulting from the Review. The two remaining offences defined in Article 122 (Protection of women) and Article 123 (Protection of patients) are being considered in the current review of the law relating to sex offences in Northern Ireland, which will extend the protections offered to vulnerable persons, as in England and Wales.

Places of Safety

3.34 Concerns have been expressed about the inclusion of a police station in the list of premises or establishments, other than a hospital, defined in Article 129(7), to which a patient may initially be removed by a constable as a place of safety. While it may be that the present definition should be preserved, the Department of Health, Social Services and Public Safety (DHSSPS) should undertake to provide a list of other suitable places at which patients may properly be detained and to which they may be delivered by a police officer

exercising new powers for the removal and detention of persons believed to be suffering from mental disorder.

Patients removed to or from Northern Ireland

3.35 Article 134 of the 1986 Order provides for the mental disorder of patients to be reclassified following their transfer from Great Britain and also provides for notification to be given in advance of a proposed transfer of a patient to Great Britain. Difficulties have arisen in practice by reason of the different between sub-categories of mental disorder and the exclusions set out in Article 3 of the Order and the corresponding statutory provisions in other parts of the United Kingdom.

3.36 It is essential that new legislation should authorise the issue of regulations dealing with the transfer of patients subject to corresponding measures enacted in adjoining jurisdictions. The lack of effective transfer arrangements with the Republic of Ireland is of special significance in view of the need to provide secure care and treatment for detained patients in the most appropriate part of Ireland.

CHAPTER 4

THE IMPORTANCE OF PRINCIPLES FOR LEGISLATION

Principles and the Mental Health (Northern Ireland) Order 1986

4.1 The work of the current Review relating to the mental health provisions in the 1986 Order has coincided with preparatory work by the Office for Law Reform (OLR) to introduce new Capacity legislation in Northern Ireland. This has provided a unique opportunity to consider the overall purpose of such legislation, the guiding principles underpinning each and gives an opportunity to develop a comprehensive approach to protecting and respecting the dignity of people with mental health problems.

4.2 While some elements of the current legislation are considered to work well (Chapter 3), it has become clear that much of the 1986 Order is not human rights compliant. Neither is it in keeping with developments in good practice, which emphasise partnership between patients and professionals and a holistic approach to care and treatment. Nor is it based on the principles which the Review has identified as essential. The individual's autonomy may be over-ridden in the interests of his own or other's safety, and the legal powers focus on compulsion, rather than ensuring appropriate treatment.

4.3 There is, moreover, no provision under the current Mental Health legislation to offer protections for patients who are incapable of consenting to admission or treatment, with the exception of particular treatments in Part IV as long as they are not resisting and are not posing a significant risk to themselves or others (The "Bournewood Gap", see Annex 3)

4.4 The Review considered the implications of including some of those provisions currently in the 1986 Order (for example finance, Guardianship and aspects of consent to treatment) within the proposed Capacity legislation. There was a reluctance to recommend that Guardianship be dealt with in a Capacity statute without retaining proportionate protections for the restrictions involved, which

are currently not included in Capacity legislation. Much of the difficulty arises because the fundamental assumptions in the statutes are different. The need to have consistency across all the areas of provision in terms of underlying principles and definitions was seen as crucial

4.5 In addition, a principled, human rights-based approach moves firmly from public protection as the priority towards safeguarding the rights and dignity of people with mental disorder and ensuring their access to appropriate care and treatment. When these have been firmly established for issues affecting the individual, it will then be necessary in some cases to balance these individual rights with the rights of others who may be placed at risk through the individual's behaviour. Adequate and proportionate provision must be ensured within legislation.

4.6 Mental Health legislation considered from a principles base requires a comprehensive approach which recognises the overlap with capacity issues, the needs of children and of those within the Criminal Justice System, including the interfaces with relevant legislation.

Requirements of Future Legislation

4.7 A rights-based approach is proposed as the guiding principle for reform of legislation. Such legislation respects the decisions of all who are assumed to have capacity to make their own decisions. Grounds for interfering with a person's autonomy must be primarily based on impaired decision-making capacity. New legislative solutions are required for issues posed by the effects of disorder of the brain or mind on decision-making which affect a person's own needs for care and treatment, his personal health, safety and welfare or the safety of others.

4.8 Legislative solutions must:

- respect and balance the key principles proposed by the Review (in Chapter 1), Autonomy, Justice, Benefit and Least Harm;

- reduce discrimination and stigma;

- be acceptable to and acknowledge the needs of users of services and their carers;

- acknowledge the need for provision of risk management and protection of self and the public, but maintain a healthcare focus;

- consider the need for "risk of serious harm" based legislation to override autonomy in those who retain capacity and find the best legislative place for this if required;

- use congruent principles, definitions and provisions to acknowledge the common population affected by Capacity and Mental Health legislation, and leave no gaps or confusion;

- acknowledge and make provision for variations in decision-making capacity over time in those affected by mental disorder, and balance these with benefit;

- clarify the interface with other legislation, for example, Criminal Justice and Children's legislation;

- be clear and efficient for professional staff to operate;

- be adequately resourced; and

- translate the intentions of, and be compatible with, the ECHR.

4.9 The Review proposes that the provision of care and treatment for mental disorder in relation to offenders or suspected offenders, and also their

protection from abuse or exploitation, should be dealt with under the same legislation as that which applies to non-offenders.

International Perspective on Legislation

4.10 There is no blueprint for this type of legislation and each jurisdiction has had to find the best solution for its own needs, culture, politics and time. However, the Review has benefited greatly from experience both internationally and elsewhere in the United Kingdom through literature reviews and contact with international and national experts. Particularly useful in this regard have been the World Health Organisation Resource Book on Mental Health, Human Rights and Legislation (WHO, 2005) and the two Reviews of Literature Relating to Mental Health Legislation commissioned by the Scottish Executive in 2001 and 2005.

4.11 The WHO Resource Book provides an international perspective on Mental Health legislation and highlights the key issues and principles that need to be incorporated into legislation for the policies and plans it implements to meet internationally accepted standards and good practice. It examines different models of achieving the best legal solution which might be tailored to each jurisdiction, emphasising the need for realistic and attainable goals within local constraints.

4.12 Progressive legislation can be an effective tool in promoting access to mental health care as well as promoting and protecting the rights of people with mental disorders. In the past, legislation has been perceived to focus on public protection and consequently may have been unnecessarily punitive and stigmatising to the individual. A principles-based legislation, to which the Review is committed, takes the different starting point of the individual's right to respect and dignity.

4.13 Legislation can also hinder policy development, for example, through not including provisions to support community treatment or through lack of enforcement powers. It works best if it is not regarded as an event but as an

ongoing process that evolves with time. This necessarily means that legislation is reviewed, revised and amended in the light of advances in care and treatment and improvements in service development and delivery. Provisions should be made in the legislation for the establishment of regulations for particular actions that are likely to need more frequent modifications. Then these can be reviewed within the process laid down and allow a flexibility and responsiveness to be built in.

4.14 The breadth of what is included under the umbrella of Mental Health legislation extends from the narrow functions of compulsory interventions for the care and treatment of people with mental illness, to the broader function of establishing an entitlement to services and rights and protections for all persons who fall under the wider term mental disorder, and then further to include the consequences of mental disorder on decision-making with protections for their health, welfare and finances. This latter group overlaps with people who have impaired decision-making from other causes (Capacity legislation).

4.15 Different countries have developed very different models (WHO, 2005). In some countries there is no separate Mental Health legislation and provisions relating to mental health are inserted into other relevant legislation. Other countries have consolidated Mental Health legislation where all issues, including mental capacity, are incorporated into a single Act. Many countries have combined these approaches as the need for different aspects of legislation has evolved over time. A principles-based approach is not bound to follow any one model, but demands that the approach be comprehensive so that the same principles can apply throughout.

4.16 In England and Wales and in Scotland the current approach is to move from consolidated Mental Health legislation which incorporates very limited capacity-type provisions for financial decisions (as currently in Northern Ireland) to separate Mental Health and Capacity legislation. However, the Millan Committee in Scotland viewed this as a developmental stage and recommended consolidation of the legislation in due course. For future

development of legislation in Northern Ireland, it is important to re-examine the purposes of these laws and how they fit the changing requirements of society and the approach the Review has adopted.

Origins of Mental Health Legislation

4.17 Mental Health legislation comes from a civil commitment and public protection background, where the emphasis originally was on detention for compulsory treatment based on the presence of mental disorder of a nature or degree to merit hospital based treatment, regardless of the capacity to consent, but dependent on the risk to self or others. In this model, a psychiatrist is usually given responsibility for decision-making and powers of removal and detention are given to other staff. Only treatments for mental disorder are authorised. These powers are closely monitored, reviewed and subject to appeal. They are expected to apply to only a few people who meet the strict criteria.

Origins of Capacity Legislation

4.18 In contrast, capacity-based schemes are a more recent legal development centred around authorising decision-making. They originally developed to provide for the management of property and finances of persons with deteriorating or enduring problems of brain or mind such as dementia or learning disability. Recent conceptual developments have moved from a status test, where a diagnosis brings with it a presumption of lack of capacity which is seen as enduring, to the use of a functional test where there is a presumption of capacity and each decision is considered separately.

4.19 If the person is found, following assessment, not to have capacity for the decision in question then substitute decision-making is authorised, either informally for others to act, or by an authorised decision-maker such as a Guardian or Deputy. Decisions must be made in the person’s best interests and significant or disputed decisions are made by a Court. Increasingly, weight is given to advance statements of preference or refusals which the

person may make while capacity is retained, or through authorising another person through lasting powers of attorney to make decisions on his behalf. Protections are largely substantive, through the process itself, rather than procedural, through a system of appeals.

The United Kingdom Position on Mental Health and Mental Capacity Legislation

4.20 As the Review considers that all persons with mental disorder should be respected and treated in the same ways, it was important to examine recent United Kingdom developments from these two standpoints, and in particular to consider those legislations which have adopted a principles base so that lessons can be learned from that experience.

4.21 In England and Wales, the Mental Health Act 1983 is essentially a civil commitment scheme that is now in the process of being amended through the MH Bill 2006. There are no proposals to include principles in the amended Act. However, it will interface with the Mental Capacity Act 2005, which is a principles-based statute.

4.22 In Scotland, the Mental Health Care and Treatment Act 2003 comes from a civil commitment background and regulates compulsory treatment for mental disorder, as defined. It also promotes the rights to services and treatment of people with mental disorder and is principles-based. It straddles the two traditions in legislation by having both a status test (mental disorder) and a functional test (impaired decision-making) as necessary together with risk for compulsory interventions. It interfaces with the Adults with Incapacity Act 2000, which also is principles-based.

4.23 The Review has considered both the 2005 Act in England and Wales and the AWI Act in Scotland, and this Report focuses on the former for a study of Capacity legislation, since it is widely acknowledged that it develops aspects of the Scottish model and, even more importantly, the OLR has proposed its use as the starting point for a model for legislation in Northern Ireland.

4.24 Given the different traditions and assumptions outlined above about Capacity provisions (previously mainly applying to patients incapable of managing their financial affairs) many people primarily concerned with mental health treatment will not be familiar with important developments in this field which have implications for future practice regarding health and welfare, for some people with mental health and learning disability issues. While some of the structures and processes in England and Wales are different and legislation would have to be adapted to transfer to Northern Ireland, it is important to become familiar with the main proposals which may transfer.

4.25 There follows an outline of this very recent legislation which the Review has taken into account even though the significance of some of these changes is only emerging. More detailed consideration is then given to the principles-based Mental Health legislation in Scotland and the interface issues between these types of legislation.

Introduction to the Mental Capacity Act 2005

4.26 The 2005 Act in England and Wales aims to protect the interests of adults who lack the ability to make decisions about their own finances, welfare or health, including medical treatment, or who are unable to communicate their decision, because of an impairment of, or a disturbance in the functioning of, the mind or brain. It is based on a functional approach to decision-making: that is, each decision is separately considered. Its application includes decisions about treatment for people with conditions from which they may recover, including mental illness.

4.27 The Act enshrines in statute current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. The Review welcomes many key aspects of the legislation, in particular that the principles are defined at the beginning of the Act. These are:

- a presumption of capacity - every adult has the right to make his own decisions and must be assumed to have capacity unless it is proved otherwise;

- the right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;

- that individuals must retain the right to make what might be seen as eccentric or unwise decisions;

- best interests - anything done for or on behalf of people without capacity must be in their best interests; and

- least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

4.28 These principles are, of course, very similar to the principles developed by this Review for inclusion in new legislation.

4.29 ***Assessing lack of capacity***. The 2005 Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision-specific" test. No one can be labeled 'incapable' as a result of a particular medical condition or diagnosis. Section 2 of the Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.

4.30 ***The capacity test.*** This includes the ability to understand, retain, use or weigh the information as part of the process of making the decision, or communicate the decision. This definition allows for the influence of delusions or disorder of mood as described in the draft Code of Practice.

4.31 ***Best interests***. Everything that is done for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if he so wishes, which the professional making the determination must consider. Carers and family members gain a right to be consulted

4.32 ***Acts in connection with care or treatment***. The Act aims to protect without excessive bureaucracy. Section 5 clarifies that, where a person is providing care or treatment for someone who lacks capacity, then the person can provide the care without incurring legal liability. The key will be proper assessment of capacity and best interests. This will cover actions that would otherwise result in a civil wrong or crime if someone has to interfere with the person's body or property in the ordinary course of caring or treatment, for example, by giving an injection or by using the person's money to buy items for them.

4.33 ***Restraint/deprivation of liberty***. Section 6 of the Act defines restraint as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm.

4.34 The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

- ***Attorney*** *(appointed under LPAs)* - The Act creates a new form of power of attorney, a Lasting Power of Attorney (LPA) to replace the present Enduring Powers of Attorney (EPA). Under a LPA donors may appoint other persons to act on their behalf if they should lose capacity in future. In addition to dealing with property and financial affairs an attorney,

acting under a LPA, may make decisions concerning the donor's personal welfare, including healthcare and consent to treatment.

– ***Court appointed deputies*** - Deputies may make decisions on welfare, healthcare and financial matters as authorised by the Court, but will not be able to refuse consent to life-sustaining treatment. Where possible, the Court will seek to resolve an issue affecting a person who lacks capacity by making a declaration (as to whether a particular act is lawful) or a single order to provide formal authority for a specific purpose.

4.35 The Act aims to support the person's own autonomy and establishes a right to engage an Independent Mental Capacity Advocate (IMCA). An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for them. The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.

4.36 ***Advance decisions to refuse treatment.*** Statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment which a doctor considers necessary to sustain life unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk".

4.37 ***Research***. The Act also sets out clear parameters for research involving, or in relation to, a person lacking capacity may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden.

Alternatively, if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights. Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project.

4.38 ***Offence of Ill-Treatment or Neglect***. The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

4.39 ***Court of Protection and Public Guardian***. The Act creates two new public bodies to support the statutory framework, both of which will be designed around the needs of those who lack capacity. A new Court of Protection will be created for England and Wales – and there will be a Public Guardian to register and supervise attorneys and deputies.

4.40 It is apparent that the Act applies to a wider constituency than people with a mental health need. There is a presumption of autonomy and a tolerance of unwise decisions. In particular, just because a person suffers from a mental disorder does not mean that his decision-making is impaired and this must be tested separately. Only those who cannot meet the capacity test for that decision are included.

Principles-Based Mental Health Legislation – Recent Developments

4.41 Since the last major review of legislation in the United Kingdom more than 20 years ago, there have been important conceptual shifts in thinking about the basis for compulsory interventions for people with mental disorder. The Richardson Report, reviewing the 1983 Act in England and Wales, was very clear about recommending an ethical, principled base which would have followed many of the provisions since introduced in Scotland, in particular the inclusion of “impaired decision-making” as one of the criteria essential to permit compulsion.

4.42 A different political climate in England and Wales eventually led to the Draft Mental Health Bill 2004, which was not principles-based and was widely regarded as more orientated towards meeting a perceived public protection, rather than a healthcare agenda. For this reason (and because it failed to gain broad enough support to be passed into law) the Review has examined the Mental Health (Care and Treatment) (Scotland) Act 2003, which has actually succeeded in translating a principles base into legislation.

Principles-Based Mental Health Legislation in Scotland

4.43 The MHCT Act 2003 could be seen as "visionary and reversionary" and most of the new provisions flow from the principles. The ethical and practical basis for compulsion was revisited by the Millan Committee and it was recommended that it should be the combination of impaired judgement, risk, and benefit to the patient. As one of the conditions, it must be shown that the patient's ability to make decisions about his or her treatment is significantly impaired by mental disorder.

4.44 Following the principle of "least restrictive alternative" has led to the introduction of Compulsory Treatment Orders (CTOs) which are not limited to a hospital setting but rather meet the person's individual needs for treatment, by specifying measures to be authorised in the care plan. The same level of protections through authorising, monitoring and appeals is ensured for all patients under a CTO, wherever treatment is delivered (hospital or community). The Orders are based on detailed care plans specifying those measures that are required to be compulsory and are authorized through Tribunals, which have been introduced for the first time, replacing the sheriff court, which formerly approved orders. Specified medical treatments are subject to a second opinion and ECT cannot be authorised for a person who has the capacity to consent but declines it.

4.45 Following the principle of reciprocity, the MHCT Act 2003 places obligations on service providers to meet patients' needs for treatment. Treatment is defined very broadly to include nursing care, psychological intervention, and

social and educational approaches. Some aspects of treatment plans are recorded as essential, with the obligation for them to be provided open to scrutiny.

4.46 The MHCT Act 2003 introduces new provisions to support of the rights of users of services, including new rights for informal patients, and rights to assessment. The introduction of Advocacy support and the encouragement of the use of Advance Statements for mental health care and treatment are the first in these islands specifically for mental health care.

4.47 Similar provisions apply for patients in the criminal justice system with different threshold criteria for those who present a risk to others, and following the MacLean Committee recommendations, a separate Risk Management Authority has been introduced which takes responsibility for all offenders. There are rights to appeal against excessive security for those treated under the Act, again under the least restrictive principle.

4.48 This legislation has had broad-based support. Problems experienced to date seem largely related to ensuring sufficient workforce to operate the Tribunals, some suggestions of over legalising of the Tribunal hearings with an adversarial rather than a facilitative tone, and the increased professional time required (Presentations to Royal College of Psychiatrists Annual Meeting, July 2006).

The Mental Health and Mental Capacity Legislative Interface

4.49 The two legislative models examined above (Mental Capacity legislation in England and Wales and Mental Health legislation in Scotland) demonstrate how principled-based legislation (dealing with both Capacity and Mental Health), can empower, support and protect persons with mental disorder in those aspects of their care and treatment which require intervention, and also protect others. There is a convergence in the shared importance of decision-making capacity as an essential criterion, with use of the same methods to

promote autonomy (participation, advocacy, LPAs, Advance Statements), and a shared emphasis on benefit or best interests.

4.50 While some aspects of the legislation have been observed to be merging conceptually, there are quite separate legal provisions covering their overlapping populations and purposes, and increasingly the interface between separate Mental Health and Capacity legislation is creating confusion. In addition, gaps in protection are being highlighted for those who fall under neither and discrimination is becoming more evident for people experiencing mental illness.

4.51 As described above, Mental Health legislation is strong on protections and appeal mechanisms for the two major areas of human rights intrusions which are legalised: that is deprivation of liberty and treatment for mental disorder without consent or against capacitous refusal. In contrast, Mental Capacity legislation acknowledges that restraint may be necessary but does not develop strong protections around it and at present (until the 2005 Act is amended) prohibits deprivation of liberty from its provisions. It only provides limited protections for treatments.

4.52 There will be situations when a person may fall under both legislations for the treatment respectively of physical and mental disorder, and others where a decision must be taken about which is the appropriate legislation to assess and treat mental disorder. Because the Mental Health statutes in England and Wales and in Scotland are now so different, the interface issues with the relevant Capacity statutes are different too, as are some of the proposed solutions.

The Mental Health and Capacity Legislation Interface in England & Wales

4.53 In England and Wales, the Joint Scrutiny Committee on the Draft Mental Health Bill 2004, which reported in April 2005, emphasised both the confusion reported between Mental Health and Mental Capacity legislation and the need for clarity. The three areas specified were: which legislation to

use where a person was deprived of liberty in protective care (Bournewood cases), where treatment without consent for mental disorder was required; and the extent to which advance decisions refusing, and advance statements requesting medical treatment for mental disorder, should be recognised.

4.54 The draft Code of Practice (issued in relation to the 2005 Act) now describes which Act should be used in particular cases and sets out the implications for people lacking capacity who are also subject to the 1983 Act. Some of the situations described in the Code point to possible injustice as well as confusion. For example, a person who has refused treatment for mental disorder under the 2005 Act, through a valid advance decision, could still be treated under the Mental Health Act, as there are no provisions in that Act to respect such refusals.

4.55 Other situations leave unresolved confusion, for example around Guardianship, where although the powers are available under the Act, robust protections are not. Depending on the degree of restriction, the person may find himself under one or the other Act with different rights. The degree of restriction or compulsion also differentiates between the Acts for issues of treatment for mental disorder. If the person is resisting treatment and restraint is needed regularly then the Mental Health Act provisions should be used.

4.56 The difficulties arise mainly from the different bases of the legislation, the different safeguards and protections, but also from the different rights and supports accorded to patients in each. The England and Wales solution appears to hinge around guidance on the nature and degree of restrictions, deprivation of liberty, restraint and force of compulsion. Only some of these problems will be remedied by the Government's proposed amendments to the 1983 Act and the proposed amendments to the 2005 Act to cover deprivation of liberty in Bournewood cases.

The Mental Health and Capacity Legislation Interface in Scotland

4.57 In Scotland, there have been issues identified by a study commissioned prior to the introduction of the MHCT Act 2003 (Gordon J, 2004). For treatment of mental disorder, if the patient lacking capacity does not resist, the AWI Act 2000 is used. Treatment in the community is permitted under both Acts (as treatment may be given under Welfare Guardianship in Scotland) but although the grounds are the same (mental disorder and impaired decision-making ability) they define both of these criteria differently. Similar populations will then come before two different decision-making bodies, the tribunal for mental health cases and the sheriff court for incapacity cases.

4.58 Although both Scottish statutes are principles-based, the emphasis of these is different and difficulties arise from different, and potentially overlapping, definitions of capacity, different decision-making bodies acting at times on the same populations, different rights and safeguards, as well as some overlapping powers.

Gaps and Inequities in Existing Provisions

Deprivation of Liberty in Accepting Persons - Bournewood

4.59 Despite its empowerment agenda, operating the 2005 Act to secure benefit for some people involves unavoidable restrictions to their liberty for their welfare: so this legislation too can be restrictive as well as facilitative. Under Section 6, any restrictions to a person's liberty must be necessary to prevent harm to the person and must be proportionate to the likelihood and seriousness of harm. But there are limits to the restrictions that can be covered by the 2005 Act as it stands and deprivation of liberty is specifically excluded.

4.60 The Bournewood case (Annex 3) highlights the gap in protection for people without capacity who do not object to their deprivation of liberty, but who do not meet the stringent criteria for risk under mental health legislation. In fact, persons lacking capacity in settings other than hospital (like care homes) if

their liberty is deprived, also find themselves without due process or appeal mechanisms.

4.61 Following the European Court of Human Rights' ruling, deprivation of liberty (which is now seen as more a matter of degree and intensity than quality of intervention) means "complete and effective control" over the patient's care and treatment. The Government proposes to remedy this gap in England and Wales by amending the 2005 Act (through the MH Bill 2006) and having a system of authorisation using the principles of that Act, and allowing review or appeal, In Scotland, the Scottish Executive is considering whether reform of the AWI Act 2000 is necessary. A solution must be found for Northern Ireland.

Protections for Compulsory Treatment

4.62 Confusion arises as a consequence of apparently having one law for decisions about physical illness and another specifically for mental illness. The simplistic separation of physical and mental illness ignores their complex interplay, accepted in both medicine and philosophy (Matthews E, 1999). For example, should a person who suffers severe depression which affects his/her decision-making capacity because of low levels of thyroid hormone, be treated under mental health legislation because it is a mental illness or capacity legislation because it is due to a physical cause?

4.63 The draft Code of Practice for the Mental Capacity Act 2005 indicates that it is not actually the origins of the mental illness but the deprivation of liberty and the compulsion required to treat it that is the distinction. However, there is discrimination in this argument as a person lacking capacity to consent to treatment for a life-threatening physical illness may also need compulsory treatment and have his/her liberty deprived to do so in his/her best interests, but will not be treated under a mental health act and will not be offered the same level of legal protection. In fact, Mental Health legislation has more legal protections for patients through both process and appeal mechanisms and if these types of protections could be afforded through Mental Capacity

legislation then both groups of patients, where they lack capacity, could be equally protected in a non-discriminatory way.

4.64 The Review considers that having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust.

4.65 Having considered the various problems illustrated above, the Review considers that Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory.

CHAPTER 5

DEVELOPING A PRINCIPLES – BASED APPROACH TO LEGISLATION

5.1 The Review considers that the principles introduced in Chapter 1 should underpin all legislative provision, whether that is for what has been previously regarded as "capacity" or "mental health" provisions. These principles are as follows:

i Autonomy: respecting the individual's capacity to decide and act on his own and his right not to be subject to restraint by others

- There should be an assumption of capacity and provision of care and treatment should be on a partnership and consensual basis, wherever possible. Respect for capacious decisions should extend to those decisions made legally in advance and where the person grants specific decision-making powers to another on his behalf, for the time when he loses capacity himself.

- Participation - users of services should be fully involved to the extent permitted by the individual's capacity, in all aspects of their care, support or treatment. Users of services should be provided with all the information and support necessary to enable them to participate. This may include the involvement of advocates and/or carers. Account should be taken of past and present wishes in so far as these may be ascertained.

ii Justice: applying the law fairly and equally

- Non-discrimination - people with a mental disorder or a learning disability should, whenever possible, retain the same rights and entitlements as other members of society.

- Equality and respect for diversity - people should receive treatment, care and support in a way that accords respect for, and is sensitive to their individual abilities, qualities and cultural backgrounds. The legislation should not discriminate on grounds of age, gender, sexual orientation, ethnic group, social class, culture or religion.

- Reciprocity - the loss of an individual's rights by detention or by compulsion to treatment and care should be matched by an obligation to provide adequate treatment and care for that individual.

- Partnership - services should develop effective partnerships to ensure continuity of care across age and service boundaries.

- Fairness and transparency - there should be fairness and transparency in decision-making, and the right to representation for challenge of due process. Proceedings should be timely.

- The specific rights of children, including the right to education, should be protected.

iii Benefit: acting in the individual's best interests

- Where interference is necessary and permissible, the best interests of the person should be protected and promoted, including protection from abuse and exploitation.

- Interventions should only be undertaken using the legislation to achieve benefits which cannot be achieved otherwise. Benefit to the person should include, but not be limited to, reduction of risk of harm to self or others.

iv Least Harm: acting in a way that does not harm the individual

- The person should be provided with the necessary care, treatment and support in the least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care. The perception of the restriction by the person himself should be taken into account.

- There should be clear guidance on the use of restrictive practices such as restraint, seclusion and time out, and these should be monitored and subject to evaluative research.

- There should be clear guidance on how and when research may be carried out with people who have impaired decision-making capacity and this should be monitored.

5.2 Those who provide care to users of services should be accorded due respect for their role and experience, be given appropriate and timely information and advice and have their views and their own needs taken into account.

5.3 The Review considers that these principles of Autonomy, Justice, Benefit and Least Harm underpinning substitute decisions should apply in a non-discriminatory way to both physical and mental health decisions, as well as welfare and financial needs. Having established an overarching legal Framework using common definitions and a principles-based approach, it should be possible to decide how the essential elements are best served in legislative provision.

5.4 The Review is mindful that any major change will bring forward new situations, dilemmas and interfaces for which solutions must be found. The Review has been able to give consideration to the most fundamental of these and will highlight others. Research and consultation on these will necessarily constitute some of the next phase of the process of reform.

5.5 In the first instance, a number of issues arise from the proposal to include capacity and mental health provisions under the same comprehensive framework including:

a. the further development of capacity law to include those elements presently under separate mental health provisions, while ensuring appropriate protections; and

b. potential difficulties in assessing the capacity of mentally disordered persons to consent to mental healthcare and treatment and of using capacity as the intervention threshold.

5.6 Consideration must then be given to:

a. the interface with Children's legislation; and

b. the consequences of adopting such an approach for Forensic patients and the interface with the Criminal Justice System.

5.7 In addition, the practical effects and any potential disadvantages for people with mental disorder as described in the 1986 Order (where the treatment in question is for that mental disorder itself) of moving from the present diagnostic and risk based criteria to a comprehensive approach with a broader definition of the population and principles-based criteria must be examined.

Developing the Law on Substitute Decision-Making to include Assessment and Treatment of Mental Disorder

5.8 It is proposed that decision-making capacity should form the basis of legislative reform. Capacity has an established basis in common law and case law. The Review adopts the definition in the 2005 Act that:

a person lacks capacity if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter if the impairment or disturbance is permanent or temporary.

The term "impairment of, or disturbance in the functioning of, the mind or brain" subsumes all those conditions presently considered as mental disorder under the 1986 Order, defined as "mental illness, mental handicap and any other disorder or disability of mind". It also includes others due to physical injury or disease such as stroke.

Autonomy and Assessing Decision-Making Capacity

5.9 A test of decision-making capacity will be central to these provisions (Eastman and Dhar, 2000). It must be reliable enough to be compatible with constitutional and human rights principles (Dawson and Szmukler, 2006). There may be concerns about moving from the familiarity of the present "test", which is the "nature and degree of the mental disorder" combined with risk. However, little work has been done on the reliability of present requirements and the significant variations in rates of detention across clinicians, hospitals and regions is likely to reflect variations in application of these traditional criteria (Peay, 2003; Perkins, 2003; Mental Health Commission (NI) Annual Reports; Mental Health Review Tribunal (NI) Annual Reports).

5.10 Both the validity and reliability of any capacity test must be carefully evaluated. Bellhouse et al. 2003, investigated in a naturalistic way the capacity of people to consent to both admission to hospital and treatment for mental disorder and the reliability of the capacity assessments undertaken. Although the study was small they concluded that decision-making capacity could be reliably assessed and this has been more recently confirmed by Cairns et al (2005) in a larger study using different assessment methods.

5.11 A mental disorder (as defined in the 1986 Order) may compromise any or all of the abilities required for decision-making. In particular, a person may fail to appreciate how the information applies to his own circumstances through the effects of disorder of mood or delusional thinking (Grisso and Appelbaum, 1998). Failure to "appreciate" is used here in a specific sense, to refer to the person's inability to accept the relevance of his/her disorder or potential treatment consequences for his/her own circumstances; and

- is counted only when choices are based on beliefs which are substantially irrational, unrealistic, or a considerable distortion of reality;
- are consequences of the person's impaired cognition or affect; and
- are relevant to the person's treatment decision.

5.12 Such considerations require that the person's functional abilities must be considered in the context of a mental state assessment, including information from third parties.

5.13 The present test in the 2005 Act, which refers to "understand, retain, use or weigh and communicate the information", does not include "appreciate" and has been considered to have a more cognitive or intellectual bias, reflecting the origins of the legislation. However, developments in the draft Code of Practice for the Act under the "use or weigh the information" element begin to address this. The Code states,

"There are cases where a person concerned can understand the information but where the effect of a mental impairment or disturbance prevents him or her using the information or taking it into account in making a decision. For example certain disorders cause people, who are able to understand and absorb information, to make decisions which are inevitable, regardless of the information and their understanding of it. A person with anorexia may be able to understand rationally the consequences of not eating, but lack the capacity to weigh these against the desire not to eat and will decide not to eat regardless of whether he or she feels hungry, the time of day etc."

5.14 The Review considers that the test and its elaboration within a Code of Practice should allow adequate consideration to be given to all those aspects of mental functioning which affect decision-making capacity and not just cognitive impairment.

Balancing Autonomy and Protection

5.15 There is an issue as to whether decision-making capacity is a separate assessment without reference to consequences and best interests, or whether, since the decision is task specific (for example, refusal of treatment) a sliding scale or "balance" approach takes the severity of the decision into account and makes a judgement of incapacity more likely as the seriousness of the potential risks for the patient increases. This latter approach has been endorsed by the English courts (Re MB (1997)). It is protective of patients' rights, as there will only be intervention when the person's incapacity to make a decision is held proportionate to the seriousness of the consequences. Recent work (Cairns et al, 2005) has developed thinking in this area and it has also been discussed by others (Gunn et al, 1999; Richardson, 1999; Buchanan 2004).

5.16 However, this raises concerns about paternalism influencing the decision of the assessing professional under the guise of best interests. With the presumption of autonomy and the protection offered by a documented process to demonstrate substantial impairments balanced with risks, paternalistic decisions are likely to be made than in the present system. The process will not tell the clinician mechanically what to decide and it should be recognised that in the end a professional judgement must be made.

5.17 At other times, clinicians will be required to decide about decision-making capacity in the absence of reliable information. This is often the case in emergencies or when the patient refuses to co-operate. Where other evidence suggests that the person's decision-making is impaired, then the balance is tipped more in favour of best interests and the necessity to act for the person's

protection is more evenly balanced. Thus the balancing of autonomy and best interests may need to be judged differently for an assessment period than for treatment.

5.18 If decision-making is the primary criterion, situations of transient or fluctuating loss of capacity, which are common in those with and recovering from mental illness, need consideration. The nature of the impairment of decision-making capacity may need to be taken into account as well as the degree. It is not necessarily in the best interests of the patient to allow transient, competent treatment refusals which result in a situation of relapse.

5.19 It will be necessary to develop provisions that allow the principle of benefit sufficient weight to preserve the person's dignity and support his autonomy by allowing continued access to required health care and treatment. For this to happen, a more sustained period of regained capacity may be required, while allowing the patient the right of appeal. Present provisions authorising intervention for limited periods of time before review and renewal is such a mechanism. A Code of Practice should give detailed guidance on this matter so that the spirit of the principles is adhered to.

5.20 The person with a known pattern of illness whose condition is deteriorating presents a particular challenge as to when to intervene in his best interests. In such situations, a treatment plan made with the person when he has capacity would inform the judgement about best interests and if it was formulated in an Advance Statement or Lasting Power of Attorney was given, then these would be respected as equivalent to the person having capacity to make the decision.

Applying the Principles

5.21 The principle of Autonomy includes participation in decision-making and expects that every effort and support is provided to encourage and enable the person with mental disorder to access mental health care and therapeutic interventions on a voluntary basis. Developments in community-based services with intensive home based treatment and assertive outreach teams

work on this basis. As in the 2005 Act, there should be a presumption of capacity and participation in decision-making supported at all levels.

5.22 Under a principles-based approach, interference with a person's decision-making, his liberty and his person on health grounds can only be justified if, despite such support:

- the individual's autonomy is compromised by impairment of, or disturbance in functioning of, mind or brain to the extent that he lacks decision-making capacity with respect to the particular risks at issue;

- any intervention is designed and intended for his benefit; and

- interventions are the least restrictive and least invasive of the options available.

5.23 In addition and, in particular, where the person objects and powers are required to prevent significant harm to the person or others, under the principle of Justice legislation should require that:

- interventions are non-discriminatory, fair and allow appeal;
- interventions to prevent harm are proportionate;
- rights removed are compensated for by appropriate services for both adults and children; and
- adequate, proportionate and timely protections are offered at all stages.

These conditions must then be translated into workable definitions, criteria and procedures.

Definition and Criteria

5.24 It is important to ensure that introducing a change of approach both addresses current problems and serves the people who need it, and that it is neither over inclusive or excessively narrow in its interpretation and operation. The

practical consequences of introducing a capacity-based approach must be anticipated.

5.25 The present criteria to assess the need for treatment of mental disorder comprise a broad definition, “mental disorder” qualified by “of a nature or degree which warrants his detention in hospital for assessment” and the likely consequences “failure to so detain him would create a substantial risk of serious physical harm to himself or to other persons”.

5.26 This would change to a broad definition “Impairment of, or disturbance in functioning of, mind or brain” qualified by “which significantly affects his decision-making capacity” and the likely consequences “failure to assess would create a significant risk to the health, safety or welfare of the person or to the safety of others”. This latter is very similar to the criteria in Scotland, although they retain the term “mental disorder” and use the term “impaired decision-making ability”.

5.27 The use of the criterion “significantly affects decision-making capacity” aims to clarify and emphasise the most significant effect of the “impairment of, or disturbance in functioning of, mind or brain”. As described above, it moves from the very imprecise “mental disorder of a nature or degree which warrants detention” to a more focused judgement. It should strengthen the grounds for challenge while acknowledging that, by their very nature, many of these assessments will require finely balanced clinical judgement.

Developments Required from the Principles

5.28 For intervention purposes, additional principles come into play. The principle of Benefit will demand that the proposed treatment intervention is an individualised care plan which takes into account what the person would likely want for himself, through his expressed or implied own wishes. It should be of benefit to the whole person and requires, therefore, that care plans for the treatment of mental disorder are holistic in their approach and content, with psychological and social elements balanced appropriately with medical

treatments. This will require the involvement of a number of different professionals and patients should expect to play as full a part as they are able in devising this. This is in keeping with developing good practice.

5.29 The principle of Reciprocity requires services to provide the programme of treatment and care with which individuals are obliged to comply. Service development must be in tandem with legislative change or this may lead to a perverse incentive with inequity for voluntary patients. Realistically too, it may not always be possible for every element of a programme of treatment to be available immediately and the Code should give guidance on how this principle is to be respected. In Scotland, there is a right of referral to the tribunal if the designated essential elements are not provided.

5.30 The principle of Least Harm requires the least restrictive alternative with respect to the assessment and treatment setting and the use of the least invasive treatment. Planned developments in services with intensive supports may reduce the use of compulsory powers, but where they are needed to support a care plan consideration must be given to this principle and the least restrictive setting may be the place the person lives, in the community.

5.31 Treatment in a community setting is not a completely new concept in Northern Ireland. There already exists a provision to enable treatment to be continued in a community setting under Article 15 of the 1986 Order. Detained patients may be granted leave from hospital under conditions specified by the RMO and this may be renewed on a monthly basis with notification to the Mental Health Commission.

5.32 Users of mental health services are particularly concerned that such measures which extend powers to treatment in the community might be enforced when they have regained capacity and special protective arrangements will need to be incorporated to ensure a reassessment in an authorized setting for those treatments specified under the legislation or if requested by an advocate or attorney. In Scotland, powers to assess and treat have effect in the most appropriate setting, community or hospital, with the necessary protections.

5.33 The Review is encouraged by the early reports from Scotland on the use of these powers and an independent study by the King's Fund on Community-Based Compulsory Treatment Orders (Lawton-Smith, 2006). The provision, although considered bureaucratic by professionals, was generally welcomed and appeared to be used at present mainly for those relapsing patients who deteriorated in their health following non-engagement. Although there were concerns expressed about resources likely to be required in future, the tone was one of "cautious optimism". A simple summary of this provision in Scotland is described in Annex 4.

Consequences of Changing the Definitions and Criteria

5.34 Under the 1986 Order there is an exclusion in the definition of mental disorder for "by reason only of personality disorder". Persons with personality disorder fall within the Review's proposed definition "impairment of, or disturbance in the functioning of, the mind or brain" which would be new in Northern Ireland. Persons with this condition should not be discriminated against by exclusion. Nevertheless, it is unlikely that many would meet the necessary criterion of significantly impaired decision-making capacity.

5.35 Experience in Scotland suggests that personality disorder on its own is very rarely considered to be associated with significant impairment of decision-making ability under their legislation. In addition, the conditions for compulsory treatment would include the requirement that it is for the person's benefit and that this cannot be provided any other way. For people with personality disorder the use of compulsory powers is likely to be counter therapeutic.

5.36 Using the proposed criterion of decision-making capacity has implications for other people currently not protected in law, those who have a mental disorder and lack decision-making capacity but, because they do not object or pose a substantial risk of serious physical harm, are treated informally and, therefore, without protections. Likewise persons who lack capacity and are objecting to

treatment but who pose a risk of serious psychological harm to themselves or others cannot be treated under present legislation. Under this approach they would be included if they can benefit from treatment.

5.37 The Review is encouraged by research evidence in this area (Bellhouse et al, 2003) which suggests that only a small number of those currently detained under Mental Health legislation in England and Wales are found to retain capacity and would not, therefore, be included in this approach. The majority of the population presently eligible for detention for treatment would meet the new criteria. Likewise, those patients without capacity referred to above, currently treated "voluntarily" and not protected, were included.

5.38 For persons with learning disability, the proposed criteria should respect their decision-making capacity when it is present and treat them in the same way as the rest of the population, allowing access to care and treatment and permitting protection as required.

5.39 The proposed application of a capacity approach must be the focus for early local research.

Children and Young People with Mental Illness or Learning Disability

5.40 Legislation for mental disorders which is based on substitute decision-making has particular implications for the interface with Children's legislation since children reach decision-making capacity at different stages in their development, their parents have special rights and responsibilities with regard to them and there already is legislation which applies to welfare. The principles and recommendations of the Review's Report, A Vision of a Comprehensive Child and Adolescent Mental Health Service (2006), provide the basis for children's services. A small number of children and young people will also require the support of specific legislation and the proposed principles for legislation recognise their particular needs.

Welfare and Services

5.41 The Children (Northern Ireland) Order 1995 (the Children Order) brings together in a single coherent statutory framework most of the public and private law relating to the care, upbringing and protection of children. This legislation is principles-based and the welfare of the child is paramount. It is strongly influenced by both the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 and by the UN Convention on the Rights of the Child 1989 (the UNCRC).

5.42 Whilst the language and emphasis is somewhat different, the principles adopted are very similar to those proposed by this Review. For example, the Children Order incorporates a best interests test for any intervention and it demands the least restrictive option and proportionality by its insistence upon a "No Order" principle. Respect is shown for the dignity and autonomy of the child and his or her family by an obligation to include them in decision-making. While it allows effective protection, it balances this with the opportunity to challenge such intervention. The principle of least harm is reflected in the requirement to avoid unnecessary delay in proceedings. Reciprocity is found in the obligation to provide appropriate services to the child's assessed need. The Children Order permits restriction and deprivation of liberty in very limited circumstances by authorising the child to be kept in secure accommodation, provided specific criteria are established, and only as an option of last resort.

Healthcare and Consent to Treatment

5.43 Under the Children Order health is defined as physical or mental health. Harm means, among other things, the impairment of health or development, and development is defined as physical, intellectual, emotional, social or behavioural development. Consent to treatment for children and young people is a very complex area, with elements from common law, statute, case law, and the Court's inherent jurisdiction.

5.44 The Age of Majority Act (Northern Ireland) 1969 creates a statutory presumption that young people over the age of 16 are capable of giving consent to any surgical, medical or dental treatment, as is any adult. However, children under the age of 16 may also be capable of consenting to medical treatment, if they are of "sufficient understanding and intelligence to understand fully what is being proposed". Case law since the original ruling has tended to demand a more rigorous test for children than adults.

5.45 The implications of a capacity approach to all substitute decision-making legislation would require the same basic approach to be applied for children. 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. When a young person is deemed to lack capacity, parents would ordinarily have substitute powers until the age of 16. However if the child's best interests are considered to be at significant risk then treatment may have to be authorised.

5.46 New capacity-based legislation would allow all the protections afforded to adults in these situations, for example, if such an assessment or treatment plan involved significant restrictions or deprivation of liberty regardless of whether the child is compliant or objecting. If parents' views are to be over-ridden, or if the child is without parents and no parental responsibility has been given, the special needs of the child must be recognised and protected in arrangements for advocacy and representation.

5.47 Children should be involved in their care planning and treatment as much as possible, in an age appropriate manner. A special situation arises with respect to Advance Statements about treatment. While the consideration of a young person's known wishes about care and treatment should be respected as part of devising his treatment plan, such statements would only have legal validity from the age of 16 (as in the 2005 Act).

Special Protections for Children and Young People

5.48 The special vulnerabilities and developmental needs of all those children and young people under the age of 18 years who may fall under the proposed approach to substitute decision-making will require special rights and protections.

Services

- Children must be assured of their right to services, including accommodation, appropriate to their age and needs.

- Children must be assured of their right to education.

Participation and Representation

- Children must be able to participicle in decision-making, for example through appropriate Advocacy services.

- Children must be provided with appropriate and accessible information.

- Children must be entitled to be represented at Tribunal hearings by appropriately trained representatives.

- Advance Statements and Refusals should only apply to persons over age 16 years.

Protections

- Periods of compulsory treatment for mental illness for children shall, without prejudice to the child, be disregarded for certain purposes (otherwise than in legal proceedings) when that child becomes an adult.

- Guidance on restrictive practices such as restraint and other deprivations of liberty should include specific reference as to how these might be applied to children and young people in accordance with the United Nations Convention on the Rights of the Child.

- Monitoring bodies should liaise and, where appropriate, work in partnership to ensure that the rights of children and young people for protection continue to be met.

Interfaces with the Criminal Justice System

5.49 People who have decision-making capacity should be free to make their own decisions. If those decisions are unwise or imprudent or if they result in a crime then those individuals must take responsibility for the decisions they have made. The principles-based approach cannot excuse people who have decision-making capacity from the consequences of their decisions. Similarly this approach cannot impose compulsion or restriction on people who have decision-making capacity, even where they are considered to pose a risk of serious harm to the public. Instead the necessary provisions and protections must be made under criminal justice legislation. There are, therefore, important interfaces with the Criminal Justice System which require further consideration.

5.50 Currently in Northern Ireland there is a complex interplay between the Criminal Justice System and the Health and Social Services. Criminal law recognises that individuals may suffer from mental disorders that, for example, excuse or reduce their responsibility for their acts or omissions or that impair their ability to participate in criminal proceedings. The present legal framework, including the 1986 Order, includes a range of measures to facilitate the treatment and care of people suffering from mental disorder. Mental health and learning disability services are provided or being developed for people who are subject to the Criminal Justice System such as people in prison, in contact with the police, on bail, attending court or on probation. The

Review supports a joint co-operative interagency approach that both meets the requirements of the Criminal Justice System while ensuring appropriate provision to meet healthcare needs (Forensic Services Report, 2006).

5.51 The proposed legislative Framework which integrates Capacity and Mental Health legislation should be applicable to all people in society, including those who are subject to the Criminal Justice System. It must integrate with the Criminal Justice legislation, for example with the law on criminal responsibility, unfitness to plead and unfitness to stand trial; it must contain a suitable range of disposal options for the courts and it must facilitate assessment and treatment, for example by providing for the transfer of mentally disordered prisoners to hospital.

5.52 Many individuals who are subject to the Criminal Justice System have mental health and learning disability needs. The Review supports the Principle of Equivalence (Forensic Services Report, 2006) which states that people who are subject to the Criminal Justice System should have access to assessment, treatment and care that is equivalent to that available to people in the rest of our society. The principles-based approach to legislative reform requires that those who have decision making capacity should have access to services on a voluntary basis and there should also be a range of measures, underpinned by legislation, that ensure appropriate provision for those whose decision-making capacity is impaired.

Public Protection

5.53 The new legislative Framework must contain measures that help protect members of society against harm from people whose decision-making capacity is impaired in such a way as to make the person a risk to others. These measures must integrate with the other public protection arrangements and must not discriminate unjustifiably against people who suffer from mental health or learning disability problems. There is widespread concern in society about crime and violence and it appears that there are frequent misconceptions

about the contributions made by people suffering from mental health and learning disability problems.

5.54 People who suffer from the more serious forms of mental illness or learning disability can, like other members of society, commit crimes but their overall contribution to crime is small. The vast majority of people with mental illness are no more likely than anyone else to commit a violent crime (Mental Health Commission, New Zealand, 2002). The greatest risk of harm that is posed by people with mental illness is to themselves rather than to others.

5.55 Nevertheless there is a modest link between mental illness and violence, particularly in some individuals who are currently experiencing symptoms of severe mental illness, not using effective medication and abusing alcohol and/or drugs. In such cases violence can be a reflection of insufficient treatment and support services (Mullan P.E. 1997). Research has shown that people who abuse alcohol and other substances and people who suffer from certain categories of personality disorder are at increased risk of committing crime.

5.56 At present in Northern Ireland, when an individual who is suffering from mental disorder has committed or appears to have committed a crime and has posed a risk to others, there is generally a response both by the Criminal Justice System and by mental health or learning disability services. Additional measures to help protect the public against violence have been introduced in other nearby jurisdictions.

5.57 In England and Wales, Multi-Agency Public Protection Arrangements were introduced in 2000 (Criminal Justice and Court Services Act 2000) and strengthened in 2003 (Criminal Justice Act 2003). These require the police, prison and probation services to work together to assess and manage the risks posed by sexual and violent offenders.

5.58 In Scotland, the interface between proposals for new Mental Health legislation and proposed measures to protect the public from serious violent and sexual

offenders was addressed by two contemporaneous reviews - while the Millan Committee was reviewing the Mental Health legislation, the Maclean Committee reviewed the arrangements for managing serious violent and sexual offenders.

5.59 The Maclean Committee made a range of proposals to address the assessment and management of risk. These included the introduction of a Risk Management Order, a new sentence – an Order for Lifelong Restriction - and the establishment of a Risk Management Authority, whose remit included developing policy, conducting research, setting standards, issuing guidance, accrediting practitioners and approving and monitoring risk management plans. These proposals complemented the proposals from the Millan Committee for new mental health legislation.

5.60 In Northern Ireland, there has been no equivalent of the Maclean Committee that has brought together a wide range of proposals to address the management of serious violent and sexual offenders although there have been a number of recent developments and proposals to improve measures to protect the public from offenders who have committed serious violent and sexual offences. These include the creation of the Life Sentence Review Commission, proposals to extend the current remit of the Multi-Agency Procedures for the Assessment and Management of Sex Offenders (MASRAM) to include violent offenders and proposals in the Review of the Sentencing Framework to introduce a discretionary release to ensure that dangerous offenders are not released until their risk is such that they can be safely supervised in the community.

5.61 The Review supports the development of an interagency risk assessment and management framework that applies to all offenders who pose a prescribed level of risk and irrespective of whether or not these individuals suffer from mental health or learning disability problems. It is essential, therefore, that the new legislative Framework interfaces effectively with existing Criminal Justice legislation and with developments in the Criminal Justice System.

Criminal Responsibility and Capacity to Participate in Legal Proceedings

5.62 Criminal law recognises certain psychiatric defences which serve to excuse or reduce the criminal responsibility of an accused person for his or her actions or omissions. These defences include "insanity" and "impaired mental responsibility".

5.63 The legal term "insanity" is included in the 1986 Order and in the Criminal Justice (Northern Ireland) Order 1996, but is now outmoded and does not correspond to any recognised clinical entity. It is stigmatising and promotes negative and unhelpful connotations of mental health and learning disability problems. It should be reviewed. A similar review by the Scottish Law Commission recommended that "insanity" be replaced by 'lack of responsibility by reason of mental disorder' (SLC Report, 2004).

5.64 The psychiatric defence of impaired mental responsibility may be invoked in homicide cases. In practice it causes substantial uncertainty and confusion. It would benefit from being reviewed, particularly with a view to giving greater guidance to clinicians, lawyers and the Courts on the correlation between legal and clinical definitions and conditions. Recommendations for review of the legal provisions in relation to mental responsibility and homicide have been made in England and Wales (The Law Commission, Murder, Manslaughter and Infanticide, Law Com No 304, 2006) and in Scotland (SLC Report, 2004).

5.65 Criminal law also recognises that an accused person may suffer from a mental disorder that renders him unfit to plead or unfit to stand trial. It appears that in cases of unfitness to plead or unfitness to be tried, the range of disposals available to the Courts (as determined by the 1986 Order and the Criminal Justice (Northern Ireland) Order 1996) may not adequately address the range of clinical conditions and circumstances that may present. For example, individuals with certain types of brain damage may be unable to instruct their legal advisors and may thus, under the current provisions, be deemed unfit to plead.

5.66 However, the current range of disposals available to the Courts, namely a hospital order with or without restriction, a guardianship order, a supervision and treatment order and an absolute discharge, may not adequately meet the clinical needs of the individual and the requirements of the Criminal Justice System. The proposed new Framework provides an opportunity to improve on the current arrangements.

CHAPTER 6

A PROPOSED COMPREHENSIVE FRAMEWORK FOR SUBSTITUTE DECISION-MAKING

Introduction

6.1 The key proposal for statutory reform is that Government should adopt a coherent and co-ordinated approach to legislative provision. This should be through the introduction of comprehensive provisions for people with mental health needs (including learning disability) who require substitute decision-making, including the overriding of refusals where a significant risk of harm is presented either to the individual or to others. A single legislative Framework is proposed for interventions in *all* aspects of the needs of people requiring substitute decision-making, including mental health, physical health, welfare or financial needs. Such a comprehensive Framework ("the Framework") is described throughout this Chapter, while a model application of the Framework ("the Model") is presented in Chapter 7.

6.2 The proposals contained within the two Chapters are not an attempt at legislative drafting, but a description and an explanation of what is considered necessary for reforming existing provision and as an aid to consultation. Detailed consideration is given to the principal situations in which the Framework might apply and how it should operate in practice.

6.3 Where there is concern about a person's capacity to make a particular (and necessary) decision, an assessment of capacity should be carried out. If it is established that the person does have capacity to make the decision, then his/her decision must be respected. If the person is found not to have decision-making capacity, however, the decision may be made by others on his/her behalf and any resulting supportive actions carried out. The Framework applies *only* to persons whose decision-making capacity is impaired.

6.4 The great majority of substitute decisions and support provided to people unable to make a decision for themselves should be arranged informally, through discussion and with the agreement of all interested parties. Where there is doubt about the extent of protection afforded to people who act with such *general authority*, however, or where more serious and/or intrusive procedures are proposed, it will be necessary to seek, and to operate under, a measure of *formal authority* – ultimately, in the form of *specific authorisation*, which will be subject to judicial approval or other specialist scrutiny.

Legislative Basis of the Framework

6.5 The Framework is based on the 2005 Act, considered in detail in Chapter 4, and is underpinned by a set of fundamental principles (see paragraph 1.8). The majority of the key provisions of the 2005 Act should be adopted in Northern Ireland, with minimal amendment. These include:

- definitions of *decision-making capacity* and *persons with impaired decision-making capacity*;

- requirements that any decision or action undertaken on behalf of a person with impaired decision-making capacity must be in his/her *best interests* and must have regard for the *least restrictive* option available;

- legal protection for the performance of (everyday) acts carried out in connection with a person's care or treatment;

- provision for *attorneys (acting under new LPAs)*, to deal with welfare (including healthcare) in addition to property and finance;

- an enlarged jurisdiction of the Court in relation to welfare, healthcare and financial matters;

- powers of the Court to make declarations and orders, and to appoint deputies;

- the recognition of *advance decisions* to refuse treatment and, in addition, *advance statements* about preferred treatment;

- safeguards in relation to research involving persons with impaired decision-making capacity;

- the provision of the services of *independent advocates*, including for persons who have no other support from family or friends;

- the issue of *Codes of Practice* to provide guidance to all those working with and/or caring for persons who have impaired decision-making capacity, including family members and carers;

- a new offence of ill-treatment or neglect of persons with impaired decision-making capacity;

- the creation of a new statutory office of the *Public Guardian*, with responsibilities to include dealing with representations and/or complaints about deputies appointed by the Court and attorneys; and

- ratification of the Convention on the International Protection of Adults.

6.6 In addition, the Framework includes the following provisions which are not within the 2005 Act:

- compulsory admission to an approved facility for assessment;

- compulsory detention in hospital for treatment;

- interventions involving supervised care or treatment in the community;

- a system for risk assessment and the management of persons who pose a risk to themselves or others by reason of mental disorder; and

- the provision of clearly defined procedures and protections for prolonged and particularly serious interventions.

6.7 Finally, the Framework takes account of the Government's proposals for addressing the *Bournewood* issue as set out in the MH Bill 2006, and includes a number of revisions and enhancements to the powers currently set out in the 1986 Order:

- a review of the role and functions of the present Mental Health Commission, which will be transferred to the Regulation and Quality Improvement Authority (the RQIA);

- a review of the role and functions of the Mental Health Review Tribunal;

- the introduction of a *nominated person* as a replacement for the 'nearest relative', with a re-definition of the corresponding role;

- an enhancement of the role and recognition of the rights of carers; and

- an extension of certain professional boundaries and functions, with the creation of two new professional offices, the *Approved Clinician* and the *Responsible Clinician*.

The Principles-Base

6.8 The Framework seeks to remain true to all four of the fundamental principles identified in Chapter 1 and elaborated upon in Chapter 5 – Autonomy, Justice, Benefit and Least Harm – while at the same time recognising that specific situations may at times draw different sets of these principles into varying degrees of tension.

6.9 The starting-point for the Framework is a presumption of autonomy, such that people with capacity to make their own decisions have a right to have those decisions respected by others. Substitute decisions may be made on behalf only of persons who do *not* have (or who are at least reasonably believed not to have) the capacity to make a specific decision (or decisions) at a specific point in time.

6.10 This means that the common law should apply to people with decision-making capacity, whereas new capacity-based provision is required for those persons with impaired decision-making capacity.

6.11 The Framework assumes that all necessary supports and enhancements to enable people to have as much control as possible over decisions about their own lives should be made available and accorded due legitimacy in the decision-making process. Such supports include the appointment of attorneys, advance decisions (to refuse interventions) and advance statements (about preferred interventions), and trained and accredited independent advocates.

6.12 The Framework also assumes that, before any decision or intervention is undertaken on behalf of someone who has (or is believed to have) impaired decision-making capacity, steps will have been taken to ensure that such are in the person's best interests, and that regard will have been given to the least restrictive alternative.

Scope of the Framework

6.13 The Framework is intended to apply in situations where (i) a decision requires to be made on a specific matter in relation to a particular person, and (ii) there are grounds to suspect that the person may not have the capacity to make that decision. Specifically, it permits intervention in the lives only of persons whose capacity to make a decision for themselves is impaired at that time because of "an impairment of, or a disturbance in the functioning of, the mind or brain" (*cf.*, section 2 of the 2005 Act). For convenience, such persons will

be referred to collectively throughout the remainder of this Chapter as "persons with impaired decision-making capacity".

6.14 As already noted, the Framework incorporates and extends many aspects of the 2005 Act. Specifically, it will support and empower persons with impaired decision-making capacity by:

- defining the concept of impaired decision-making capacity in such a way as to balance all aspects of the decision-making process (see above, paragraphs 5.11 to 5.13), with the resulting definition elaborated upon in a Code of Practice;

- incorporating a "best interests" test, identical to that detailed in section 4 of the 2005 Act;

- requiring that, before any action or decision is taken, regard must be given to whether its purpose can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action (*cf.*, section 1(6) of the 2005 Act); and

- incorporating a hierarchy of powers and protections which relate proportionately to the degree of interference with the person's autonomy (including any significant restrictions upon, or deprivation of, his/her liberty) on the one hand, and a need to recognise and respect the person's dignity on the other.

6.15 Such a proportionate hierarchy of powers and protections is rooted firmly in the principle of least restriction. This means that assessments, for example, should be carried out in the most appropriate setting available, with services provided in the person's local environment if at all possible (*cf.*, the Review's Report, A Strategic Framework for Adult Mental Health Services (June 2005)). The use of intensive supports in this way may avoid the need for compulsory powers.

6.16 The Framework is intended to apply to substitute decision-making on behalf of *all* persons with impaired decision-making capacity, including those whose decision-making is impaired as a result of a mental disorder – irrespective of whether that impairment is permanent or on a fluctuating or temporary basis, e.g. due to a recurrent mental illness (see above, paragraph 5.18) – and with equivalence for those who are subject to the criminal justice system.

6.17 It does *not* extend to people who have a mental disorder but whose decision-making capacity is not impaired. As such, it is essential that the Framework be seen as just one aspect of a comprehensive reform and modernisation of *all* parts of the system of care and treatment for people with a mental disorder, irrespective of whether they have impaired decision-making capacity.

6.18 It is contemplated that the Framework will provide for all aspects of a person's needs, including those which relate to issues of property and finance. However, the greater part of the proposals in this Chapter will relate to decisions in respect of (all) health and welfare needs.

Interventions and Intervention Plans

6.19 In recognition of both a broader applicability of the Framework and also of the fact that, in practice, many situations involve a combination of health and welfare elements, the term *intervention* (rather than "care" or "treatment") will generally be used to indicate those actions which are undertaken on behalf of a person with impaired decision-making capacity. Interventions include actions in relation to medical, nursing, psychological or care needs, habilitation or rehabilitation (including education and training in work, social and independent living skills) and specific welfare arrangements.

6.20 Where a proposed intervention is sufficiently serious and/or intrusive that it requires specific authorisation (see above, paragraph 6.4), full details must be submitted in the form of an *Intervention Plan* (see paragraph 6.21 on the content of Intervention Plans, and 6.30 on the need for them to be submitted to the RQIA for approval and authorisation.). An Intervention Plan will be

prepared after full consultation with and, wherever possible, the agreement of, the person, his/her representatives and carers and any other interested parties, including, as appropriate, any professional or multi-disciplinary team who will be responsible for providing the resulting intervention.

6.21 The content of Intervention Plans will obviously vary, depending upon individual circumstances. As a minimum, it is anticipated that *all* Intervention Plans will include the following:

- a declaration from the Responsible Clinician that:

  - the person's capacity to make a decision for him/herself is impaired because of "an impairment of, or a disturbance in the functioning of, the mind or brain" (and with the most likely reason(s) for such impairment clearly indicated);

  - any proposed decision or intervention has been exposed to a rigorous application of the Framework principles, in particular those of the person's best interests and the least restrictive alternative;

  - the proposed intervention is available and is likely either to prevent the person's condition from worsening, or to alleviate its symptoms or effects;

  - if the proposed intervention was not to be provided, there would be a significant risk to either (i) the health, safety or welfare of the person or the safety of others or (ii) the person and/or others of serious harm (as appropriate – see paragraph 7.31); and

  - the intervention could not be provided other than by way of the proposed Intervention Plan;

- full details of the person's assessed needs and the nature of the proposed intervention (which will generally be in the form of a multi-disciplinary care plan), including any elements of significant restriction and/or deprivation of liberty;

- details of the setting in which the intervention is to be carried out (i.e. in a community setting or an approved facility); and

- details of the rights of the person (and/or of his/her representative) to appeal against the Intervention Plan.

6.22 Those components of an Intervention Plan which are considered essential should be indicated as such, and there will be a responsibility on service-providers for these to be provided.

Balancing Powers and Protections

6.23 Persons with impaired decision-making capacity may be vulnerable in certain situations and in a variety of ways. So, in addition to promoting autonomy, strong provisions aimed at protecting a person's dignity and human rights must be included within the Framework. Measures should be provided within law to protect individuals from the consequences of both their own harmful actions, or lack of action, and the actions of others.

6.24 Interventions should be founded only on due legal process. For those with impaired decision-making capacity who are unable or unwilling to agree to such interventions, there should be adequate arrangements for appeal and for the involvement of advocates and/or carers, amongst others, who are able to represent them and speak on their behalf.

6.25 As already indicated, a proportionate relationship should exist between any interventions which may be performed by way of the Framework and its associated protections: the more intrusive and significant the intervention

proposed in relation to a person with impaired decision-making capacity, the greater the degree of protection and safeguards he/she should be afforded.

6.26 Likewise, the Framework seeks to ensure that persons who either withhold their co-operation or otherwise do not agree to a proposed intervention, either verbally or by way of their behaviour, should also be afforded an appropriate and proportionate level of protection.

Judicial and Administrative Provisions

6.27 The ultimate source of judicial authority in relation to any issues affecting persons with impaired decision-making capacity in Northern Ireland should continue to be the High Court. It is not considered either necessary or appropriate in a small jurisdiction to create a separate Court of Protection. Responsibility for the disposal of Court business at appropriate venues and by assigned Judges, Masters or other judicial officers may properly be determined by the Lord Chief Justice.

6.28 The appointment of a Public Guardian for Northern Ireland, similar to that being introduced in England and Wales (see above, paragraph 4.39), would provide the support required to ensure the proper discharge of responsibilities granted to deputies and others by Court Orders, to register Powers of Attorney and supervise the role of attorneys, and to deal with enquiries and the investigation of complaints. The Public Guardian would also assist in seeking to resolve disputes or disagreements between persons with impaired decision-making capacity, their representatives and other interested parties without recourse to proceedings before the Court.

6.29 In a limited number of situations, there will be a need to provide appropriate intervention for persons with impaired decision-making capacity which involves significant infringements of their liberty and autonomy. It is proposed that the special protections now prescribed in Parts II, III and IV of the 1986 Order should be replaced by a requirement that an Intervention Plan should be prepared in any case where it is proposed to:

- admit the person compulsorily to an approved facility for assessment and/or ongoing intervention;

- introduce an intervention which involves either a significant restriction upon, or a deprivation of, a person's liberty (albeit excluding those individuals considered as *Bournewood* cases, for which separate provision will be made – see paragraph 7.45); or

- introduce certain "prolonged or particularly serious interventions" (see below, paragraphs 7.54 to 7.58).

6.30 In all such cases, a copy of the Intervention Plan should be submitted for approval and authorisation to the designated independent monitoring and regulation body, the RQIA, which is to assume responsibility for the functions of the current Mental Health Commission.

6.31 The RQIA should be concerned not just with persons who are subject to compulsory detention. It should also monitor and regulate *all* aspects of services provided to people with a mental disorder, irrespective of their location (i.e. in the community, hospital or prison) and also of whether or not they have decision-making capacity. Specifically, in addition to those functions specified in the 1986 Order, the RQIA should:

- draw up and monitor the implementation of Good Practice Guidelines in relation to the Framework – to include guidance on what will constitute acts which involve either *significant restriction* upon, and/or *deprivation* of, a person's liberty;

- protect the interests and promote the wellbeing of all persons with impaired decision-making capacity, by keeping their treatment and care, including the use of any compulsory powers and general restrictions (i.e. those that might be imposed in any particular setting for the common good), under regular review;

- approve and authorise all Intervention Plans; and

- monitor the effective operation of all new legislation.

6.32 Finally, a re-constituted independent *Tribunal* should be established as the specialist judicial forum with responsibility to review and hear appeals with regard to the legality of Intervention Plans. It should be open to the person him/herself, the RQIA or any representative of the person with impaired decision-making capacity (including an independent advocate, who should be appointed at an early stage in the process by the RQIA in all such cases) to apply to have an Intervention Plan reviewed. The Tribunal may exercise its functions proportionately with regard to the methods by which it hears appeals, depending upon the seriousness of each individual case.

6.33 The RQIA and the Tribunal should work to common principles and in a complementary manner across the entire Framework. It is essential that within each of the two bodies the appropriate level and form of specialist expertise and training be provided and regulated, to ensure that they each retain at all times the levels of competency required for their respective functions to be carried out.

Promoting Autonomy and Safeguarding Interests

6.34 The Framework advocates the involvement of the individual in the decision-making process to the greatest extent possible, and endorses the use of both advance decisions and advance statements as a way of assisting the substitute decision-making process. The scope of each of these provisions should extend to decisions and interventions which relate to a person's mental disorder, as well as to any physical condition he/she may have. The former must be respected and considered equivalent to a person's contemporaneous refusal, and if they refer to life-sustaining interventions they must be in writing and witnessed. The latter must be taken into account as a valid expression of a person's wishes when his/her best interests are being decided. Any instance of

an advance decision or advance statement being overruled must be reported to the RQIA.

6.35 The Framework also recognises the role that other people, including carers, can have in substitute decision-making (*cf.*, section 4 of the 2005 Act, which specifies that in determining *best interests* for a person with impaired capacity the views of, amongst others, "anyone engaged in caring for the person or interested in his welfare" should be taken into account). Where substitute decisions are to be taken, it is essential that, where appropriate, carers and/or advocates be kept informed of any decisions being made and of any processes open to them to challenge those decisions. However, it should be remembered that a person may be capable of refusing the involvement of a previous carer even if his/her judgement is impaired about other aspects of his/her management. In such situations, the appointment of some other appropriate *nominated person* should be facilitated.

6.36 The Framework provides for attorneys, independent advocates and Court-appointed deputies, all with roles very similar to those detailed in the 2005 Act. Thus, for example, individuals, including those who are users of mental health services, may appoint an attorney to make decisions on their behalf in the event of a subsequent impairment of capacity and such attorneys will have essentially the same authority with regard to specified decisions as if they were the persons with impaired decision-making capacity themselves. Independent advocates can be appointed when a person with impaired decision-making capacity has no other form of independent representation available – and they *must* be appointed when particularly serious issues (e.g. concerning deprivation of liberty or irreversible healthcare interventions) are involved. The appointment by the Court of a deputy solely for the purpose of making substitute-decisions on healthcare is only likely to arise where an agreed position among the various concerned parties is proving impossible to secure.

6.37 Where disputes arise amongst concerned parties, it is recommended that a mediation service be provided as a first response, certainly in cases thought

capable of being settled through negotiation and in matters concerning essentially welfare (including financial) issues, with the Public Guardian as the next recourse. Likewise, the use of mediation and, if necessary, "second opinions" from appropriate specialists (not necessarily from the same profession as the original) could offer protection in contentious healthcare decisions. Ultimately, the Framework envisages access to the Court as a means of resolving disputes, with a subsequent right of appeal in particular cases. Such access should be facilitated by the provision of free legal aid.

Compulsory Assessment and Intervention

6.38 There have been substantial changes in policy and practice over the period since the 1986 Order became law. For example, the responsibility of GPs to provide a service to their patients out-of-hours has passed to Boards, and doctors working out-of-hours are less likely to have a direct knowledge of those persons who might require a compulsory assessment in relation to their decision-making capacity and the degree of risk they present to self or others. At the same time, the introduction of Crisis Response and Home Treatment Teams has resulted in nursing and other professionals becoming increasingly skilled at mental state and risk assessment. The Framework envisages that, in addition to GPs, other appropriately trained clinicians (including nurses and clinical psychologists) – referred to as *Approved Clinicians* – could complete a recommendation for compulsory admission to an approved facility for assessment and that, on arrival, the person should immediately be examined by a medical doctor. It is also envisaged that the separate and distinct role of the Approved Social Worker as applicant for compulsory assessment should continue.

6.39 In order to ensure that persons with impaired decision-making capacity who require either assessment and/or intervention on a compulsory basis can have access to the most appropriate form of professional management available, the Framework envisages that the role of the Responsible Medical Officer should be extended, subject to appropriate training and ongoing monitoring, to professions other than psychiatry (such as clinical psychology), and re-named

accordingly the *Responsible Clinician*. The constitution of Tribunals should be extended accordingly, to allow relevant non-medical clinicians to be included.

6.40 Persons for whom an assessment is to be carried out compulsorily must be seen by their Responsible Clinician at the start of the period of assessment, and regularly thereafter.

6.41 The Responsible Clinician will be responsible for co-ordinating and submitting Intervention Plans for approval to the RQIA (see above, paragraphs 6.20 and 6.30). The RQIA will be charged with confirming the legality of the process being adhered to, and will take such action as is appropriate in regard to this, including referral to the Tribunal if necessary. In addition, the RQIA will be responsible for assessing the quality of the content of proposed Intervention Plans, and for their approval. Panels may be constituted for this purpose, the membership of which should be drawn from a range of both lay and professional backgrounds, with each professional having an appropriate level of experience of either the type of mental disorder and/or the intervention proposed in relation to the case in hand. The RQIA may also request the assistance of an independent "second opinion specialist" in this process.

Research

6.42 Research is a particularly sensitive subject when a person's autonomy is compromised. Consideration should reflect the need to enhance properly conducted research to provide knowledge about the causes of incapacity and about diagnosis, treatment, care and the needs of people who lack capacity. Where research for such purposes can be carried out effectively only on persons whose decision-making capacity to consent is impaired, this should be permitted within the Framework, provided appropriate specified safeguards are assured. The Review recommends accepting the provisions and protections of the 2005 Act to allow such research to proceed (see above, paragraph 4.37). Safeguards should be designed so as not to discourage such research and hence deprive people of benefit. Users of services as well as

carers should have a meaningful input into the research agenda. The RQIA should be specifically charged with the role of promoting such input.

Training and Awareness-Raising

6.43 Training (on a multi-disciplinary basis, where appropriate) and awareness-raising are essential if the new legislation envisaged by the Review is to be successfully introduced. Not only must it be ensured that those individuals and professionals who will be required to operate the Framework processes are competent to do so, but it must be ensured also that the general public, users of services and carers are kept fully informed at all stages of its introduction and operation, and that user and carer representatives participate in its development.

CHAPTER 7

A MODEL APPLICATION OF THE FRAMEWORK

Introduction

7.1 The essential components of a comprehensive Framework for substitute decision-making were presented in Chapter 6. In this Chapter, additional details are provided of how the Framework might operate in practice and of its possible impact on the lives of people with impaired decision-making capacity. This is done by way of a model application of the Framework ("the Model") which is summarised in the form of a flow diagram at the end of the Chapter. The Model is one example of a number of possible out-workings of the Framework.

Determination of Impaired Decision-Making Capacity

7.2 The Framework applies *only* to persons who have impaired decision-making capacity. Determining that a person has impaired decision-making capacity is a two-stage process: first, it must be demonstrated that he/she has "an impairment of, or a disturbance in the functioning of, the mind or brain"; and second, it must be demonstrated that it is because of that impairment or disability that the person is unable to make the decision at hand. The first component requires a determination that the person has some form of mental disorder (e.g. mental illness, learning disability, autistic disorder or acquired brain injury), while the latter should be determined through a similar procedure to that set out in section 3 of the 2005 Act but with the addition of an assessment of the person's *appreciation* of any information that is relevant to the decision to be made (see above, paragraphs 5.11 to 5.13).

7.3 A person may be determined at a particular point in time to have impaired decision-making capacity for a specific decision but then, perhaps because the effects of his/her mental disorder are temporary and/or fluctuating, he/she may be determined subsequently no longer to have such an impairment. Indeed this is often to be expected as an outcome of intervention. In order to decrease

the likelihood of relapse, in cases where it can be anticipated that a person's decision-making capacity will change over time, provision should be made in a Code of Practice for both the nature of the person's illness or condition and any relevant historical information to be taken into account when assessing his/her decision-making capacity in relation to any proposed course of treatment which should be complied with over a period of time (see above, paragraph 5.19).

7.4 It is the individual who will be responsible for carrying out a proposed intervention who must ultimately be satisfied as to whether or not a person has impaired decision-making capacity, although it may at times be advisable to request an assessment by an appropriate specialist healthcare professional (usually a psychiatrist or a psychologist).

Substitute Decisions and Associated Interventions

7.5 The Model recognises three main types of decision and intervention, depending on the one hand on both their severity and the extent to which they intrude upon a person's autonomy, and on the other on the level of authority which is required before they can be carried out. These three categories are referred to respectively as *general interventions*, *formal interventions* and *specifically authorised interventions*.

7.6 All interventions proposed and undertaken by way of the Model, whether general, formal or specifically authorised, should comply with Good Practice Guidelines to be drawn up and overseen by the RQIA (see above, paragraph 6.31).

General Interventions

7.7 The great majority of decisions and interventions carried out on behalf of persons with impaired decision-making capacity will fall within the category of general interventions. These include a good many of those described as "acts in connection with care and treatment" in section 5 of the 2005 Act (and

elaborated upon in that Act's draft Code of Practice), and range from such basic activities as the performance of personal, and sometimes intimate, care tasks (e.g. washing, dressing, feeding and personal hygiene tasks), through to routine and relatively benign activities such as shopping (e.g. for grocery items).

7.8 For any decision or intervention to be considered a general intervention within the Model, the following conditions must apply:

- the person either has, or is at least reasonably believed to have, impaired decision-making capacity (as detailed above, in paragraph 7.2);

- any proposed decision or intervention is in keeping with the Framework principles, in particular those of the person's best interests and the least restrictive alternative;

- the person has been supported and included within the decision-making process to the greatest extent possible, and does not disagree (nor is he/she considered likely to disagree in the future) with the action(s) proposed; and

- there is agreement amongst all concerned parties – including the person's carers, any advocate or attorney who may be involved and, if different, the individual(s) who will be responsible for carrying out the proposed decision or intervention – that:

    - the intervention constitutes neither a significant restriction upon, nor a deprivation of, the person's rights and liberty (*cf.*, Article 5(1) of the ECHR);

    - neither do they constitute either a "prolonged or particularly serious intervention" (as defined below, in paragraphs 7.54 to 7.58, i.e. interventions which require a second specialist

opinion, are expected to be prolonged or are likely to have irreversible consequences) or one of a very limited number of situations for which the Courts have previously directed that a Court declaration must *always* be sought;

- the interventions proposed are likely to meet the specific needs of the person for care and protection; and, where appropriate,

- satisfactory care management procedures, including arrangements for monitoring and regular reviews, either are, or will be put, in place.

7.9 Provided *every* condition in this list is fulfilled, general interventions may be carried out under common law, with only minimal administrative constraints and with the persons who perform them having a measure of protection from legal liability for their actions.

7.10 However, if either the person with impaired decision-making capacity and/or any other concerned party (see above, paragraph 7.8) does not agree or otherwise objects to any proposed decision or intervention, or if it is adjudged that the scope of the intervention extends beyond that of a general intervention, it should be considered a formal intervention instead and the procedures and additional safeguards which are detailed in the following section should apply.

Formal Interventions

7.11 The defining feature of formal interventions is that they require and are subject to a prescribed administrative procedure which is regulated by a local Health and Social Services Trust – including appropriate provision for assessment, intervention, appeal and review in all cases.

7.12 Examples of the kinds of intervention which are likely to constitute a formal intervention within the Model include the following:

- healthcare interventions ranging from the relatively minor (e.g. routine dental treatment) to those that are significantly invasive and/or complex (such as admission to hospital for certain medical or surgical treatments);

- interventions undertaken on an emergency basis with the intention of saving a person's life (e.g. where the person is unconscious) or where there is an immediate risk of serious harm being caused to either the person him/herself or to some other individual(s) – such as when the person is behaving in a violent or dangerous manner (but see paragraph 7.14, below);

- other such interventions as are currently permitted under the 1986 Order where there is a risk of harm to self or others, because of a mental disorder;

- low-level acts of restriction (as will be determined and specified by the RQIA in the Code of Practice – e.g. the use of arm-splints to prevent a person from injuring him/herself by striking his/her head); and

- where it is believed to be in the best interests of a person with impaired decision-making capacity to be placed within a hospital or a care home in circumstances where his/her liberty may be deprived, and for whom there are no objections to that proposed placement *(Bournewood).*

7.13 With two specific exceptions, formal interventions, just like general interventions, require that the entire list of conditions set out in paragraph 7.8 apply before any intervention can be implemented. The two exceptions are as follows:

- although the agreement of the person with impaired decision-making capacity is to be anticipated, it is recognised that this will not always be the case and, provided every other condition in the list is fulfilled, a

formal intervention may still proceed – so long as it is considered by all other concerned parties to be both necessary and in the person's best interests – even in the absence of the person's agreement; and

- in the case of interventions carried out on an emergency basis, it is essential that only the first two of the list of conditions applies.

7.14 Although interventions carried out on an emergency basis will generally be deemed formal interventions within the Model (see above, paragraph 7.12), if any such intervention is considered likely to be repeated or continued over a period of time (i.e. beyond a specified period to be prescribed by the RQIA), it should be considered a specifically authorised intervention instead and the procedures and additional safeguards which are detailed in the following section should apply.

Specifically Authorised Interventions

7.15 Specifically authorised interventions are those which, because of their very high level of intrusiveness and/or complexity, require the imposition of a more robust procedural system and, proportionately, additional safeguards for those persons with impaired decision-making capacity on whose behalf they are carried out.

7.16 The Model recognises six specific types within three main categories of specifically authorised interventions:

- those which involve either (i) depriving a person with impaired decision-making capacity of his/her liberty (and where, unlike the *Bournewood* situation, the person either objects or otherwise does not agree to that deprivation) and/or (ii) the use of any kind of significant restriction (which can be undertaken, as in the 2005 Act, only when such action is believed to be both *necessary* and *proportionate* to the degree of risk of harm to the person and/or others that is presented by his/her behaviour at the time – *cf.*, section 6 of the 2005 Act);

- those which constitute a “prolonged or particularly serious intervention” - those which (iii) require a second, specialist opinion, (iv) are expected to last for a lengthy period, or (v) are likely to have certain irreversible consequences, but which do not need to be performed on an emergency basis (neurosurgery, for example, or the administration of long-term medication for the relief of psychiatric symptoms); and

- those where (vi) it has previously been directed that all future such cases should be referred to the Court for a declaration – including the withholding or withdrawal of artificial nutrition and hydration, for example.

7.17 Specifically authorised interventions which fall within either of the first two of these categories ((i) to (v)) require a detailed, multi-disciplinary Intervention Plan to be submitted for initial approval and authorisation to the RQIA, which will then be responsible for ongoing and regular review of same. Those which fall within the final category (vi) will continue to be referred to the Court.

Objections to Proposed Decisions and Interventions

7.18 Objections to general and formal interventions should be directed in the first instance to the Public Guardian and the appropriate Health and Social Services Trust respectively, while those against the content and the legality of Intervention Plans should be directed initially to the RQIA and the Tribunal respectively. If resolution cannot be achieved at those levels, however, it is possible for *any* case to which the Framework applies to be referred ultimately to the Court for a declaration.

Applicability of the Framework

7.19 As already indicated, the applicability of the Framework in particular instances depends on both (i) whether or not the person has impaired decision-making capacity and (ii) the level of risk (if any) involved. Throughout the remainder of this Chapter any reference to a person's *assessment* should be taken to mean an assessment of *each* of these factors.

7.20 In situations where it is unclear if a person has impaired decision-making capacity (see below, especially paragraphs 7.28 to 7.30), the higher and more immediate the risk appears to be (e.g. where a person presents as being at risk of imminent suicide), the greater the emphasis should be on the person's protection: There should be a presumption of impaired decision-making capacity pending a formal assessment, and arrangements should be made for such an assessment to be carried out (in an approved facility, if need be).

Where Decision-Making Capacity is Not Impaired

7.21 Where a person is determined *not* to have impaired decision-making capacity, the Framework does not apply to that person and any decision that he/she makes, even if it appears to be unwise and even if, ultimately, it might bring about his/her death, must be respected.

7.22 This is the case irrespective of which (or both) of the two components of impaired decision-making capacity (see above, paragraph 7.2) the determination is founded upon. Thus someone who has a mental illness, for example, but whose decision-making capacity is not impaired (i.e. the person retains the capacity to make a decision for him/herself), may not be included within the Framework (but see paragraphs 7.23 and 7.24). It is the case also irrespective of whether a particular decision or intervention relates to a person's mental or physical health, and of whether his/her behaviour presents a risk to the safety of self and/or of others.

7.23 Individuals suffering from a mental disorder (or a suspected mental disorder, which requires assessment) and who have been assessed as retaining decision-making capacity, should be able to access an appropriate professional service for their care and treatment on a voluntary basis. Should they refuse services, however, and their behaviour is such as to place either themselves and/or others at risk, they must take responsibility for the consequences of any decisions they might make:

> *"A competent patient has an absolute right to refuse consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his/her death"*
>
> (Dame Elizabeth Butler-Sloss, 2002).

7.24 Any risk associated with a person with a mental disorder who presents a significant risk to others only – not to self – but who has been assessed as having decision-making capacity may need to be managed through alternative legislative provision within the Criminal Justice System (see above, paragraph 49).

Where Decision-Making Capacity is Impaired and There is No Significant Risk

7.25 If it is determined (or at least reasonably believed) that a person *does* have impaired decision-making capacity, and it is believed also that there is no significant risk involved to either the person or others, any decision and/or intervention that is proposed on behalf of that person may be undertaken – provided it is in his/her best interests, regard is paid to the least restrictive alternative, and the appropriate degree of authority/authorisation is secured.

Where Decision-Making Capacity is Impaired and There is Significant Risk

7.26 The Model envisages that a hierarchy of emergency powers to intervene in order to protect a person with (suspected) impaired decision-making capacity who may be vulnerable to neglect or ill-treatment will be developed, including

a *duty to inquire* (*cf*., the MHCT Act 2003) placed on Trusts and warrants for entry to premises for a health and welfare examination and/or to remove a person to a place of safety.

7.27 Where a person has impaired decision-making capacity and there is believed to be "a significant risk to the health, safety or welfare of the person or the safety of others" – the same level of risk as applies in the MHCT Act 2003 – a period of assessment may be indicated. Depending on the risk involved, this may be either in the community, in the person's usual environment, or in an approved facility. It may also, depending on the circumstances, be either with or without the person's agreement (see below, paragraphs 7.32 to 7.40, for more on assessments.)

Where Decision-Making Capacity is Unclear

7.28 Where the status of a person's decision-making capacity is unclear and he/she agrees to an assessment being carried out, that assessment should take place in the least restrictive setting that is appropriate to his/her particular circumstances.

7.29 What may happen when a person's decision-making capacity is unclear but he/she does *not* agree to an assessment, depends upon the degree of risk involved. If there is "a significant risk of serious harm to self or others" (a higher level of risk than that specified above, in paragraph 7.27 – see paragraph 7.31, below) then the person may be assessed. Although it might be possible for this assessment to take place in a community setting, it is much more likely that, given the level of risk involved, it will occur in an approved facility and on a compulsory basis. (Again, see paragraphs 7.32 to 7.40 for details of assessments; see also paragraph 7.20 for the need for an increased emphasis on the person's protection in situations of uncertain decision-making capacity and both high and immediate risk.)

7.30 If a person requires an assessment but there is *not* "a significant risk of serious harm to self or others", then, unless he/she agrees to an assessment being

carried out on a voluntary basis, no further action may be taken under the Framework (albeit paragraphs 7.23 and 7.24, above, may still apply) and the person must take the consequences of any decisions he/she might make.

Assessments and Assessment Outcomes

7.31 The Model distinguishes between two separate levels of risk as the bases on which an assessment may be authorised compulsorily, if necessary: "a significant risk to the health, safety or welfare of the person, or the safety of others" (paragraph 7.27) and "a significant risk of serious harm to self or others" (paragraph 7.29). The former, lower level is intended primarily to facilitate the protection of individuals who are already known to have impaired decision-making capacity, while the latter, higher level seeks to restrict those instances where a person's lack of agreement to an assessment can be overruled to the highest levels of risk only.

Assessments

7.32 The preferred location for assessments undertaken as part of the Framework is the person's usual environment. However, the actual setting will depend on both the immediacy, nature and degree of any risk that is presented, and on whether the person offers any objection. The least restrictive approach should be adopted, and if it can be made safe for the person to remain in his/her usual environment, the assessment should be carried out there – with, for example, the authorisation for such assessment requiring that the person (and/or his/her carers) facilitate access by specified professionals and/or attend at specified locations.

7.33 It is anticipated that the majority of assessments will be carried out in the community, under *formal authority* (i.e. in accordance with a prescribed administrative procedure which is regulated by a local Health and Social Services Trust – see above, paragraph 7.11). This will certainly be the case where there is little or no risk involved and where the person offers no objection.

7.34 However, if it is not possible for an assessment to proceed in the person's usual environment – perhaps because of a failure on the part of the person to agree, or because of significant risks to either the person and/or others associated with his/her remaining there – consideration should be given to whether the risks presented by the situation require the assessment to be carried out in an approved facility instead.

7.35 Provided the person raises no objections, some assessments carried out in an approved facility might also proceed on the basis of formal authority only.

7.36 However, where there is a significant level of risk involved and/or the person objects to an assessment being carried out, *specific authorisation* will be necessary (*cf*., paragraph 7.15). This will involve the submission of an *Interim* Intervention Plan, in a format similar to that of a (full) Intervention Plan (see paragraph 6.21), to the RQIA.

7.37 In practice, if there exists a "significant risk to the health, safety or welfare of the person, or the safety of others", he/she should be referred immediately for assessment to a community-based multi-disciplinary mental health or learning disability team which is resourced to provide such a service (*cf*., the Review's Strategic Framework for Adult Mental Health Services Report). If the person is unwilling to allow an assessment to take place, however, then proportionate action may need to be taken to ensure that he/she has access to appropriate care and treatment, and an assessment should be authorised through an application for same by the appropriate health and social care professional(s).

7.38 Whenever authorisation is given for a person to undergo a compulsory assessment – irrespective both of the level of risk on which the authorisation is granted and of the location of the assessment – this should be for a maximum of 28 days rather than the 14 days currently allowed within the 1986 Order for compulsory assessment. This longer period is to facilitate the enquiries, investigations and consultation that are needed and, where appropriate, the development of a (multi-disciplinary) Intervention Plan. The protection

currently offered by Article 10 of the 1986 Order, for the disregarding of periods of assessment for certain legal purposes if the person is not detained thereafter for treatment/intervention, should be extended accordingly.

7.39 During the assessment period, if the person has no alternative form of independent representation available, an independent advocate (with responsibilities and duties similar to those detailed in sections 35 to 41 of the 2005 Act with regard to what are there called *independent mental capacity advocates*) should be engaged at as early a stage as possible to assist the person's understanding of the legal procedures involved – including his/her rights in relation to the assessment process – and also to ensure that the person's own views are as fully articulated and communicated as possible to those who will be responsible for carrying out any proposed interventions.

7.40 Responsibility for determining the level of security required for persons admitted for a period of assessment (and, if appropriate, subsequent intervention) from the Criminal Justice System should remain with the Criminal Justice System throughout the time that the person remains engaged with the Framework processes.

Assessment Outcomes

7.41 There are essentially two possible outcomes to a period of compulsory assessment. The first applies if at any time throughout the assessment it is determined either that the person does *not* have impaired decision-making capacity and/or that the "risk" grounds on which the assessment had originally been authorised do not (or no longer) apply: once either of these becomes evident, the person should be discharged forthwith. (Alternatively, of course, the person may agree instead to be treated voluntarily, at any time either during or at the end of the assessment period.)

7.42 The second possible assessment outcome assumes that by the end of the assessment period it has been determined not only that the person *does* have impaired decision-making capacity, but also that the respective "risk" grounds

on which the assessment had originally been authorised do apply. Here, if any intervention that requires specific authorisation is then proposed, the person's Responsible Clinician must submit an Intervention Plan to the RQIA for approval before the end of the proposed 28-day assessment period. (The subject and operation of Intervention Plans will be returned to below, at paragraph 7.46.) Otherwise, once the assessment is ended, the person will remain subject to the Framework processes on exactly the same basis as anyone else, and general and/or formal interventions may be applied (with the usual safeguards – see paragraphs 7.7 to 7.10 and 7.11 to 7.14 respectively) as appropriate.

Interventions Involving Low-Level Restriction and/or Deprivation of Liberty

7.43 The Framework recognises that care must be exercised in the regulation of restrictive practices in general, and restraint in particular. The RQIA will be responsible for regulating, and for preparing and disseminating guidelines for the safe and effective usage of, restrictive interventions.

7.44 The distinction between *deprivation of* and *restriction upon* a person's liberty is essentially quantitative, i.e. one of degree. Deprivation is where "complete and effective control" is exercised over a person's care and movements, including where a person is required to reside in a specific facility in order to receive treatment for his/her mental disorder (*cf.*, the *Bournewood* case). Restrictive interventions include a variety of forms of restraint – whether physical, mechanical, or chemical (i.e. through the use of medication) – or specifying particular individuals with whom a person with impaired decision-making capacity should not live or associate.

7.45 Relatively low-level restrictions (to be determined by the RQIA), plus cases of *Bournewood* deprivation (i.e. where a non-objecting person with impaired decision-making capacity is moved into a hospital or care home), are each considered *formal interventions* within the Model (see above, paragraphs 7.11 and 7.12). Thus they may be undertaken only in accordance with procedures drawn up and regulated by, and under the authority of, a local Health and

Social Services Trust. They must also be regularly reviewed by that Trust. In *Bournewood* cases, such reviews must be carried out at least annually, even when there are no objections, and any objections which do arise and which cannot be resolved at Trust level may be referred to a Court for resolution.

Specifically Authorised Interventions Requiring an Intervention Plan

7.46 The vast majority of *specifically authorised interventions* (i.e. all those which do not as a result of a previous Court direction require a Court declaration) will need a multi-disciplinary Intervention Plan to be drawn up and submitted for approval and authorisation to the RQIA. The minimum content expected of an Intervention Plan was presented above, in paragraph 6.21, and, for ease of reference, is reproduced here:

- a declaration from the Responsible Clinician that:
    - the person's capacity to make a decision for him/herself is impaired because of "an impairment of, or a disturbance in the functioning of, the mind or brain" (and with the most likely reason(s) for such impairment being clearly indicated);
    - any proposed decision or intervention has been exposed to a rigorous application of the Framework principles, in particular those of the person's best interests and the least restrictive alternative;
    - the proposed intervention is available and is likely either to prevent the person's condition from worsening, or to alleviate its symptoms or effects;
    - if the proposed intervention was not to be provided, there would be a significant risk to either (i) the health, safety or welfare of the person or the safety of others or (ii) the person

and/or others of serious harm (as appropriate – see paragraph 7.31); and

- the intervention could not be provided other than by way of the proposed Intervention Plan;

- full details of the person's assessed needs and the nature of the proposed intervention (which will generally be in the form of a multi-disciplinary care plan), including any elements of significant restriction and/or deprivation of liberty;

- details of the setting in which the intervention is to be carried out (i.e. in a community setting or an approved facility); and

- details of the rights of the person (and/or of his/her representative) to appeal against the Intervention Plan.

7.47 The precise content of an Intervention Plan will depend upon the individual circumstances, although any compulsory elements must always be detailed. So too must any components which are considered essential, since it is anticipated that there will be a responsibility on service-providers for these to be provided.

7.48 These apart, the content of an Intervention Plan will depend upon whether or not it is intended to include any measures that could be deemed to constitute (i) either a significant restriction upon, or a deprivation of, the person's liberty, or (ii) a prolonged or particularly serious intervention. These are dealt with respectively in the following two sections, wherein further details about Intervention Plans will be presented as appropriate.

Interventions Involving Significant Restriction and/or Deprivation of Liberty

7.49 Interventions involving relatively low-level restrictions and/or cases of *Bournewood* deprivation (i.e. where a non-objecting person with impaired

decision-making capacity is moved into a hospital or care home), were considered above, in paragraphs 7.43 to 7.45. They are each considered *formal interventions* within the Model.

7.50 More significant restrictions (again, as will be determined by the RQIA), as well as cases of deprivation in which there is not agreement, constitute *specifically authorised interventions* within the Model. As with all interventions, these may only be undertaken if they are in the best interests of the person with impaired decision-making capacity. Additionally, and in accordance with section 6 of the 2005 Act, they must also be both *necessary* and *proportionate*. However, whereas the 2005 Act sanctions the use of such interventions in relation to the likelihood of harm occurring to a person with impaired decision-making capacity only, the Model extends that authorisation to cases of *other* people being placed at risk by the person's behaviour as well – e.g. a person with paranoid delusional beliefs, the subject(s) of whose beliefs may be at serious risk of harm, whether physical or psychological. (This is in line with the underlying principle of Benefit, since it cannot ultimately be of benefit to a person for his/her behaviour to be allowed to place other individuals at risk – not least because, by so doing, he/she may face a period of incarceration.)

7.51 All interventions which include either deprivation and/or significant restrictions on a person's liberty must be specified within an Intervention Plan, to be drawn up by the person's Responsible Clinician and to include, as a minimum, the information detailed above, in paragraph 7.46.

7.52 The Intervention Plan should be submitted to the RQIA for initial approval, on each occasion it is amended significantly (as defined in a Code of Practice) and at least annually thereafter. This may require the establishment of a panel comprising a range of both professional expertise and service user- and carer-representation, to approve both the process and the content of the proposed Intervention Plan. In addition, for interventions amounting to a deprivation of liberty, the Intervention Plan should be referred to the RQIA after an initial 28

days and should be reviewed by the RQIA at 6-monthly intervals thereafter, rather than yearly.

7.53 If the person has no other form of independent representation, an independent advocate must be appointed on his/her behalf in cases where a significantly restrictive intervention is proposed, and either the person, the independent advocate and/or the RQIA should be able to refer any decision or intervention to the Tribunal. For interventions amounting to a deprivation of liberty, an independent advocate must be appointed on behalf of the person in any event, i.e. even if he/she already has an alternative form of independent representation. The Tribunal will have discretion over which appeals it hears.

Prolonged or Particularly Serious Interventions

7.54 In recognition of the fact that the most serious and prolonged interventions should carry with them the most robust forms of protection for persons with impaired decision-making capacity, the Model identifies three specific categories of such. These have all been described above, in paragraph 7.16:

- interventions requiring a second specialist opinion, including situations where:
  - the person with impaired decision-making capacity either objects to, or does not agree to, a major invasive intervention;
  - there is no agreement on what constitutes the person's best interests (e.g. due to different views amongst relevant parties, a significant possibility that the adverse effects of the proposed intervention may outweigh its benefits, or where a potentially life-sustaining intervention is subject to dispute);
  - the proposed intervention falls outside the scope of recognised clinical guidelines; or

- a specific regulated intervention, such as ECT, is proposed;

- certain prolonged interventions; and

- procedures with irreversible consequences.

7.55 As with all decisions and interventions carried out on behalf of persons with impaired decision-making capacity, any prolonged or particularly serious intervention must be adjudged to be in the person's best interests, and regard must be had of the least restrictive alternative. In addition to providing details about the proposed intervention itself, any resulting Intervention Plan should include a declaration in respect of each of the areas specified above, in paragraph 7.46.

7.56 In the case of interventions which require a second opinion, one appropriate specialist approved by the RQIA and not otherwise involved in the case must concur with the Intervention Plan, while two such independent and appropriate specialists must concur with Plans involving interventions which have irreversible consequences.

7.57 Intervention Plans in respect of prolonged and particularly serious interventions should be submitted to the RQIA for initial approval, each time they are amended (if indeed they are amended), and thereafter at least every 6 months (for second opinion cases) or annually (for prolonged interventions).

7.58 Also, as with Intervention Plans specifying deprivation of liberty (see paragraphs 7.52 and 7.53), for those which specify prolonged or particularly serious interventions an independent advocate must be appointed on behalf of the person, even if he/she already has an alternative form of independent representation. Also, either the person him/herself, the independent advocate and/or the RQIA may refer any decision or intervention to the Tribunal, and the Tribunal will have discretion over which appeals it hears.

Interventions Requiring a Court Declaration

7.59 The Courts have previously directed that there exist a (limited) number of situations (e.g. non-therapeutic sterilisation) wherein *only* the Court should be able to authorise a particular intervention (see above, paragraph 7.16). The Model contemplates that all such cases will continue to be referred to the Court for a declaration.

Persons Involved in Criminal Proceedings

7.60 The Framework should support the principle of equivalence, that those who are subject to the Criminal Justice System should have access to treatment and care that is equivalent to that available to other members of our society. Thus service users should be facilitated to access appropriate services primarily on a voluntary basis and with a minimum of restriction, commensurate with public safety. Arrangements in the Framework for people who are subject to the Criminal Justice System, such as assessment of decision-making capacity and the implementation of Intervention Plans should, as far as possible, be equivalent to those applicable to everyone else. The timescales that apply to these provisions should generally be the same as apply outside the Criminal Justice System and the safeguards for those with impaired decision-making capacity must be at least as robust. The provisions of the Framework should facilitate and promote detailed assessment of individuals so that decisions affecting their future can be made by the relevant bodies after consideration of all the necessary information.

Transfer of Prisoners to Approved Facilities for Assessment, Treatment and Care on a Voluntary Basis

7.61 At present, prisoners who suffer from physical health problems that warrant inpatient treatment in hospital are generally admitted to hospital to receive the treatment they require, while retaining their status as prisoners and remaining subject to the requirements of the Criminal Justice System. Equivalent high quality treatment should be available to prisoners who suffer from mental

health problems. There is no system in routine use in Northern Ireland whereby a prisoner who is suffering from a mental health or learning disability problem that warrants treatment in hospital and who has decision-making capacity and gives his or her consent may be transferred to hospital to receive assessment, treatment and care on a voluntary basis. Measures should be introduced to allow the transfer of such prisoners to an appropriate facility (usually a hospital) so that they can receive care on a voluntary basis rather than being subject to compulsory powers of treatment. Such individuals would retain their status as prisoners and thus be subject to the requirements of the Criminal Justice System.

Assessment Orders and Intervention Orders

7.62 Under the proposed new legislation the Magistrates Courts, Crown Courts and, additionally, the Court of Appeal should be given powers to authorise the assessment of an individual's decision-making capacity and associated risks, and this may require admission to an approved facility (usually a hospital). This process of remand for assessment should be similar to admission for assessment for people in the community. Where appropriate, this may be followed by an Intervention Order to enable further compulsory treatment and care. When the Court remands an individual to hospital for assessment or treatment it should indicate whether the Responsible Clinician may give the person temporary leave from hospital or whether the decision to grant leave is to be reserved to the Court. Once an individual no longer requires assessment or treatment the new legislation should facilitate his or her prompt return to Court for alternative disposal.

7.63 New legislation should contain provisions to enable Courts to make compulsory Intervention Orders (similar to the current Hospital Order, Interim Hospital Order and Guardianship Order). It is important that people are assessed in detail before such disposals are made and a Court should record its reasons if it makes an Intervention Order without first making an Assessment Order or Interim Intervention Order.

7.64 When an individual is to be made subject to the powers of the new legislation, those who are making an application or recommendation must have seen the individual within a specified period of time. The same timescales should apply whether or not the individual is involved in criminal proceedings.

7.65 In the case of acquitted persons with recommendations for assessment, these recommendations should provide sufficient authority to permit the individual to be assessed in an appropriate location.

Intervention Orders Combined with Other Sentences

7.66 In Scotland, Hospital Directions have been introduced which allow a Court to impose a sentence of imprisonment, including a life sentence for murder, and at the same time to authorise that the convicted person is admitted to and detained in hospital. Similar disposals have also been introduced in England and Wales. Hospital Directions are considered particularly appropriate in certain cases, for example where there is not considered to be a strong association between the offender's mental disorder and the offence, or the alleviation of those aspects of the person's mental state which are likely to respond to treatment may not substantially reduce the extent to which the offender presents a risk to the public.

7.67 The Review recommends that it should be possible for the Court to combine an Intervention Order with certain other specified sentences such as a prison sentence or a Custody Probation Order. When making such a disposal the Court should state the options it has considered and the reasons for its decision. Appropriate appeal mechanisms are required to enable the individual to appeal against the Intervention Order component of the disposal.

Restriction Orders

7.68 Under the provisions of the 1986 Order, a Restriction Order may be superimposed on Hospital Orders or Transfer Direction Orders in certain cases where an individual is suffering from mental illness or severe mental

impairment and it appears that it is necessary for the protection of the public from serious harm. No comparable disposal is available to the Courts in situations where an individual is not suffering from such a mental condition yet poses a similar risk of serious harm to the public. While the Review recognises the importance of measures designed to protect the public from serious harm it is concerned that Restriction Orders may unjustifiably discriminate against people suffering from certain types of mental disorder.

7.69 Currently, the Secretary of State is authorised to make decisions about people who are subject to Restriction Orders, such as whether to grant the individual leave from hospital, to transfer him to another hospital, to discharge him from hospital or to recall him to hospital. It has been suggested (*cf.*, both the Richardson Report and the Millan Report) that such decisions should be taken by a body that is manifestly independent of political influence. It would seem appropriate for the new legislative framework to incorporate future measures in relation to the risks posed by people suffering from mental disorder within a wider and independent risk management framework that addresses the full range of people who pose a risk of serious harm to the public.

Transfer Between Prison and Approved Facilities

7.70 The 1986 Order contains provisions to enable the Secretary of State to direct the transfer of prisoners to hospital for treatment but not for assessment of their mental condition. The Framework should include provisions for the relevant authority to transfer prisoners to approved facilities (usually hospital) for assessment, followed, if appropriate, by submission and approval of Intervention Plans. Transfers between prison and approved facilities should occur within the same timescales as experienced by service users in the community.

Arrangements for Transferred Prisoners on Expiry of Sentence

7.71 Where a person subject to an Assessment Order or an Intervention Order would be entitled to be released from prison, but it is considered that the

prisoner requires continued detention under the legislation, it should be necessary for the continued detention to be authorised by the Tribunal (or to have the right of appeal to a Tribunal) and the individual should be treated as if subject to normal civil procedures.

Appeals Against Excessive Restriction in Hospital

7.72 The principle of treating people under conditions of security no greater than is justified by the degree of danger they present to themselves or others is strongly supported. In Scotland, the MHCT Act 2003 includes measures to enable appeal against detention in excessively restrictive circumstances. It is proposed that similar measures, informed by the Scottish experience, should be introduced in Northern Ireland.

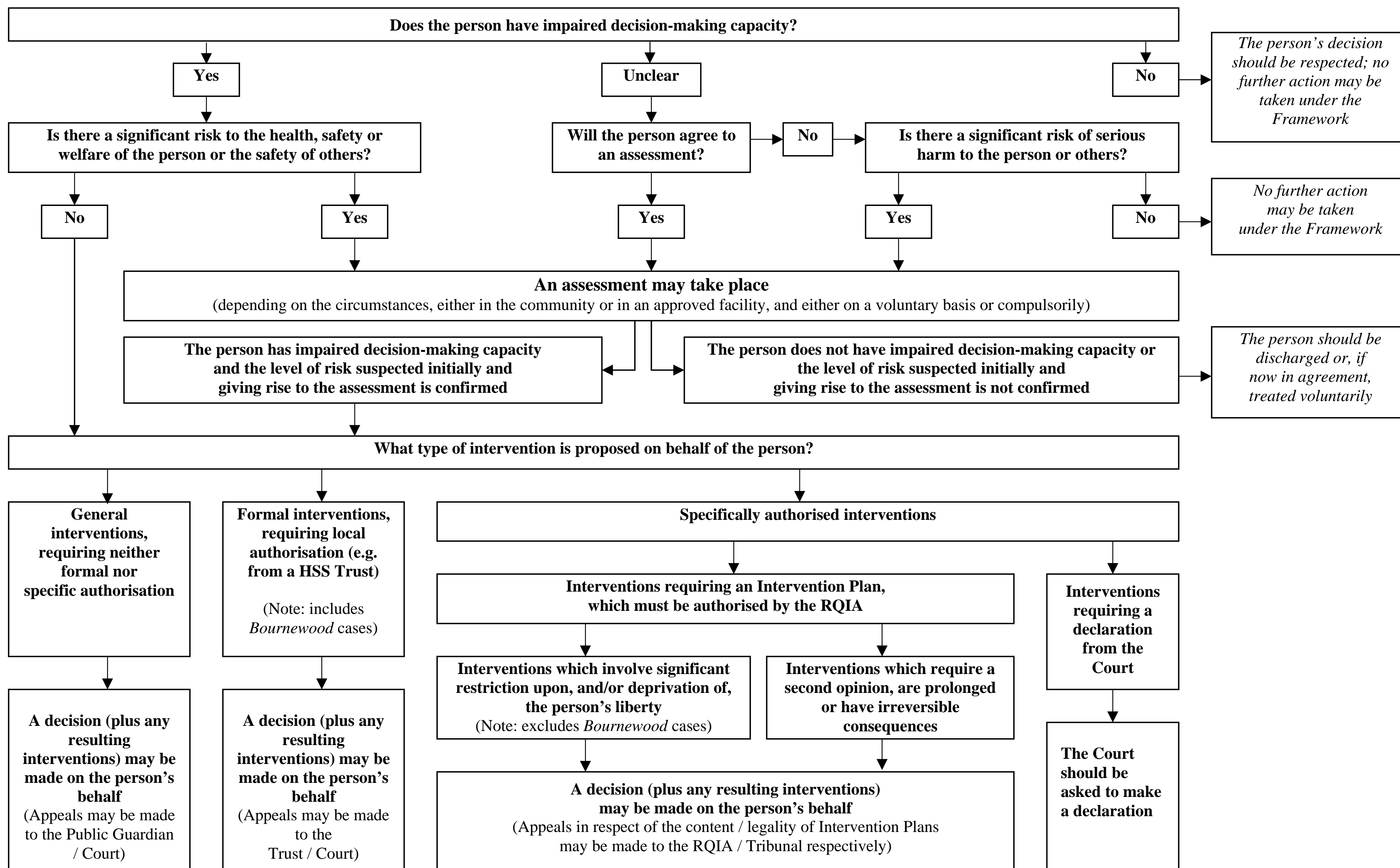
Patients Removed To and From Northern Ireland

7.73 Currently, people who are remanded to prison and who are suffering from mental disorder that warrants transfer to a high security facility cannot be transferred to a hospital outside Northern Ireland. There is no maximum security facility in Northern Ireland and thus these individuals are denied the opportunity of assessment and treatment. Mechanisms must be found to enable urgent access to treatment in high security facilities when necessary and these may require additional legislative change.

7.74 Arrangements should also facilitate transfers between other jurisdictions, including in emergencies and for short periods, for example to facilitate visits or rehabilitation programmes.

Flow Diagram Summarising Action in Cases of (Suspected) Impaired Decision-Making Capacity where a Decision Must Be Made and there is No Attorney or Valid Advance Statement

(Notes: Any decision taken must (i) be in the person's best interests and (ii) take account of the least restrictive alternative; the person should have access to advocacy at all levels of the diagram)



CHAPTER 8

THE WAY FORWARD

The Journey So Far

8.1 The Review's detailed consideration of the need for reform of Mental Health legislation has persuaded us that the time is right for a principle-based approach to legislative provision for our community. At its heart is the need for regard for human dignity and for the human rights of every citizen. This approach has led us to propose a new legislative Framework based on explicit principles.

8.2 As noted earlier, the expression of these Framework proposals is not an attempt at legislative drafting but an explanation of what we believe is necessary for reforming current legislation applying a principle-based approach. Many of the proposals involve new considerations for legal provision in healthcare practice, for example a capacity approach to mental health provision, advance statements about treatment, treatment in the least restrictive setting. The details presented in the Model have been provided to show how such a Framework might work in practice and as an aid to illustrate those issues which will need further research, development and consultation**.**

Recommendations

8.3 The Review, therefore, makes the following recommendations which will establish the basis of and set the direction for, change in legislation.

1. New Mental Health and Capacity legislation for Northern Ireland should be based on agreed principles.

2. These principles should support the dignity of the person and be explicitly stated in the legislation.

3. The principles should be:

   i Autonomy - respecting the individual's capacity to decide and act on his own and his right not to be subject to restraint by others.

   ii Justice - applying the law fairly and equally.

   iii Benefit - acting in the individual's best interests.

   iv Least Harm - acting in a way that does not harm the individual.

4. These principles should apply in a non-discriminatory and balanced way to all healthcare decisions, as well as to welfare and financial needs.

5. Grounds for interfering with a person's autonomy should be based on his or her impaired decision-making capacity.

6. A comprehensive legislative framework for mental health and capacity should be introduced.

7. The definition of incapacity in the Mental Capacity Act 2005 should be adopted in Northern Ireland, specifically that:

   "a person lacks capacity if in relation to a matter at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary."

   Impairment of, or disturbance in the functioning of, the mind or brain should subsume mental illness, mental handicap and any other disorder or disability of mind. It should include disorders due to injury or disease such as stroke. The test of capacity should include all those aspects of mental functioning which affect decision-making capacity (not just cognitive impairment).

8. Specific key provisions of the Mental Capacity Act 2005 should be adopted in Northern Ireland, with minimal amendment. These include:

   - the definitions of decision-making capacity and persons with impaired decision-making capacity;
   - a requirement that any decision or action undertaken on behalf of a person with impaired decision-making capacity must be in his/her best interests and must have regard for the least restrictive option available;
   - legal protection for the performance of (everyday) acts carried out in connection with a person's care or treatment;
   - provision for attorneys, acting under Lasting Powers of Attorney (LPAs), to deal with welfare (including healthcare) in addition to property and finance;
   - an enlarged jurisdiction of the Court in relation to welfare, healthcare and financial matters;
   - powers of the Court to make declarations and orders, and to appoint deputies;
   - the recognition of advance decisions to refuse treatment and, in addition, advance statements about preferred treatment;
   - safeguards in relation to research involving persons with impaired decision-making capacity;
   - independent advocates;
   - Codes of Practice;

- a new offence of ill-treatment or neglect;
- the appointment of a Public Guardian; and
- ratification of the Convention on the International Protection of Adults.

9. The following provisions, which are not within the Mental Capacity Act 2005 and are currently governed through Mental Health law, should be included in new legislation:

   - compulsory admission to an approved facility for assessment;
   - supervised intervention in the community;
   - a system for the management of risk;
   - provision for prolonged and particularly serious interventions;
   - the role and functions of the Mental Health Commission, which will be transferred to the Regulation and Quality Improvement Authority;
   - the role and functions of the Mental Health Review Tribunal;
   - the introduction of a nominated person as a replacement for the 'nearest relative', with a re-definition of the corresponding role;
   - an enhancement of the role and recognition of the rights of carers (such as family or friends) and
   - an extension of certain professional boundaries and functions, with the creation of two new professional posts, the Approved Clinician and the Responsible Clinician.

10. Children and young people under the age of 18 who fall under the proposed approach to substitute decision-making should be afforded the special protections described in paragraph 5.48.

11. People who are subject to the Criminal Justice System should have access to assessment, treatment and care which is equivalent to that available to all other people.

12. Legislation must provide appropriate public and individual protection to the community against harm from individuals whose decision-making capacity is impaired and who present a risk to others. On the other hand, legislation must not discriminate unjustifiably against people who suffer from a mental health problem or learning disability.

13. An inter-agency risk assessment and management framework should be developed, which applies to all offenders who pose a prescribed level of risk and irrespective of whether or not these individuals suffer from a mental health problem or learning disability.

14. Training programmes on the proposed new legislation are essential for those individuals and professionals who will be required to operate it. The legislation, Code(s) of Practice and related training programmes should all be introduced at the same time.

15. The general public, users of services and carers must be kept fully informed at all stages of the introduction and operation of new legislation. Users of services and carer representatives must participate in its development.

16. Adequate resources must be made available to operate the procedures and bodies prescribed by the legislation.

17. The proposed application of a capacity approach to interventions should be the focus for early local research.

18. The proposed comprehensive legislative framework should be taken forward through a joint initiative involving the Office of Law Reform, the DHSSPS, the Northern Ireland Court Service and the Northern Ireland Office, to translate the proposals into new provision for Northern Ireland.

Next Steps

8.4 A great deal of discussion and consultation both within the Review and with a number of external experts, extending over several years of endeavour, have gone into the development of the present Framework proposals. The next essential step is consultation with the wider community of stakeholders in Northern Ireland.

8.5 The opinions of all stakeholders on the proposals are essential as we seek to gauge the support for a principles-based approach for meeting the health and welfare needs of our citizens. Comments are welcome, therefore, on both the body of the text and the specific recommendations.

8.6 The final report will include advice to Government on a number of issues considered essential for the successful introduction of new legislation. These include the need to establish an inter-departmental task force to take forward the process of developing a single legislative framework for Northern Ireland. It will highlight the need for research, evaluation and monitoring of any new legislative framework on matters related to the effectiveness and comprehensiveness of provision and on whether or not parallel developments are required in DHSSPS and other Departments, for example on risk management.

8.7 The Review considers that the successful introduction of new legislation will depend critically on the effective implementation of the recommendations of all of the other

reports of the Bamford Review on policy and services. Indeed, consideration may need to be given to a phased introduction to aspects of legislation in tandem with appropriate supporting service development.

8.8 Finally, to ensure that legislative change translates into meaningful improvements in the lives of those it is there to support, a well-resourced strategy for the education and training needs of all those individuals likely to be involved in the application of legislative provision, with an information programme for the general public, service users, carers and professionals, will be essential. We see this Report and the consultation process as the first step.

Annex 1

TERMS OF REFERENCE FOR THE BAMFORD REVIEW

1. To carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986.

2. To take into account:

   - the need to recognise, preserve, promote and enhance the personal dignity of people with mental health needs or a learning disability and their carers;

   - the need to promote positive mental health in society;

   - relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity;

   - evidence – based best practice developments in assessment, treatment and care regionally, nationally and internationally;

   - the need for comprehensive assessment, treatment and care for people with a mental health need or a learning disability who have offended or are at risk of offending; and

   - issues relating to incapacity.

3. To make recommendations regarding future policy, strategy, service priorities and legislation, to reflect the needs of users and carers.

Annex 2

MEMBERSHIP OF THE LEGAL ISSUES WORKING COMMITTEE AND ITS SUB-GROUPS

LEGAL ISSUES WORKING COMMITTEE

Convenor:	Master Brian Hall	Master, Office of Care and Protection
•	Prof David Bamford*	Chair of the Review
•	Mrs Angela Bell	Criminal Justice Division, NIO
•	Dr Fred Browne	Consultant Forensic Psychiatrist, Shannon Clinic
•	Miss Marie Crossin	Chief Executive, CAUSE
•	Mr John James	User Representative
•	Mr Mervyn Morrow QC	Deputy Chair, Mental Health Review Tribunal
•	Mr Winston McCartney*	User Representative
•	Dr Mary McClean	Carer Representative
•	Prof Roy McClelland	Chair of the Review
•	Dr Maria McGinnity	Consultant Psychiatrist, Muckamore Abbey Hospital
•	Prof Tony McGleenan	University of Ulster/Bar Library
•	Mr Noel McKenna	Carer Representative
•	Mrs Mary O'Boyle	Assistant Director, Mental Health, Holywell Hospital
•	Ms Kitty O'Kane	User Representative
•	Miss Anne Rafferty	Criminal Justice Division, NIO
•	Mr Alastair Rankin	Solicitor
•	Miss Brenda Ross	Criminal Justice Division, NIO
•	Dr Oliver Shanks	Consultant Psychiatrist
•	Master Hilary Wells	Master, Office of Care and Protection

* During the work of the Review Mr Winston McCartney and Professor David Bamford sadly died. Professor Roy McClelland (who had been acting as Deputy Chair) succeeded Professor Bamford as Chair of the Review.

SUB-GROUP 1 - **which considered Definitions and Terminology, Personality Disorder and the needs of Children and of People with Learning Disability**

Membership:

Convenor:	Dr Maria McGinnity	Consultant Psychiatrist, Muckamore Abbey Hospital
•	Dr Ivan Bankhead	Consultant Clinical Psychologist, Homefirst Trust
•	Mrs Christine Bateson	Crisis Response Team, Homefirst Trust
•	Mr Maurice Devine	Consultant Nurse in Learning Disability
•	Dr Aine Downey	Lay Member, Mental Health Review Tribunal
•	Dr Ruth Elliott	Consultant Clinical Psychologist
•	Mrs Anne Fenton	Director of Professional Legal Studies, QUB
•	Dr Peter Gallagher	Consultant in Child and Adolescent Psychiatry, Antrim
•	Mrs Bernadette Hamilton	Co-ordinator, Approved ASW Training Programme Northern Ireland
•	Mr John James	User Representative
•	Dr Mary McClean	Carer Representative
•	Dr Graeme McDonald	Consultant Psychiatrist, Mater Hospital
•	Dr Artie O'Hara	Consultant Psychiatrist, Gransha Hospital
•	Mrs Maureen Piggot	Chief Executive, MENCAP
•	Dr Pauline Prior	Senior Lecturer, School of Sociology and Social Policy, QUB
•	Master Hilary Wells	Master, Office of Care and Protection

Co-opted to consider the Needs of People with Learning Disability

•	Dr Petra Corr	Consultant Clinical Psychologist, Muckamore Abbey Hospital
•	Dr Michael Curran	Consultant Psychiatrist, Foyle Trust
•	Dr Jennifer Galbraith	Consultant Psychologist, Foyle Trust
•	Mr Paddy McLoone	Assistant Principal Social Worker, Foyle Trust
•	Dr Caroline Marriott	Consultant Psychiatrist, Muckamore Abbey Hospital

SUB-GROUP 2 - which considered Compulsory Assessment and Treatment, and Guardianship (under Part II), the role of the Mental Health Review Tribunal (under Part V) and the role of the Mental Health Commission (under Part VI)

Membership:

Convenor:	Professor David Bamford	Chair of the Review
•	Dr Paul Bell	Consultant Psychiatrist, South and East Belfast Trust
•	Dr Jim Campbell	Senior Lecturer in Social Work, QUB
•	Dr Michael Curran	Consultant Psychiatrist, Foyle Trust
•	Dr Noeleen Devaney	Medical Director, Down Lisburn Trust
•	Miss Brenda Donnelly	Official Solicitor to the Supreme Court
•	Mr Philip Gilpin	Solicitor
•	Dr Helen Harbinson	Consultant Psychiatrist, Ulster Community and Hospitals Trust
•	Mrs Phil Hughes	Principal Officer, Dementia Services, Homefirst Trust
•	Ms Michelle McMaster	Carer Representative
•	Mr Mervyn Morrow QC	Deputy Chair, Mental Health Review Tribunal
•	Mr Brendan Mullen	Director of Mental Health, Ulster Community and Hospitals Trust
•	Mrs Mary O'Boyle	Assistant Director, Mental Health, Holywell Hospital
•	Mrs Marion O'Neill	Chair, Mental Health Commission

The Sub-Group which considered Compulsory Assessment and Treatment, chaired by Dr Jim Campbell, also co-opted:

•	Mrs Christine Bateson	Crisis Response Team, Homefirst Trust
•	Mr Martin Daly	User Representative
•	Dr Mary McClean	Carer Representative

The Sub-Group which considered Guardianship, chaired by Mrs Phil Hughes, also co-opted:

- Ms Marilyn Beare — Community Nursing Service Manager, Homefirst Trust
- Mr Jack Chapman — Carer Representative
- Dr Jennifer Creegan — Psychologist, Downshire Hospital
- Ms Eileen Harvey — Clinical Services Manager, Down Lisburn Trust
- Mrs Karen Howell — Assistant Principal Social Worker, Ulster Community and Hospitals Trust
- Mr Jim McCluney — Senior Social Worker, South and East Belfast Trust
- Dr Kerry Ng — Staff Grade Psychiatrist, Muckamore Abbey Hospital
- Ms Claire Quigley — Mental Health Commission
- Ms Angela Trainor — Carer Representative
- Other User Representatives in this Sub-Group did not wish to have their names disclosed.

The Sub-Group which considered the Mental Health Review Tribunal was chaired by Mr Mervyn Morrow QC

The Sub-Group which considered the Mental Health Commission, chaired by Dr Noeleen Devaney, also co-opted:

- Dr Stephen Compton — Consultant Psychiatrist, Mater Hospital
- Mr Patrick Convery — OT Services Manager, Foyle Trust
- Miss Marie Crossin — Chief Executive, CAUSE
- Mr Glenn Houston — Chief Executive, Craigavon and Banbridge Trust
- Dr Mandy Irvine — Consultant Psychologist, Muckamore Abbey Hospital
- Mrs Lucy McManus — Director of Nursing, Armagh and Dungannon Trust
- Mrs Julie Thornton — Manager of the Registration and Inspection Unit, Northern Health and Social Services Board
- Mr Jim Walsh — Mental Health Alliance Co-ordinator

SUB-GROUP 3 - **which considered Consent to Treatment (under Part IV), the Management of Property and Affairs of Patients (under Part VIII) and Enduring Powers of Attorney**

Membership:

Convenor:	Master Brian Hall	Master, Office of Care and Protection
•	Mrs Fiona Bagnall	Resident Magistrate
•	Mrs Maeve Bell	Carer Representative
•	Mrs Mairead Buckley	Office of Care and Protection
•	Mr Laurence Evans	Mental Health Services Manager, Daisy Hill Hospital
•	Miss Heather Gibson	Barrister at law
•	Mr John James	User Representative
•	Miss Linda Johnston	Solicitor
•	Mrs Rosalind Johnston	Deputy Official Solicitor
•	Dr Roger Manktelow	Lecturer, University of Ulster
•	Dr Caroline Marriott	Consultant Psychiatrist, Muckamore Abbey Hospital
•	Prof Roy McClelland	Chair of the Review
•	Dr Clare Monaghan	Consultant Psychiatrist, South Tyrone Hospital
•	Mr Tommy Monteith	Community Psychiatric Nurse, Foyle Trust
•	Mr Alastair Rankin	Solicitor
•	Mr Henry Toner QC	Bar Library

The Sub-Group which considered Consent to Treatment, chaired by Dr Clare Monaghan, also co-opted:

•	Dr Jim Anderson	Consultant Psychiatrist, Ulster Community and Hospital Trust
•	Ms Jacqueline Carey	User Representative
•	Mrs Martha McClelland	User Representative and Convenor, Experts by Experience Reference Group
•	Dr Michael Mannion	Consultant Psychiatrist, Holywell Hospital
•	Dr Sheelagh Mary Rea	Consultant Psychiatrist, Foyle Trust

SUB-GROUP 4 - which considered Offenders with Mental Health needs, including those with Personality Disorder

Membership:

Convenor:	Dr Fred Browne	Consultant Forensic Psychiatrist, Shannon Clinic
•	Mrs Angela Bell	Criminal Justice Division, NIO
•	Dr Ian Bownes	Forensic Psychiatrist, Tyrone and Fermanagh Hospital
•	Mrs Deborah Devaney	Carer Representative
•	Dr John Farnan	Forensic Medical Officer
•	Mr Brendan Fulton	Assistant Chief Probation Officer, Probation Board for Northern Ireland
•	Dr Geraldine Henry	Consultant Psychiatrist, Holywell Hospital
•	Mr George Keatley	Deputy Director, NI Court Service
•	Dr Harry Kennedy	Consultant Forensic Psychiatrist, Dublin
•	Mr Bill Lockhart	Chief Executive, Youth Justice Agency
•	Dr Philip McClements	Chief Medical Advisor (Prisons), NIO
•	Mr Noel McKenna	Carer Representative
•	Mrs Cathy McPhilips	Assistant Director of Mental Health
•	Dr Colin Milliken	Consultant Psychiatrist, Muckamore Abbey Hospital
•	DCI Gary Mullan	Police Service of Northern Ireland
•	DSgt David Wallace	Police Service of Northern Ireland
•		

Annex 3

THE BOURNEWOOD (HL) CASE

This case concerns Mr L who is incapable of giving consent or objecting to medical treatment. He had been cared for in Bournewood hospital for around 30 years until March 1994 when he was discharged to live with paid carers on a trial basis.

In July 1997 Mr L was removed from his existing carers in the community and re-admitted to Bournewood hospital as he had been agitated when making his weekly visit to a day care centre run by a local authority. In line with standard practice, Mr L was not compulsorily detained under the 1983 Act but admitted on an informal basis under the common law doctrine of necessity because he was compliant and did not resist admission. The consultant in charge of Mr L subsequently advised his carers on clinical grounds not to visit him due to concern that he would think he would be able to leave with them.

Mr L was not formally detained until December 1997 following a Court of Appeal ruling that the detention in July 1997 had been unlawful. Through his carers Mr L sought judicial review of the decision to admit him to hospital, a writ of habeas corpus to secure his release and damages for false imprisonment and assault. This was refused at first instance. Although Mr L successfully appealed to the Court of Appeal this decision was overturned in the House of Lords who held that he had not been detained.

The case was referred to the European Court of Human Rights (ECtHR). The Court considered that Article 5(1) of the ECHR requires the existence in domestic law of adequate legal protections and fair and proper procedures. Compulsory committals under the 1983 Act provide procedural rules on, amongst other things, who may propose admission, for what reasons and what kind of medical and other assessments are required. However, in contrast there are no fixed procedural rules relating to the admission or detention of compliant incapable patients.

Reliance on the doctrine of necessity for admission or treatment of such patients is arbitrary due to the lack of procedural safeguards and therefore, the ECtHR opined, unlawful. Such safeguards are required to protect individuals against any misjudgement or professional lapse of the relevant healthcare professional. The court held that Article 5(1) of ECHR was breached in Mr L's case and outlined the following types of procedural safeguards that they believed are required:

(1) procedures for fixing the purpose or basis of an admission (eg for assessment and for treatment) and who can propose admission;

(2) procedures for establishing time, treatment or care limits attached to an admission;

(3) procedures for continuing clinical assessment to ensure there is still a disorder warranting detention; and

(4) procedures for representatives being able to make objections or applications on behalf of the patient.

The ECtHR also found that it had not been demonstrated that Mr L had available to him a procedure to have the lawfulness of his detention reviewed by a court. Judicial review was the only method of challenge that was of any consequence and that was insufficient for the purpose of reviewing the lawfulness to detain at the time of Mr L's domestic proceedings.

At that time, before the Human Rights Act came into force, judicial review was not wide enough to adequately examine the merits of the clinical views as to the persistence of mental illness such as to justify detention. Therefore the court held that article 5(4) of the ECHR was also breached.

> (Extracted from The Adults with Incapacity (Scotland) Act 2000 Draft Guidance for Local Authorities on when to invoke the Act).

Annex 4

DEVELOPMENTS IN MENTAL HEALTH LAW – TREATMENT IN THE COMMUNITY IN SCOTLAND

COMPULSORY TREATMENT ORDERS UNDER THE MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003

Compulsory Treatment may be given either in hospital or in a community setting (based on the least restrictive alternative) when the criteria for this are met.

After the 28 day period of assessment allowed under a Short Term Detention Order an application is made to a Tribunal for approval of a Compulsory Treatment Order. This must accord with the principles underlying the Act and take into account Advance Statements the person may have made with regard to treatment, the role of the named person and the provisions made for advocacy support.

The process of application is co-ordinated by and is the responsibility of a specially trained "Mental Health Officer" (MHO). The process is multi-disciplinary and requires in-depth consultation with all parties, including the patient at all stages. The application has two medical reports, the MHO's report and the Proposed Care Plan. The possible measures that may be authorised include the patient:

- to be detained in hospital;
- to receive medical treatment in or out of hospital;
- receive community care services or other services;
- to reside in a specified place;
- to afford access to MHO, RMO, and others; and
- to get permission from the MHO to change residence.

Some essential elements of the Care Plan may be identified as "recorded matters" and there is a responsibility on the RMO to report if these essential elements are not provided. There is a duty upon Health Authorities that these should be provided as required by the principle of reciprocity.

The definition of "Medical Treatment" is broad and includes nursing care, psychological intervention and rehabilitation (which includes education, training in work, habitation and social and independent living skills).

The contents of the Care Plan cover four key areas:

- the needs of the patient;
- the actions proposed to meet these;
- the objectives of these actions; and
- the parties who undertake responsibly to carry out all the actions.

Unmet need is also recorded. Emphasis is on the least restrictive alternative at all stages. The Code of Practice emphasises the need for all involved in the delivery of care and treatment to work in close multi-disciplinary collaboration.

If a person does not comply with specific conditions – for example does not attend for medical treatment - then the Order allows the patient to be conveyed to an approved place for the purpose of receiving treatment. The person may be detained for up to six hours for treatment to be given,

If a person is not complying with measures in the community-based CTO, there are powers given to remove him to hospital for up to 72 hours in certain conditions and this period of detention may be extended if the Care Plan needs to be revised. The use of force in giving treatment under any circumstances is not permitted, other than for a patient in hospital.

The powers given are individual to the patient's needs and proportionate to the level of compulsion required (ie. least restrictive).

These measures were only put into operation in October 2005 and the Scottish Mental Welfare Commission, which monitors the operation and implementation of the Act, is visiting every person who is subject to a Community CTO to check whether elements of the Care Plan are indeed being provided.

Annex 5

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