Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Mental Capacity Bill: Consultation Responses and Proposed Way Forward

17 January 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Paul Givan (Chairperson)
Mr Raymond McCartney (Deputy Chairperson)
Mr Stewart Dickson
Mr Alex Easton
Mr Tom Elliott
Mr William Humphrey
Mr Alban Maginness
Ms Rosaleen McCorley
Mr Patsy McGlone

Witnesses:

Mr Tom Haire	Department of Justice
Mr Gareth Johnston	Department of Justice
Mr Michael Kelly	Department of Justice

The Chairperson: I welcome Gareth Johnston, head of criminal justice policy and legislation division, and Tom Haire and Michael Kelly, also from the criminal justice policy and legislation division. This session will be recorded for the Hansard report, which will be published in due course on the Committee web page. Mr Johnston, I will hand over to you to update the Committee.

Mr Gareth Johnston (Department of Justice): Thank you for your welcome. When we appeared before you in June 2012, we outlined plans to publish a consultation paper on extending proposed mental capacity legislation to the criminal justice system in Northern Ireland. The consultation formally launched on 6 July and ran until 12 October, but a number of responses were received after the consultation closed and we were happy to include those in our analysis.

By way of background, Committee members may recall that Professor Bamford's review of mental health recommended a single legislative framework for the reform of mental health law in Northern Ireland. It advocated the introduction of mental capacity legislation broadly in line with the Mental Capacity Act 2005 in England and Wales. Indeed, I understand that in the Republic of Ireland, they are looking at a similar model at the moment. However, a key difference between Bamford's envisaged approach and what is in place in other jurisdictions was its advocacy of the application of those mental capacity principles and safeguards to people who are subject to the criminal justice system, not just to the general population. The Justice Minister subsequently endorsed the approach taken by Professor Bamford and his review team.

Both the Justice Committee and the Health Committee wrote to us about that approach, and recognising the importance that you and a range of other stakeholders attach to the creation of a

single piece of legislation on mental capacity, the Justice Minister and Health Minister agreed to a joint Bill. I know that the Committee has a paper on considering the options for Committee scrutiny of that Bill, and I understand that you are to discuss that following our briefing. I should just say that although I recognise that it is a matter for the Assembly, we in the Department want to suggest that an ad hoc joint Committee approach would have significant advantages. The principles and safeguards in the Bill that are common across the justice system and the health system could be considered together, and, of course, a single Committee would be much easier for the voluntary and community sector to engage with. Having said that, we recognise that it is an issue for the Committee and the wider Assembly.

I will go back to the report on responses. We needed to find a way to deliver on the Bamford proposal, so we consulted on a number of key ideas, including the principles and safeguards underpinning the Bill; how, on a day-to-day basis, the justice system would operate in a capacity-based environment; the existing statutory powers available to the court and the Department of Justice (DOJ), like place-of-safety powers; and the issue of emerging capacities in under-16s. Key for us has been how to balance public protection and our duty of care when a person is detained with judicial independence and concepts of autonomy and best interests that underpin this legislation.

We have now compiled a summary of responses report, which I understand you have. It adopts a thematic approach, stepping through, for example, the general comments, court powers, departmental and tribunal powers and police powers, before considering equality issues and the way forward. To support the consultation process, we convened a series of consultation workshops across criminal justice agencies to consider the application of mental capacity principles, safeguards and protections. In addition, the Justice Minister and Health Minister attended a mental capacity law event in September, which was organised by Chambré in association with Disability Action. The conference provided a very useful forum to discuss the impact of the proposals and to help inform our consultation on criminal justice issues.

Alongside that, the Department continues to meet regularly with its project steering and external reference groups to discuss the consultation exercise and to explore policy proposals. The project steering group includes criminal justice and health representatives, and the stakeholder reference group is drawn from the voluntary and community sectors and from relevant professional groupings with an interest in mental capacity and mental health issues. The Department of Health, Social Services and Public Safety (DHSSPS) is represented on both our groups, and we are working very closely with that Department.

I will make some general comments about what we received from the consultation exercise. We had 34 responses from a wide spectrum, including professional bodies, voluntary organisations and the statutory health and justice sectors. There is a table at the back of the summary paper that shows the respondents.

I will deal first of all with comments on the principles and safeguards that we said should underlie the legislation. All the respondents agreed, in broad terms, to the application of mental capacity principles to the criminal justice system. In day-to-day decisions, there was widespread support for the proposal that those working within the criminal justice system should be bound by the Bill's principles and safeguards, just as much as within the health and social care system. We agree with consultees. We support the presumption of capacity and we respect substitute decision-making arrangements to the extent that that is appropriate within the justice system and does not conflict with existing statutory or common law duties.

On the kind of day-to-day contacts that people within the justice system have, we again agree with consultees. We support the application of the principles in full when it comes to day-to-day tasks, day-to-day decision-making and delivery of services as they arise within the criminal justice system. All those who are required to make an intervention, be it on health, welfare or finance grounds, will be required to comply with the Bill's principles. So, for example, if a prisoner with mental health issues or learning difficulties needed an appendix operation, the same arrangements for obtaining consent would apply as would apply outside prison. There will be a tiered system of safeguards for the person lacking capacity according to the seriousness of the intervention and the resistance expressed by the person.

That was about general principles, but the consultation paper moved on to consider some specific issues for the justice system — powers that the police, the courts or the Department have. I will turn to each of those. First of all, on places of safety, the consultation paper described current police powers that allow a constable to remove a person to a place of safety who appears to be suffering

from a mental disorder and is in need of immediate care or control. None of the consultees questioned the need for a place-of-safety power.

We take the view that the existing police power to remove a person who may be suffering from a mental disorder to a place of safety should be retained. We see the power as one of conveyance, and its purpose is to allow the proper examination and assessment of the person in a place of safety by a medical practitioner, and to allow, if appropriate, his or her interview with an approved social worker. A proper assessment by suitably qualified professionals in a more appropriate and non-public location is really what this is about — assessment that is potentially diversionary and avoids arrest. We see that being retained as a police power, much as it is in current legislation, but with some practical changes. We will be retaining the 48-hour period for places of safety. The majority of consultees agreed with that. We will take a power that will allow us to change that time period, but any change would be subject to an affirmative resolution in the Assembly.

Again, based on support from consultees, we are proposing powers to enable the transfer between one or more places of safety, still within the 48-hour maximum period, but it would allow, for example, someone who is taken initially to a police station to be transferred to a hospital or a more suitable location. A code of practice on a statutory footing would ensure that a hospital or other therapeutic facility was the default place of safety. Police stations would only be used in exceptional circumstances; for example, where someone was too violent to be taken to hospital immediately.

I will move to the specific issues on court powers. Courts currently have various powers to make orders in respect of people who are unfit to plead or who plead insanity, and who are found to have committed the acts that have been complained of. Those powers require the court to take evidence from medical practitioners and set down the conditions to be met before appropriate mental health disposals may be used. We explored three options in the consultation paper. One was to continue to give the courts complete discretion. The second was a requirement that, as part of making those orders, the courts should order a capacity assessment. The third was a middle option to allow the courts to retain, overall, an ultimate authority but required them to take account of a number of factors in reaching their decision, including the mental capacity of the individual.

Following the consultation, we believe that the courts should retain their current independence in choice of sentence, but that capacity would be one of the issues to be taken into account. Any mental health disposals should still be chosen on the basis of two professional reports, which would undoubtedly reflect a capacity assessment.

We also invited comments on the removal or adjustment of existing court powers. In particular, we proposed that a new kind of community order should be available to the courts, which gained support in our consultations. That would bridge the current gap between the supervision and treatment order and the hospital order, and would allow for more authoritative provisions on the likes of residence and treatment compliance. Where necessary, it would allow a person to be admitted to hospital for periods of assessment or treatment.

We sought comments on the powers that the Department has over the transfer of individuals with mental illness to and from prison and hospital, which are the powers of transfer, recall and approval of leave. We felt that there needed to be a continuing statutory mechanism to move prisoners who needed to move out of custody and into a healthcare setting for a period. In light of responses to the consultation, we take the view that the Department's powers to transfer those in custody with a mental health condition to a hospital setting should be retained. We also took the view that arrangements for the transfer from prison to hospital for examination should be subject to a capacity test. Where there is a lack of capacity, the protection and safeguard requirements in the Bill would be brought into play. Where there is capacity, the person's consent to treatment would be required. Again, that reflects arrangements in the community.

I will turn to perhaps the most controversial aspect of our proposals. We sought views on a proposal whereby a prisoner with mental health issues could be compulsorily transferred to hospital, even where capacity existed for the person to make their own decision on treatment. The proposal provoked some of the strongest responses amongst consultees, with the vast majority showing very little support for the concept of a set-aside arrangement and a number exposing potential practical problems about patient care. Given the views expressed and the potential practical difficulties to which a set-aside could lead, we do not propose to proceed in that way.

It was always clear that the number of people with serious mental health problems who would fall into those arrangements would be small. At the same time, we are very much aware of our duty of care

towards people in custody with mental health problems who may present a risk to themselves or to others. To help ensure that those people are properly assessed, we are proposing to replicate an assessment model being created in the community context in the Bill. That will allow the short-term transfer out of custody and into the health system of people who fall into that category for examination and assessment. A healthcare professional could authorise transfer for examination under certain specific circumstances, such as where there is an illness, where failure to examine would result in serious harm to self or others, where transfer is necessary for proper examination, where it is in the person's best interests and where the person lacks capacity in relation to transfer to hospital for an examination.

I will talk about equality issues that came up in particular with regard to under-16s. On equality and human rights assessments of the package of proposals as published, we formed the view that what was being proposed was broadly compliant, while recognising an impact on under-16s, to whom the whole Bill will generally not apply. This really relates to the underlying policy of the Bill, in which we are involved, but the proposals are very much being put forward by DHSSPS. We had a number of comments on this. We accept the comments made by consultees on the need for re-screening of the proposals. I can say that the proposals will be re-screened. There is an existing commitment on the part of both Departments to subject the Bill as a whole to an equality impact assessment (EQIA).

Finally, you will recall that we invited the Northern Ireland Law Commission to carry out a review of the law around unfitness to plead, alongside the work that we in the Department were doing. I thought I should just quickly provide the Committee with an update. The commission launched a consultation paper on 16 July, and the consultation ran until 19 October. The commission received a number of insightful and helpful responses, and conducted meetings with key stakeholders during the consultation period. The commission is working on drafting a report containing recommendations for a reform of the law on unfitness to plead, as well as draft instructions to legislative counsel, which are being prepared with a view to the inclusion of the recommendations in the Mental Capacity Bill. Subject to the Committee's views, we will be progressing our instructions to counsel with a view to both Departments — ourselves and DHSSPS — bringing a joint Bill to the Assembly in December.

Legislation is, of course, just one way in which we respond to the challenge of dealing appropriately with people with mental health issues, personality disorders or learning difficulties who come into contact with the criminal justice system, but it is an important way. We are very happy to take questions.

The Chairperson: Thank you very much, Mr Johnston. You covered a lot of the issues for members. I have a question around the issue of, where there is the capacity, you will still require the person's consent to treatment before they would be transferred to detention in a hospital for that treatment. Talk me through that again. If someone is deemed to have the capacity to make that decision, you cannot force them. Ultimately, if they do not consent to treatment, you have decided that you would not be able to override that and force them to go to hospital for treatment.

Mr Johnston: That is very much about the principles underlying the Bill, which are about people being able to take responsibility for their decisions. All of us make good decisions. Sometimes, we make bad decisions. The Bamford approach would very much have been: why should people who have mental health issues be treated any differently? That having been said, under existing arrangements, a wide range of people have already been transferred to hospital from prison who have, say, serious schizophrenia, difficulties in appreciating the extent of their own condition or auditory hallucinations. It is not difficult to see that, in those sorts of circumstances, which exist for the vast majority of transfer direction orders that go across my desk, people are going to lack capacity to make decisions, and so substitute decision-making is going to have to swing into effect.

Mr McCartney: I have a number of questions. On what basis did the Department make the decision not to carry out the EQIA?

Mr Johnston: We screened the proposals that we were going out to consultation with. Now, that was at an early stage of our policy development, but we screened those proposals. We screened them out in terms of doing an EQIA. We recognised that there was an impact on young people in particular, but we felt that that was mitigated by the proposals that we were putting forward for a different pathway, by which young people who were in need of treatment could obtain it and be transferred, if necessary, from custody to a health setting. I know that that has evoked a range of concerns in the sector, and, as I said, we will now proceed to screen those proposals again. In any event, we are proposing that, come a little closer to the summer when we have the Bill drafted, we will, jointly with DHSSPS, consult

on an EQIA that covers the whole Bill, not only our parts but the health parts. Therefore, that will take a holistic approach to what is going into the legislation.

Mr McCartney: Would the EQIA not also have achieved that? Rather than waiting until the end of the process where there is perhaps a need for an EQIA, which might hold back the progress of the Bill, would it not be better to do it at the beginning?

Mr Johnston: I take the point, which has been made to us by a number of organisations. When we screened the proposals, we felt that the arrangements and protections that were in the Bill were mitigating factors against any impact on under-16s. As regards under-16s, I emphasise that the intention is that there will still be arrangements that will allow young people in need to get the help that they need. We are conscious that, in the justice system, we deal with some of the most vulnerable young people. A young person who is in trouble on the street and is maybe evincing signs of mental distress will be able to be brought to a place of safety. A young person in the juvenile justice centre can be transferred to hospital if that is what is needed. There will be important protections around all of that, including automatic referral to a mental health tribunal for independent review. We always have to act in accordance with the best interests of the child. So, although there may not have been an EQIA, the issues around under-16s have been very thoroughly examined.

Mr McCartney: Yes, but the Department finds itself in a place where it says that the Bill as it goes forward will have only a minor impact on under-16s, yet the Children's Law Centre (CLC) gives practically the opposite view to that. It says that this will have no positive impact in relation to the Bamford proposals. So, would the EQIA put us in the position where you have a more objective analysis rather than people being accused of having a subjective analysis or opinions?

Mr Johnston: You come down here to the underlying principles of the Bill. The Children's Law Centre has suggested to the Department of Health, Social Services and Public Safety and us that the Bill should apply to under-16s, and that has been the central concern. DHSSPS is very much in the lead on that issue, because it is about the central principles of the Bill. The Health Minister has confirmed that the Bill should not generally apply to people under 16, and that is because you cannot have a statutory presumption of capacity for people under 16. A child's inability to take a particular decision is most likely to be due to their developmental stage rather than to an impairment or a disturbance in the functioning of the mind or the brain.

DHSSPS and, indeed, ourselves do not want to disturb the principle of parental responsibility, which is key, and the complex set of provisions and safeguards that are already in the Children (Northern Ireland) Order 1995. There are certainly issues about age of majority and about consent more widely. The Department of Health, Social Services and Public Safety recognises that, and we recognise that. DHSSPS is advocating a separate cross-departmental project to consider those issues. So, in response to the points that the CLC has made, it is not that anyone is denying that there are issues there. It is just that we really do not feel that a Mental Capacity Bill is the right context in which to take those forward.

Mr McCartney: How would the legislation interfere with the principle of parental responsibility if it were tabled in such a way that that was protected in the case of under-16s? It seems that there is a massive gap in that you are taking forward a new piece of legislation to bring us, as the Department says, into the 21st century, but we are leaving behind a large of section people who are under 16. This could apply to them, but we have no provision. We are going to rely on older pieces of legislation, yet this was an opportunity to modernise legislation to cover under-16s as well.

Mr Johnston: There may be a case for looking again at some of the issues, and DHSSPS is open to do that in the right context. However, if you make an assumption that under-16s have capacity, that means that under-16s who do not have mental health issues have a capacity to make decisions about where they live, schooling and all sorts of other issues that we say are really a matter of parental responsibility. The problem is that if we use this Bill to do the things that the Children's Law Centre might like us to do, we will end up with a lot of unintended consequences in areas that are already very well and very satisfactorily regulated by the likes of the Children Order.

Mr McCartney: I do not see how the concept of parental responsibility would be interfered with if you were to legislate to protect people under 16 within the terms of this Bill.

Mr Johnston: At the moment, decisions for under-16s are, ultimately, made by parents. By introducing the presumption of capacity, you would be saying that a lot of those decisions could potentially be made by children, unless you could prove that a child lacked capacity. In many ways, these are questions that are more for DHSSPS to answer. However, that would completely turn around the approach to parental responsibility that legislation has had until now.

As I said, we do not deny that there are issues to be dealt with in our Department and every Department about how we treat the likes of the age of majority. However, we just do not feel that this Bill is the right context for that.

Mr Elliott: Thanks for the presentation. Gareth, you mentioned the issue of community options. I want to explore those a little bit more. Will the courts have powers over those community options? Will they be part of that? How will that operate? I am just trying to get a handle on how those arrangements will work.

Mr Johnston: The community options in the Bill that DOJ is involved in are the orders that would be available where someone was found unfit to be tried and there was a subsequent finding of fact that they had committed the acts complained of or where someone pleads insanity in court, which happens very rarely. Where a court is in the position of having to deal with someone who is not fit to be tried and who has mental health issues or whatever, what options are available to it?

At the moment, the options that are available are, broadly speaking, absolute discharge, a supervision and treatment order, a hospital order, prison or a guardianship order, although that is very little used and we propose that we would not continue with it. There are a few other options as well. In that menu of options, there is quite a big gap between the supervision and treatment order and the hospital order, and the criteria for a hospital order are quite narrow. We are trying to bridge that gap with a more flexible community order, which is a kind of community compulsion order. It would allow a court to give an order that somebody would be treated in the community and would be subject to a range of conditions, which might include conditions about their treatment or where they live. There would be some flexibility in that order as it moved forward, so that if someone needed periods of admission to hospital, that could be achieved under the order, probably with a role for the Mental Health Review Tribunal. We are looking at the detail of that. We are talking about quite a restricted range of individuals. However, in what we are doing, we are trying to mirror, as far as possible, what would be available in civil society.

Mr Elliott: Who would be responsible for them in the community? Would it be the Department of Health or the Department of Justice?

Mr Johnston: It would depend on precisely what orders had been put in place. There might not just be one of these community compulsion orders. Depending on the nature of the offences, there might also be, for example, a sexual offences prevention order. In recent years, we have realised the importance of having clarity on who has the lead responsibility. That might vary from case to case, but the important thing is to have clarity in individual cases.

Mr Elliott: I assume that that would help to deal with cases that are potentially similar to the one in Donagh.

Mr Johnston: A number of issues were thrown up by the Donagh case, one of which was the gap between the supervision and treatment order and the hospital order. That is part of the reason why we are trying to plug that gap.

Mr McGlone: Sorry I was a bit late. I was held up with another appointment. I apologise for missing the earlier part of your presentation.

I want to come to the issue of third parties, covered in section 9 of your paper. Paragraph 9.3 states:

> *"The South Eastern Health and Social Care Trust and Northern Ireland Prison Service felt that there was a need for clarity in roles between these third parties and the person's legal adviser."*

Will you explain that to me, please? I was browsing through this last night and trying to ascertain what precisely was meant by that. Do you feel that there is an issue with that?

Secondly, paragraph 10.10 from section 10 that deals with offending and public protection states:

> *"The South Eastern Health and Social Care Trust felt that the proposal was flawed on four grounds. Principles and equity – Bamford said that those who retain capacity, whatever their condition must be allowed to decide and bear the consequences. Mentally disordered persons who present a risk to themselves or others and have capacity must be treated in exactly the same way as those without mental disorder."*

Again, will you clarify what that means? Someone who presents a risk to themselves or others does not seem, to me, to be in a particularly capable place, if capacity is the order of the day.

Mr Johnston: On the first point, the Bamford proposals and the Bill will bring into play a range of protections for people who lack capacity. If a decision needs to be taken — it could be about health, welfare or finance; it might be about how a prisoner spends their earnings or to do with a prisoner needing elective surgery — and someone lacks capacity, your first stop is with their nominated person. If the nominated person has concerns, you would go to an advocate. Ultimately, you can go to a panel convened by the trust. The point that the South Eastern Health and Social Care Trust made was about the importance of clarity of those responsibilities, alongside the responsibilities of the person's lawyer. To those, I might add the responsibilities of other people in the justice system, such as the appropriate adult whom we see at earlier stages of the system.

Someone's nominated person or advocate could be their lawyer, but we recognise that that needs to be clarified. We are still in the process of producing the instructions, so I cannot, at this stage, give you a final chapter and verse on the clarification. However, it is very much an issue that we are dealing with in the office.

Mr McGlone: So, to your mind, that is a relevant matter.

Mr Johnston: Yes. We have taken account of the point.

On the second point about paragraph 10.10 and the proposal being flawed, that was our proposal on a set-aside arrangement. We have heard all that has been said, and we are proposing an alternative arrangement. Your point is well made. Based on our conversations with consultant psychiatrists and others who have contact with the justice system, we expect that the majority of those people will probably not be capacitous to make decisions about their treatment. However, we need to be conscious of the very small number who still might be and of the arrangements we put in place.

Mr McGlone: Thanks for that.

The Chairperson: No one else has indicated. Finally, do you have an idea of what the resource implications will be? I note that, in your paper, you say that you will develop a full resource requirement for this, but do you have something in mind for what that might be?

Mr Johnston: DHSSPS is doing a full assessment of all the resource implications. This obviously has massive implications for the health service. In our initial discussions within the justice system, particularly with the Prison Service, there was an assumption that it would be dealt with using existing resources. Now that we are at the point where we know in a bit more detail what all this will involve, we want to go back and revisit that assumption. The plan is to have a fuller statement of resource requirements when we launch the consultation on the Bill coming up to the summer.

Mr McCartney: These are just observations. As regards the EQIA being set aside and the re-screening process, I think that you should look at the contention that this will have only a minor impact on under-16s. As the Bill is taken forward, perhaps we can get some sense of the pathways and protections in place for under-16s if the legislation goes ahead as you propose, although it still has to be decided by the Committee and the Assembly. I would like a commentary on that as well.

Mr Johnston: I certainly take that on board.

Mr McCartney: Thank you.

The Chairperson: OK. Thank you very much.

Unless there is any further information from the Department, are members happy to send a copy of the Department's report and responses on the way forward and the Hansard report of this evidence session to the Health Committee for its information, given that this impacts it as well?

Members indicated assent.