BMA

Northern Ireland

Briefing paper for the Ad Hoc Joint Committee on the mental capacity bill

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Introduction

BMA Northern Ireland is both a Professional Association and a Trade Union which represents the medical profession across all branches of practice. Our mission is "we look after doctors so they can look after you".

BMA has 155,000 members worldwide and 75% of doctors and medical students are members in Northern Ireland.

BMA Northern Ireland welcomes the opportunity to give evidence to the Ad Hoc Joint Committee on the mental capacity bill (MCB). Doctors have a number of professional duties and they are strictly regulated by the General Medical Council (GMC) across a number of areas covered by the proposed MCB. It is therefore important that there is read-across to the regulatory requirements of the GMC.

BMA Northern Ireland, in its response to the consultation on the MCB in September 2014, welcomed the introduction of a single legislative framework. Our comments will be focused on the clauses that impact significantly on clinicians as they care and treat their patients across a number of clinical areas, specialities and in different settings.

Establishing whether a person has capacity

Clause 4 (c)

Whilst broadly similar to provisions in other jurisdictions in the United Kingdom, the addition of clause 4 (c), *'is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision',* may make the criteria for making a decision more stringent and indeed raise the bar in relation to the threshold for capacity. In addition, there are no legal precedents for the judicial interpretation of what 'appreciate' means. For example, the relevance to the

treatment of people with depression or anorexia who may retain cognitive capabilities but whose judgment is impaired, is clear. Although under the Mental Capacity Act in England, those, such as people suffering from severe anorexia nervosa, have been found to lack capacity in relation to food refusal because of their inability to 'use or weigh' the relevant information. Great care needs to be taken therefore to ensure that these changes do not result in many more people, particularly those suffering from mental disorders who may present a risk of harm to themselves, being found to lack capacity due to the addition of this clause.

This addition also creates a subjective element to the functional test of capacity and without precedents to aid interpretation this may prove difficult for clinicians.

Establishing what is in a person's best interests

Clause 7 (9)

Under the checklist for best interests, clause 7 (9) states, *'That person must, in relation to any act that is being considered, have regard to whether failure to do the act is likely to result in harm to other persons with resulting harm to P.'* This is a broad statement and requires further clarification as no definition of harm is given. On the face of this, it would be plausible to extend this to include psychological harm to an adult who lacks capacity and harms others. Although the extent to which a 'best interests' judgment in relation to an individual can or should incorporate the interests of others has been addressed by the courts[1], they have largely focussed on individuals with whom the incapacitated adult has a significant personal relationship such that their interests interpenetrate or overlap. To incorporate the interests of third parties who have no relationship with the incapacitated adult in order to protect that third party from a risk presented by the incapacitated adult looks like a significant departure for which, to our knowledge, there is no statutory or common law precedent. Arguably, an attempt to incorporate the security and safety interests of third parties into an assessment of the index individual's 'best interests' risks incoherence.

[1] See, for example: *Re G (TJ)* [2010] EWHC 3005 (COP) (Morgan J). *Re Y (Mental Patient: Bone Marrow Donation)* [1997] Fam 110.

Bringing risk to others into a definition of best interests is probably the clearest point at which the differences between the separate historical approaches to the mentally disordered and those lacking decision-making capacity come into tension. The law in relation to adults lacking decision-making capacity has focussed on promoting their interests; mental health law has always also looked to managing risk to others. Rather than reducing stigma, there may be some risk that such an approach could increase it. In attempting to mitigate some of the consequences of such an approach it may, paradoxically, risk putting pressure on the liberty rights of a far larger group of individuals. This needs to be carefully considered and if not amended within the MCB, the code of practice needs to be explicitly clear on the definition of harm and 'other persons.'

Furthermore, the assessment of the likelihood of harm to other persons with resulting harm to the person lacking capacity is likely to be, at best, an imprecise science. This criterion carries a risk that this judgment may only be made properly in hindsight.

Second Opinion needed for certain treatment

Chapter 3, 16 (1) (a) (b)

It is understandable that treatment with serious consequences such as surgery would require a second opinion and this is welcome. But we also wish to note that nothing in the MCB should prevent the provision of timely and appropriate medical treatment. In an emergency, treatment must not be delayed for the purposes of identifying whether a deprivation of liberty has taking place or seeking its subsequent authorisation.

BMA Northern Ireland in its response to the consultation on the MCB in September 2014 argued that, whilst welcoming the aim of the legislation to bring parity of esteem between mental and physical health, the identification of electroconvulsive therapy (ECT) as a treatment with serious consequences and requiring a second opinion actually reinforces and discriminates between physical and mental illnesses. We also noted at this time that the anaesthetic requirement is much less than for surgery and the likelihood of serious consequences considerably less.

Deprivation of Liberty

Clauses 24 to 34

BMA Northern Ireland welcomes these clauses as currently those who are deprived of their liberty in Northern Ireland are not legally protected. However we recognise that case law in this area is rapidly evolving, therefore developing an effective code of practice will pose a considerable challenge. Section 9 (2) of the MCB provides health professionals with protection from liability where they may have to restrict the liberty of an incapacitated adult. However the difficultly for doctors is identifying the point at which the intensity and duration of restraint amount to a deprivation of liberty (DOL). BMA has produced guidance on the deprivation of liberty under the mental capacity act and in this guidance for health professionals, we outline examples of measures that may restrict an individual's liberty[2]. These are based across a range of situations, including treatment in an intensive care unit, a hospice, in care homes and extra care housing. Examples include:

- the use of chemical or physical restraint
- the use of sedation
- the use of catheters or intravenous drips
- high levels of monitoring
- restrictions on movement
- Raised bed rails
- Use of CCTV
- Door and movement sensors
- Locked doors

Whilst some of these examples in isolation may not amount to a deprivation of liberty, when combined, or where they are applied with particular intensity or for sustained periods they may. Ultimately, the question of whether a person is deprived of their

[2] BMA, (2015) *Deprivation of liberty under the mental capacity act: key points for professionals.* LONDON BMA

liberty is a legal one and doctors will need guidance as to how this applies in practice across all settings and all areas of medical practice.

Recent case law has made it clear that there is a DOL even if deprivation is with the person's compliance or lack of objection to their placement, the purpose of placement is benign or the extent to which it enables them to live a relatively normal life for someone with their level of disability is objectively successful. [3] This will mean that a process of authorisation will be required for a great many patients in Trust-run and independent residential settings and indeed community settings where community residence requirements are imposed under the MCB. [4] We note with concern clause 24 (2) (a) (i) defines, *'the detention of P, in circumstances amounting to a deprivation of liberty, in a place in which care or treatment is available for P'*, and we believe that this definition is very broad and potentially unworkable.

Schedule 2 para 2(4) outlines the provisions for short-term deprivation of liberty to allow detention for the purposes of examination. This is likely to be the most frequent use of compulsory detention replacing as it will the current Mental Health Order 1986 Forms 1, 3 and 5 for application for admission for assessment in general and psychiatric hospitals. Two questions are posed by this schedule:

1. The MCB does not include specimen forms but rather outlines what the content of these forms should be. It would be inequitable (and probably lead to legal contest) not to have a standard set of forms across Northern Ireland. It is recognised that this may be a matter for secondary legislation or the Code of Practice but clarity in a reasonable timescale will be needed.
2. The Mental Health Commission was subsumed into the Regulation, Quality and Improvement Authority (RQIA) which has a scrutiny role currently for all detentions under MHO 1986. It is not clear from the MCB who will have a scrutiny role not only over DOLs but also of the effectiveness of the mental

[3] P v Cheshire West and Chester Co; P and Q v Surrey County Co [2014] UKSC 19

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_Supreme_Court_DoLS_Judgment.pdf

capacity legislation. BMA Northern Ireland notes that the House of Lords'[5] report into the Mental Capacity Act 2005 recommended that overall responsibility for the Act be given to an independent body whose task it would be to oversee, monitor and drive forward implementation of the Act. We are disappointed that the MCB does not confer powers to set up such an independent scrutiny body. We note that Schedule 8 (51) *Functions of RQIA* does not confer this role to them and furthermore we are not convinced that the RQIA could fulfil this role.

Part 15 Supplementary

Clauses 276 – 277 Codes of Practice

The importance of the development of the codes of practice to accompany this legislation cannot be underestimated. We welcome clause 276 (6) which clearly states, '*before preparing or making any alteration in a code under this section, the Department must consult such bodies as appear to it to be concerned.'* BMA has significant expertise in this area and we have developed guidance and toolkits for doctors and as such would welcome the opportunity to be closely involved in the development of the code of practice for the medical profession. [6]

General Issues

Education and training

There is clearly a need for a robust and comprehensive programme of education and training prior to the introduction of the new legislation which would also form part of continual professional development for doctors.

The MCB significantly changes the nature of the presumption of capacity and as such the impact on all healthcare professionals will be considerable. There will no doubt be a major resource issue with capacity assessments and HSC Trusts will have to provide

[5] House of Lords, (2014) *Mental Capacity Act 2005: Post-Legislative Scrutiny.'* HL Paper 139 London TSO
[6] http://bma.org.uk/practical-support-at-work/ethics/mental-capacity/mental-capacity-tool-kit

training for staff employed by the Trust. However as this applies to all settings, where treatment takes place, the impact on other sectors such as the independent and voluntary and community sectors is likely to be extensive.

BMA Northern Ireland believes that the process for assessing capacity must be robust yet straightforward to avoid making further demands on doctors' workloads through excessive paperwork and bureaucracy without the corresponding infrastructure, resources and training available. In addition, general practitioners are independent contractors and it is important that this process becomes workable and responsive to their patient needs.

Summary and Conclusions

BMA Northern Ireland recognises that this is a complex area of law and practice and there will always be a degree of uncertainty. The principles approach in the MCB is a positive development and a desire to ensure that mentally disordered individuals have equality of rights- equal respect for their autonomy as those suffering from physical disorders, something which is whole-heartedly welcome across the medical profession.

However, it is the implementation of this legislation that will make a difference to people's lives and give much needed clarity to doctors as they interact with their patients. It is important that lessons are learnt from the passage of the Mental Capacity Act in England and the delays in the production of the codes of practice are not replicated here in Northern Ireland. In addition the House of Lords inquiry provides valuable insights and lessons should also be taken from this report in terms of implementation.

BMA Northern Ireland will work in partnership and contribute to the development of the codes of practice, education and training materials and subsequent regulations.

Ends
7th July 2015