Written Evidence to the Ad Hoc Joint Committee on the Mental Capacity Bill

1. The Children's Law Centre

1.1 The Children's Law Centre (CLC) is an independent charitable organisation established in September 1997 which works towards a society where all children can participate, are valued, have their rights respected and guaranteed without discrimination and where every child can achieve their full potential.

1.2 CLC undertakes training and research on children's rights, produces information on a wide range of children's rights topics and makes submissions on law, policy and practice affecting children and young people. We have a dedicated free phone legal advice line for children and young people and their parents and carers, known as CHALKY, through which we offer free legal advice and information on a wide range of children's legal rights issues. CLC also has a youth advisory group called youth@clc that act as peer advocates and inform our work. CLC provides free legal representation in strategic cases. We represent young people at the Mental Health Review Tribunal. We also provide legal representation in a limited number of strategic cases via judicial review and have experience of submitting written and making oral interventions as a Third Party to proceedings in a small number of cases with a particular focus on children's rights. Within our policy, legal, advice and representation services we deal with a range of issues in relation to children and the law, including the law with regard to some of our most vulnerable children and young people, such as looked after children, children who come into conflict with the law, children with special educational needs, children living in poverty, children with disabilities, children with mental health needs and children and young people from ethnic minority backgrounds.

1.3 Our organisation is founded on the principles enshrined in The United Nations Convention on the Rights of the Child (UNCRC), in particular:

- Children shall not be discriminated against and shall have equal access to protection.
- All decisions taken which affect children's lives should be taken in the child's best interests.
- Children have the right to have their voices heard in all matters concerning them.

1.4 The UK Government as a signatory to the UNCRC is obliged to deliver all of the rights contained within the Convention for children and young people. In compliance with these obligations CLC believe that the human rights standards contained in the UNCRC should be reflected in all laws and policies emanating from the Northern Ireland Assembly as one of the devolved regions of the UK Government.

1.5 CLC has been very involved in discussions and consultation processes leading up to the introduction of this Bill and is the "lead" organisation in the children's sector in respect of the proposed new mental health legislation.

From its perspective as an organisation which works with and on behalf of some of our most vulnerable and socially excluded children and young people, both directly and indirectly, CLC is grateful for the opportunity to provide written evidence on the Mental Capacity Bill. Our written evidence relates only to those matters within the Bill that relate to children and young people under 18. **We would specifically draw your attention to section 19 of this paper which details some of the necessary amendments which are required to the Mental Health (NI) Order 1986 for under 16s.**

CLC would very much welcome the opportunity to present oral evidence to the Ad Hoc Joint Committee on the Mental Capacity Bill, as we believe that the Bill has potentially far reaching implications for the protection of children's rights.

2. Background

2.1 CLC has been engaged in mental health law and policy reform over the past 14 years and was represented on the Human Rights and Equality sub group of the Bamford Review of Mental Health and Learning Disability (the Bamford Review) and over a two year period made detailed submissions to the reports produced by the Child and Adolescent, Legal Issues and Social Inclusion sub groups. CLC has engaged with both the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DoJ) from the earliest stage of the development of their proposals for a new framework for mental health and capacity legislation in Northern Ireland, following on from the Bamford Review. CLC has sought legal counsel's advice to inform government in its deliberations as to how best to protect children with mental health needs under the new legislation. CLC is a member of both the DHSSPS's and the DoJ's Legislation Reference Groups and has made a number of detailed written submissions throughout the development of the proposals for new mental health and capacity legislation to date. In all of our representations to the DHSSPS and the DoJ, CLC has based on our practice consistently detailed our concerns with regard to the particular circumstances and vulnerabilities of children with mental ill health in Northern Ireland. In particular, we have consistently raised concerns with regards to the DHSSPS's and DoJ's proposals to exclude under 16's from the Mental Capacity Bill, and the retention of the Mental Health (Northern Ireland) Order 1986, with some amendments for under 16s. The ability to legislate for the capacity of under 16s was highlighted by the effect of Article 44 of the Mental Capacity Act in England and Wales whereby the offence of ill treatment or neglect of a person who lacks capacity also applies to under 16s. (This is discussed in detail in section 21 of this paper) CLC has repeatedly highlighted that the exclusion of under 16s from the scope of the new Mental Capacity Bill will result in them suffering differential adverse impact, as they will not be afforded the safeguards and protections contained within the legislation.

2.2 In their 2014 consultation document both Departments acknowledged the key recommendation of the Bamford Review that:

"There should be a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern Ireland".[1]

Despite this recommendation, the Mental Capacity Bill will only apply to those aged 16 and over the retention of the Mental Health (Northern Ireland) Order 1986 for under 16s will effectively mean that both Departments have failed to give effect to one of the key recommendations of the Bamford Review. Children aged under 16 will not have access to the enhanced protections of the Mental Capacity Bill by virtue of their age alone.

3. Child and Adolescent Mental Health in Northern Ireland

3.1 Research has shown that there has been a significant increase in the number of children and young people with mental health needs in Northern Ireland in recent years.[2] It is estimated that 10% of children between 5 - 15 years old in Northern Ireland have a significant mental health issue[3] and that there has been an increase of 70% in the last 25 years of the number of teenagers with depression and anxiety.[4] It was recognised by the Chief Medical Officer as far back as 1999 that approximately 20% of children and young people in Northern Ireland will suffer significant mental health problems before their 18th birthday.[5] Recent research carried out with 752 children suggests that this figure may be higher, with 27% stating they have had a concern about their mental health.[6]

3.2 It has also been recognised that the incidence of mental health problems among vulnerable groups of children and young people is disproportionately high, including children and young people with disabilities[7] and those living in poverty[8] as well as children in conflict with the law[9] and care experienced children[10] or those in need of safe and secure accommodation.

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[1] Draft Mental Capacity Bill (NI) Consultation Document, May 2014, Department of Health, Social Services and Public Safety and Department of Justice, Joint Ministerial Foreword, para.1.6.
[2] A Vision for a Comprehensive Child and Adolescent Mental Health Service – The Bamford Review, November 2005.
[3] Chief Medical Officer (1999), Health of the public in NI: report of the Chief Medical Officer 1999: Taking care of the next generation. Belfast: DHSSPS.
[4] 'Time Trends in Adolescent Mental Health', The Nuffield Foundation, (2004 Seminars on Children and Families: Evidence and Implications).
[5] A Vision for a Comprehensive Child and Adolescent Mental Health Service – The Bamford Review, November 2005.
[6] CLC and Save the Children, Children's rights survey to inform young person's report to the Committee on the Rights of the Child, January 2015.
[7] Miller et al., 2003; O'Reilly and Stevenson, 2003; Muldoon et al., 2005.
[8] General Consumer Council Northern Ireland, 2002.
[9] Northern Ireland Human Rights Commission (NIHRC) 'In Our Care', March 2002, p.91; Criminal Justice Inspectorate Northern Ireland (CJINI) 'Inspection of the Juvenile Justice Centre', October 2004, p.115 - 117; Department of Health, Social Services and Public Safety (DHSSPS) 'Young People in Regional Care Centres and Youth Justice', October 2004, p.24.
[10] Social Services Inspectorate 'Secure Care Report', June 2002; NICCY/QUB Research, 2004, p.89; Teggart, T. and Menary, J 'An Investigation of the Mental Health Needs of Children Looked After by Craigavon and Banbridge Trust' in Childcare in Practice Volume 11(1), p.39.

3.3 Children and young people with mental health needs are over-represented within the criminal justice system. The prevalence of mental health needs among young people in custody has been found to range from 46% to as high as 81%.[11] The Mental Health Foundation's report, "The Mental Health of Young Offenders"[12] concluded that:

"...despite a scarcity of robust data, there is general agreement in the literature that young people in the Juvenile Justice system exhibit higher levels of psychosocial and psychiatric problems than the general population – at least three times higher."

It has been reported that 95% of young prisoners aged 15 to 21 suffer from a mental disorder. 80% suffer from at least two mental health problems. Nearly 10% of female sentenced young offenders reported already having been admitted to a mental hospital at some point.[13]

3.4 CLC is aware from its own work of the high levels of mental health needs amongst residents of the Juvenile Justice Centre (JJC). The Criminal Justice Inspectorate for Northern Ireland (CJINI) has repeatedly highlighted that young people within the JJC have significant mental health needs. Of the 30 children in residence in the JJC on 30th November 2007, 20 had a diagnosed mental health disorder, 17 had a history of self-harm, 8 had at least one suicide attempt on record, 8 were on the child protection register and 14 had a statement of special educational needs.[14] CJINI has also reported in 2012 that from a sample of 50 young people in the JJC, 38 of whom were on remand and 12 of whom were sentenced, the Youth Justice Agency Statistics and Research Branch found that 38% of the sample had a statement of special educational needs, whilst 14% had a recognised (or in one case, suspected) learning disability. Almost all the children and young people had experienced some form of trauma in their lives, such as suicide of a family member(s) or friend(s), or parental mental health needs. 23% of the sample had been diagnosed with Attention Deficit Hyperactivity Disorder and a further 4% were suspected to have the disorder. Other mental health issues were also evident, such as depression. 32% of the sample had self-harmed.[15] In its most recent inspection of the JJC published in May 2015, CJINI has reported that mental health remains especially problematic and that many children who entered the JJC were in poor physical and mental health. They reported that a 2011 audit of the JJC showed that 43% of the JJC population were already known to Community Adolescent Mental Health Services, but had not been attending.[16]

4. The Bamford Review of Mental Health and Learning Disability

[11] 'The Mental Health of Young Offenders' Mental Health Foundation, Hagell, 2002.
[12] 'The Mental Health of Young Offenders' Mental Health Foundation, Hagell, 2002.
[13] 'Not a Marginal Issue: Mental health and the criminal justice system in Northern Ireland', Criminal Justice Inspection Northern Ireland, March 2010.
[14] 'Not a Marginal Issue: Mental health and the criminal justice system in Northern Ireland', Criminal Justice Inspection Northern Ireland, March 2010, p.50.
[15] 'Early Youth Interventions: An inspection of the contribution the criminal justice agencies in Northern Ireland make to preventing children and young people from entering the criminal justice system', July 2012, p. 9 - 11.
[16] 'An announced inspection of Woodlands Juvenile Justice Centre' Criminal Justice Inspection Northern Ireland, May 2015, p.41 - 42.

4.1 The Bamford Review completed its work in 2007 and produced a series of 10 reports covering all aspects of mental health and learning disability services concluding with its Comprehensive Legislative Framework document. The Bamford Review made numerous recommendations for reform of both services and the law. The Bamford Review report on children and adolescents entitled ''A Vision of a comprehensive Child and Adolescent Mental Health Service" made 54 recommendations for the reform of CAMHS and specifically considered the issues of mental health and learning disability services for children and young people. The Comprehensive Legislative Framework document produced as part of the Bamford Review stated that:

"…*while some elements of the current legislation are considered to work well.., it has become clear that aspects of the Mental Health (NI) Order 1986 may not be 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* *(our emphasis)."*[17]

4.2 The proposed framework for new mental health and capacity legislation set out in the Comprehensive Legislative Framework report of the Bamford Review recommended special protections for children and young people under the age of 18. It stated that:

"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 *(our emphasis)."*[18]

These included the need for children to be assured of their right to services which under the recommendations of the Review were to include age appropriate accommodation, a right of access to education, a right for young people to participate in decision making about themselves, a right to information, and a right to be represented at Mental Health Review Tribunal hearings by representatives who were appropriately trained. The Review also recommended that extra protections should be put in place for children who were subject to compulsory detention. These were to include matters such as periods of compulsory treatment for mental illness as a child being disregarded in adulthood e.g. for the purposes of having to declare same. With regards to the use of restrictive practices (such as restraint or deprivation of liberty), the Review recommended these should include specific reference as to how these might be applied to children and young people in accordance with the UNCRC.[19] Further it is worth noting that in delivering CLC's Annual Lecture in 2014, Professor Juan E Méndez, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment commented that:

"Children and juveniles who suffer mental or psycho-social disabilities should be afforded special protection as a critical component of the obligation to prevent torture and ill-treatment."[20]

4.4. The Comprehensive Legislative Framework report of the Bamford Review stated that any new legislation in relation to mental health must be principles based. This report set out four overarching principles of autonomy, justice, benefit and least harm which formed the basis of the Bamford Review's proposals for legislative reform. The

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[17] A Comprehensive Legislative Framework, August 2007, p.25.
[18] A Comprehensive Legislative Framework, August 2007, p.47.
[19] A Comprehensive Legislative Framework, August 2007, p.45.
[20] Children's Law Centre Annual Lecture 2014, 'Mental Health in Juvenile Detention: A Preventative and Human Rights Based Approach', 13th March 2014

Principles of the Mental Capacity Bill deviate from those envisaged by the Bamford Review. This is discussed in detail below in the section on Principles of the Mental Capacity Bill.

4.5 The Bamford Review was also clear that the new legislative framework for mental health and capacity should be applicable to all those in society including those who are subject to the criminal justice system.[21]

4.6 CLC notes that the proposals of both the DHSSPS and the DoJ for the Mental Capacity Bill are not Bamford compliant. The Bamford Review noted that the Mental Health (Northern Ireland) Order 1986 was not human rights compliant and did not recommend its retention. It is very concerning therefore that it is now proposed that it should be retained for under 16s. CLC has serious concerns that rather than being afforded special rights and protections, children and young people aged under 16 will not even have access to the protections and safeguards outlined in the Mental Capacity Bill.

5. Children and Young People under the age of 16

5.1 With regard to children and young people under 16, it has been stated that the Mental Health (Northern Ireland) Order 1986 will be retained with some amendments as an interim measure pending the carrying out of a review of the Children (Northern Ireland) Order 1995 to include compulsory powers of detention for mental illness. **The retention of the Mental Health (Northern Ireland) Order 1986 for any group was not recommended by the Bamford Review, and is particularly inappropriate in relation to children and young people for whom the Review recommended that additional safeguards and protections were required, not fewer.**

5.2 The Department stated in their 2014 consultation document that the retention of the Mental Health (Northern Ireland) Order 1986 for under 16s would be a temporary measure pending the completion of a 'separate project' to examine the evolving capacities of children under the age of 16. This separate project was first suggested in 2012 and to date no details have been provided as to the scope of this project, who will carry out the project, the timescale for this project, the availability of resources for this project or the terms of reference for this project. CLC have asked the Department for these details on several occasions and as yet have received no substantial response. It is our understanding that the separate project will examine the issue of evolving capacities in children. Whilst CLC welcomes the proposal to examine the evolving capacities of children aged under 16, and the potential policy and legislative developments which should flow from such a project, we note that this project will appear to focus on evolving capacity. Given that the proposed new Mental Capacity Bill addresses those who lose capacity, we fail to see how the new project will address our concerns regarding the exclusion of under 16s who lose capacity from the scope of the Bill.

5.3 CLC further understands from evidence provided by DHSSPS officials to the Committee for Health, Social Services and Public Safety that the 'separate project' has now been included by the DHSSPS within a proposal to undertake a comprehensive review of the Children (Northern Ireland) Order 1995 and will not be

[21] A Comprehensive Legislative Framework, August 2007, p.48.

conducted until the next Assembly mandate.[22] We note however that any decision to proceed with such a review will be a decision for whoever is the next DHSSPS Minister. While a review of the Children (Northern Ireland) Order 1995 is necessary and welcome for other reasons, we do not believe that the Children (Northern Ireland) Order 1995 is the appropriate vehicle for the inclusion of compulsory powers of detention for assessment or treatment of a mental illness in young people under the age of 16. The Children (Northern Ireland) Order 1995, whilst requiring review, covers issues such as the location and quality of care a child receives, the identity of those with parental responsibility and who and when others should have regular contact with the child it does not deal with issue covered by the Mental Capacity Bill.

Given the breadth and scope of the issues involved in a separate project to consider the emerging capacities of children and young people, combined with a review of the Children Order, which in itself is a large and complex piece of legislation, CLC considers it unlikely that a review of the Children Order would be completed even within the next Assembly mandate. It was also recognised by DHSSPS officials in their evidence to the Committee for Health, Social Services and Public Safety that any review of the Children Order would be a bigger project than the Mental Capacity Bill itself.[23] It is therefore unlikely that a review of the Children (Northern Ireland) Order 1995 will be concluded within the next Assembly mandate and it is wholly uncertain whether this work will be a priority under future Ministerial arrangements. Further it is our view that any proposal to expand the legal issues covered by any new Children Order, to include those legal issues addressed in the Mental Capacity Bill and legal issues associated with the emerging capacity of children, which has implications across all aspects of children's lives, would not be a "review" of the Children (Northern Ireland) Order 1995 but rather be a proposal for a new very different and sizeable piece of complex and composite legislation.

It is therefore extremely likely that the retention of the Mental Health (Northern Ireland) Order 1986 for under 16s will be an enduring situation, rather than an interim measure.

5.4 CLC has consistently detailed its concerns with regard to the proposal to exclude under 16s from any new legislation and has emphasised the need to ensure that any new legislation is compliant with the UNCRC, particularly Article 2 (the right of the child to non-discrimination), Article 3 (ensuring the best interests of the child are a primary consideration), Article 6 (the right to life, survival and development), and Article 12 (the right to be heard and have views taken into account).

In particular, we fail to see how proposals to exclude children and young people under the age of 16 with mental health difficulties or a learning disability from the protections and safeguards contained within the new legislation have the best interests of the child as a primary consideration, or ensure children's rights without discrimination, given that the exclusion will be based on no criteria other than age alone. In addition, CLC is very concerned that the exclusion of under 16s from the scope of the Mental Capacity Bill is not compliant with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), in particular Article 7, which refers to the right of children with disabilities to enjoy all human rights and fundamental freedoms on an equal basis with other children and Article 12 which

[22] 'Mental Capacity Bill: DHSSPS Briefing' Committee for Health, Social Services and Public Safety, Official Report (Hansard), Wednesday 22nd January 2014, p.3.
[23] 'Mental Capacity Bill: DHSSPS Briefing' Committee for Health, Social Services and Public Safety, Official Report (Hansard), Wednesday 22nd January 2014, p.4 – 5.

states that the aim of the UNCRPD is full and equal legal capacity for everyone. **It is also CLC's view that a number of Articles of the European Convention on Human Rights (ECHR) are potentially engaged, including Article 2, the right to life, Article 3, the right to protection from torture or inhumane and degrading treatment, Article 5, the right to liberty and security, Article 6, the right to a fair trial, Article 8, the right to respect for private and family life and Article 14, the right not to have Convention rights secured in a discriminatory way. The Northern Ireland Assembly may only make provisions within its legislative competence. Section 6(2)(c) of the Northern Ireland Act 1998 states that incompatibility with the ECHR is one of the circumstances in which provisions will fall outside legislative competence.**

5.5. Both the DHSSPS and the DoJ have stated that their rationale for the exclusion of under 16s from the scope of the Mental Capacity Bill is the belief of both Departments that the test of capacity contained in the Mental Capacity Bill cannot be applied to children in the same way as adults because of their developmental stage.

CLC does not accept this argument. On a practical level, we have repeatedly referred to the fact that the capacity of children aged under 16 is currently constantly assessed by professionals such as judges, lawyers, doctors, psychiatrists and social workers. CLC have been informed by mental health specialists that best practice with regards to under 16s is not reflected in the law as it currently stands and that in the majority of cases the views of the child regarding their treatment are respected.

We also believe that the exclusion of under 16s from the Mental Capacity Bill on this basis runs contrary to the obligations contained within the UNCRC and the UNCRPD. The UNCRC recognises the evolving capacities of children under Article 5. Article 12 of the UNCRC states that:

"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

The Committee on the Rights of the Child has produced General Comment No.12 on the right of the child to be heard.[24] Its aim is to try and assist States in understanding the right of the child to be heard and participate and to support them in effectively implementing Article 12.[25] In explaining what is meant under Article 12 by a child capable of forming their own views, the Committee on the Rights of the Child states that this provides an obligation to assess the capacity of the child to form an autonomous opinion to the greatest extent possible. This means that States parties cannot begin with the assumption that a child is incapable of expressing her or his own views. On the contrary, States parties should presume that a child has the capacity to form her or his own views and recognise that she or he has the right to express them; it is not up to the child to first prove her or his capacity. The Committee emphasises that Article 12 imposes **<u>no age limit</u>** on the right of the child to express her or his views, and discourages States parties from introducing age limits either in law or in practice which would restrict the child's right to be heard in all

[24] 'General Comment No.12 (2009) The right of the child to be heard' United Nations Committee on the Rights of the Child, CRC/C/GC/12, 20th July 2009.

[25] 'General Comment No.12 (2009) The right of the child to be heard' United Nations Committee on the Rights of the Child, CRC/C/GC/12, 20th July 2009, para.8.

matters affecting her or him.[26] Rather than recognising the evolving capacities of children and young people, the approach adopted here by the Departments is in breach of, and runs entirely contrary to the UNCRC given that capacity will only be assumed under the Bill in people aged 16 and over.

5.6 The UNCRPD is also clear in stating under Article 3 that one of the principles of the Convention shall be respect for the evolving capacities of children with disabilities. Article 7 provides that in all actions concerning children with disabilities, the best interests of the child shall be a primary consideration. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.

5.7 The Bamford Review Report on a Comprehensive Legislative Framework also recognised that children reach decision making capacity at different stages in their development and that the capacity of children and young people is evolving. It recommended that consideration be given to a rebuttable presumption of capacity between the ages of 12 and 16. The Bamford Review stated that:

"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."[27]

The Comprehensive Legislative Framework report also recognised the need for children and young people who lack capacity to have equal access to the protections and safeguards of any new mental health and capacity legislation.

"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."[28]

It is clear that the approach being taken by both the DHSSPS and the DoJ is non-compliant with their human rights obligations and is in conflict with the Bamford Review, which suggested a recognition of the evolving capacities of young people, which would mean that where a mature young person under the age of 16 was deemed to have had capacity and then to have lost capacity due to a mental illness or learning disability, they should come within the scope of the Mental Capacity Bill and have access to the protections and safeguards therein.

5.8 **CLC has consistently stated that to ensure human rights compliance and to reflect good practice, both Departments need to include under 16s within the scope of the legislation and provide protections and safeguards for the mature**

[26] General Comment No.12 (2009) The right of the child to be heard' United Nations Committee on the Rights of the Child, CRC/C/GC/12, 20th July 2009, para.20-21.
[27] A Comprehensive Legislative Framework, August 2007, p.47.
[28] A Comprehensive Legislative Framework, August 2007, p.47.

minor under 16 who lacks decision making capacity due to an impairment or disturbance in the functioning of the mind or the brain.

6. Principles of the Mental Capacity Bill

6.1 Clause 1 of the Mental Capacity Bill sets out the principles upon which the rest of the Bill is based. The Bill is underpinned by the principles of autonomy and best interests. The Comprehensive Legislative Framework report of the Bamford Review stated that any new legislation in relation to mental health must be principles based however, it set out four overarching principles which formed the basis of the Bamford Review's proposals for legislative reform. These were:

- Autonomy - respecting the individual's capacity to decide and act on his own and his right not to be subject to restraint by others;
- Justice - applying the law fairly and equally;
- Benefit - acting in the individual's best interests;
- Least Harm - acting in a way that does not harm the individual.[29]

6.2 CLC would submit that the principles of the Mental Capacity Bill are not those envisaged by the Bamford Review. The principle of Autonomy remains in place; however the Justice principle has been removed and the key Bamford principles of Least Harm and Benefit have been replaced with a Best Interests principle. This is a clear deviation from both the proposals of the Bamford Review and previous policy positions as stated by the DHSSPS and the DoJ.

6.3 Under the principle of autonomy within the Mental Capacity Bill if someone over the age of 16 is being asked to make a decision about a particular matter then it must firstly be assumed that the person has capacity unless it is established otherwise. The Mental Capacity Bill also states at clause 1 that a lack of capacity cannot be assumed based upon the person's age, appearance, a condition of the person, or an aspect of the person's behaviour which might lead others to make unjustified assumptions about the person's capacity. Clause 5 entitled, "Supporting person to make decision" sets out the practicable steps that must be taken to ensure compliance with the principle of autonomy. This clause as currently drafted is unclear and the consultation in 2014 by the DHSSPS and DoJ stated that clarification as to how the person is to be supported will require significant detail within the Codes of Practice. The Code of Practice is as yet unavailable however, making it impossible to comment on the sufficiency of the support that will be provided to enable a person to make a decision.

6.4 The second overarching principle of the draft Bill is that of Best Interests. Clause 2(2) of the Bill states that, *"The act or decision must be done, or the decision must be made, in the person's best interests."* Clause 7 of the Bill then inserts a checklist of considerations which must be complied with in determining what would be in the person's best interests. Matters listed in clause 7 of the Bill include that a person's best interests cannot be determined on the basis of age, appearance or any other characteristic of the person. Clause 7(4)(a) states that it must be considered whether it is likely that the person will at some time have capacity to make the particular decision for themselves. Clause 7(5) states that *"the person must, so far as practicable, encourage and help P to participate as fully as possible in the determination of what would be in P's best interests".* However it is unclear what the level and type of this help and encouragement will be. Clauses 7(6)(a - c) require

[29] A Comprehensive Legislative Framework, August 2007, p.4

account to be taken of the persons past wishes and feelings, again there is no detail as to how this will be achieved, or any written statement; and consideration must be given to the beliefs and values of the person and any other factors likely to influence the person's decision if they had capacity. The strength to be given to the person's past wishes, feelings and values or how these are to be established is unclear, as are the methods to be employed to obtain same.

6.5 Clause 7(7)(a) of the Mental Capacity Bill places an onus on the intervener where practicable and appropriate to consult with "relevant people" when making the best interests determination. Relevant people are defined as the nominated person, the independent advocate, anyone named by the person to be consulted on the matter, anyone engaged in the person's care or interested in their welfare, any attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney or any High Court Appointed Deputy.

Clause 7(8) states that the intervener must consider whether the same purpose can be achieved by in a way that is less restrictive of the person's rights and freedom of action. Under clause 7(9) the intervener must have regard to whether failure to do the act proposed would be likely to result in harm to other persons with resulting harm to the person lacking capacity.

Whilst it can be seen that, subject to the detail as yet unavailable through the Code of Practice, the two main principles of the autonomy and best interests contained with the Mental Capacity Bill could bring a substantial benefit to persons who lack capacity, they are a deviation and fall far short of the principles based approach recommended by the Bamford Review of Mental Health and Learning Disability as we have already outlined above.

6.6 In relation to the best interests principle currently outlined within the Bill and its application to 16 and 17 year olds, consideration must be given to Article 3 UNCRC. CLC is concerned that the best interests clause contained within the Mental Capacity Bill does not reflect the wording of Article 3, as it is not provided that the best interests of the child shall be a primary consideration. The UN Committee on the Rights of the Child has, in its General Comment No.14 on the right of the child to have his or her best interests taken as a primary consideration, made it clear that any assessment of a child's best interests must include respect for the child's right to express his or her views freely, with due weight given to these views in all matters affecting the child, in line with another general principle of the Convention, Article 12. The Committee is clear that Article 3 cannot be correctly applied if the requirements of Article 12 are not met.[30] States must also ensure appropriate arrangements, including representation, when appropriate, for the assessment of best interests; the same applies to children who are not able or willing to express a view.[31] The fact that the child is in a vulnerable situation (e.g. has a disability) does not deprive him or her of the right to express his or her views, nor reduces the weight given to the child's

[30] General Comment No.14 (2013) on the right of the child to have his or her best interests taken as a primary consideration' United Nations Committee on the Rights of the Child, CRC/C/GC/14, 29th May 2013, para. 43.
[31] General Comment No.14 (2013) on the right of the child to have his or her best interests taken as a primary consideration' United Nations Committee on the Rights of the Child, CRC/C/GC/14, 29th May 2013, para.44.

views in determining his or her best interests.[32] Given these clear views of the Committee on the Rights of the Child around the effective implementation of Article 3 UNCRC, and the importance that is placed on hearing the views of the child, we are concerned that the level and type of encouragement and help that will be offered to 16 and 17 year olds to participate in making determinations about their best interests is not specified.

6.7 In relation to the impact that the Codes of Practice have upon the principles of the legislation, the Bamford Review warned in the Comprehensive Legislative Framework report that:

"*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 upon in Codes of Practice.* ***The new legislation, the Codes of Practice and related training programmes must be introduced at the same time (our emphasis).***"[33]

It is therefore essential that the Codes of Practice are published for consultation, with screening and Equality Impact Assessment (EQIA) having been conducted as soon as possible so that they can ultimately be published at the same time that any new legislation comes into force. Given the significant level of detail relating to the legislation that will be contained within the Codes of Practice it is critical that they are properly scrutinised by the Committee alongside the primary legislation. All training provided in relation to the Mental Capacity Bill must be accessible, widespread and accredited in order to be beneficial for service users and professionals.

The House of Lords Select Committee on the Mental Capacity Act 2005 has produced a post legislative scrutiny report on the 2005 Act.[34] The Committee stated that whilst the Mental Capacity Act 2005 was considered to be both a significant and progressive piece of legislation with relevant principles, they felt that the Act had not been well implemented and further stated in relation to the presumption of capacity contained within the act that:

"*The presumption of capacity as set out in the Act — a person must be assumed to have capacity unless it is established that he does not — is widely misunderstood. At times, it is used to justify non-intervention by health or social care services, either erroneously or, in some cases, deliberately.*"[35]

CLC would be particularly concerned if a finding of capacity in a young person aged 16 or over would be used as a barrier to providing them with the therapies or services that they require. CLC is concerned that unless a comprehensive Code of Practice and accessible, widespread and accredited training is provided at the point the Mental Capacity Bill comes into force, the situation which has developed in England and Wales will be replicated here.

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[32] General Comment No.14 (2013) on the right of the child to have his or her best interests taken as a primary consideration' United Nations Committee on the Rights of the Child, CRC/C/GC/14, 29th May 2013, para.54.
[33] A Comprehensive Legislative Framework, August 2007, p.5.

7. Part 2 – Lack of Capacity: Protection from Liability, and General Safeguards

7.1 Clause 9 of the Bill provides the basis for the codification of the common law doctrine of necessity, placing this doctrine on a statutory footing. The doctrine provides for situations whereby it is necessary to break the law to carry out an act or deed. Part 2 of the Bill has a wider application than the existing common law because it applies to all acts in connection with a person's care, treatment and personal welfare. Part 2 of the Bill also requires additional safeguards to be put in place in the case of a serious intervention before the intervener can rely upon the legal protection of the Bill. Except for emergency situations, where a person carries out an act and does not comply with any one of the safeguards which the Bill says they should apply, the intervener may be held liable for the act in question. An intervener who commits a negligent act will not have the benefit of protection from liability under the Bill and the DHSSPS will have the power to state in regulations other acts that will not be included unless authorisation is obtained from the High Court.

7.2 Clause 12 of the Bill outlines the use of restraint. Under this clause anything done by an intervener which restricts a person's liberty of movement whether they resist or not, or the use or threat of force with the intention of securing the doing of another act, which the person resists, then the intervener must ensure that the act of restraint is a proportionate response to the likelihood of harm that will be suffered by the person and proportionate to the seriousness of the harm concerned. These conditions must be met when a person is instructing or authorising another person to carry out the act of restraint. If the restraint amounts to a deprivation of liberty then clauses 24 and 25 of the Bill apply.

Restraint is one of the greatest infringements on a young person's rights that can occur in either a hospital or specialist children's home setting. Whilst it is recognised that in some cases restraint is a necessary intervention, it is also essential that the Mental Capacity Bill provides the maximum protection for young people who may be subject to restraint. There does not appear to be any additional safeguards put in place for 16 and 17 year olds who may be subject to restraint. It is essential that any provisions relating to restraint take account of the young person's rights and that they protect against restraint which could amount to torture or cruel, inhuman or degrading treatment or punishment in line with Article 15 of the UNCRPD. Both Departments should also recognise the protection of the integrity of the person contained in Article 17 of the UNCRPD and the child's rights under Article 3 of the ECHR and Article 19 of the UNCRC.

7.3 Under clauses 19 – 34 of the Mental Capacity Bill certain acts must be authorised by Trust Panels. A Trust panel must authorise an act when the act is a deprivation of liberty, or is one of a number of acts that together amounts to a deprivation of liberty, or the act imposes an attendance requirement or a community residence requirement or the act is, or is done in the course of, the provision of treatment with serious consequences; and the nominated person objects; and the person who lacks capacity resists; or the act is done while the person is being deprived of their liberty,

or subject to either an attendance requirement or a community residence requirement.

If an intervener requires authorisation from a Trust Panel they must follow the procedure set out in Schedule 1 of the draft Bill in all matters listed above. The exception to this is where the act is the short term detention of a person who lacks capacity in a hospital, in circumstances amounting to a deprivation of liberty, for the purposes of examination. An authorisation for this purpose is covered by Schedule 2 of the Mental Capacity Bill.

Under Schedule 1 of the Bill if an application for an authorisation is made a Trust must constitute a panel to consider the application. Applications for authorisation will be heard by Trust panels made up of 3 persons with relevant expertise. However, no explanation of what amounts to relevant expertise has been provided by either Department. The Panel may conduct an oral hearing at which those making the application, the person lacking capacity, the nominated person and the independent advocate may give evidence. No information has been given as to whether the person will have the right to be legally represented at the Trust Panel. The Panel will give its decision within 7 working days of being constituted. It is unclear as to what intervention will occur in the intervening period. There has also been no reason provided as to why the Trust Panel cannot provide its decision on the day of the Panel. This would clearly be in the best interests of the patient.

7.4 The Bill will allow each of the five Health and Social Care Trusts to operate separately in relation to the panel authorisation process. The fact that there will not be a regional panel system will mean that different Trust Panels could decide similar issues in different ways. A panel authorisation process may also make it more difficult for a young person to challenge an intervention to the Mental Health Review Tribunal, as the intervention will already have been adjudicated upon. **This panel process was not recommended by the Bamford Review and it is the view of CLC that the Mental Capacity Bill should <u>not</u> include a system of Trust Panels in relation to authorisation as the system that is proposed is flawed, has the potential to lead to inconsistent decision making between different Trust areas, will be subject to legal challenge and disadvantages the patient should they subsequently wish to challenge the authorisation to the Review Tribunal or to the High Court.**

7.5 The Mental Capacity Bill sets out in clauses 24 – 29 the process for applying to deprive the liberty of a person over 16 who lacks decision making capacity. To deprive a person of their liberty is a very serious interference with their rights and in addition to the other safeguards contained within the Bill such a deprivation of liberty must be authorised to ensure compliance with the European Convention on Human Rights and to comply with the ruling in the Bournewood case.[36] What actually amounts to a deprivation of liberty is difficult to define and is generally assessed on a case by case basis. Both Departments have stated that the Code of Practice will provide guidance on the sort of circumstances that may amount to a deprivation of liberty.[37] This again demonstrates the need for the Code of Practice to be produced in a timely manner, be fully consulted upon and to be subject to Committee scrutiny alongside the Bill. Worryingly the clauses within the Mental Capacity Bill on deprivation of liberty safeguards appear to focus heavily upon providing the person who wishes to deprive another person of their liberty with protection, rather than

[36] *HL v UK* 45508/99 (2004) ECHR 471.
[37] Draft Mental Capacity Bill (NI) Consultation Document, May 2014, Department of Health, Social Services and Public Safety and Department of Justice, Joint Ministerial Foreword, para.2.55.

ensuring that no one is unlawfully deprived of their liberty. This is evidenced by clause 24(2) which provides the intervener with protection against civil or criminal liability if the remainder of clause 24 is complied with.

7.6 Clauses 24 and 25 are worded in such a manner as to limit the types of deprivation of liberty that can be authorised, but this is based on the decision maker not being able to have access to the protection from liability contained within part 2 of the Bill rather than being a positively framed duty to ensure that no person is unjustly deprived of their liberty.

Given that the Bill applies to all persons aged 16 and above we would suggest that the deprivation of liberty of a young person within a children's home or boarding school for children and young people with additional needs should be inserted into the clause 24(2) of the Bill in order to provide protections to young people who lack capacity and are resident within these types of facilities, otherwise an application will have to be made to the High Court to allow for such matters.

If an individual wishes to challenge a deprivation of their liberty then they will ultimately have to bring the matter before the High Court. As it is intended that the deprivation of liberty safeguards will protect some of the most vulnerable individuals in society, the safeguard is significantly weakened if legal aid is not available to all who wish to challenge a deprivation of their liberty, regardless of financial eligibility criteria for legal aid. We would urge the DoJ to address this issue by ensuring the availability of legal aid so that this safeguard is available to all and to amend the Mental Capacity Bill and the Legal Advice and Assistance Regulations to include the provision of legal aid in all such circumstances.

7.7 Much of what is being proposed by the Departments in the Mental Capacity Bill mirrors the deprivation of liberty safeguards in the Mental Capacity Act 2005. It is essential that the mistakes of the Mental Capacity Act 2005 are not replicated in Northern Ireland. It should be noted that the House of Lords felt that the deprivation of liberty safeguards system in England and Wales was so poor that:

"The only appropriate recommendation in the face of such criticism is to start again."[38]

7.8 **The deprivation of liberty safeguards as proposed in the Mental Capacity Bill apply only to persons who are not detained and aged over 16.** Under 16s, who have their liberty deprived due to their compliant nature, as opposed to as a result of detention, have therefore no means of challenging the deprivation of their liberty; the deprivation does not have to be justified as would be the case if they were over 16 and as they are voluntary patients there is no easy means of challenging such a deprivation of liberty either by way of a Mental Health Review Tribunal or to the High Court. It was held in the Bournewood case that existing methods of challenge including judicial review and *Habeas Corpus* were not sufficient means of protection in deprivation of liberty cases. **In addition, as it is proposed that under 16's will fall outside the scope of the Mental Capacity Bill they will have no legal right to access the deprivation of liberty safeguards to protect their Article 5 Right to Liberty ECHR rights.** It is CLC's opinion that the Bournewood case made no distinction between the rights of those aged under 16 and those aged over 16 to have safeguards put in place to guard against an unjustified deprivation of their

[38] Mental Capacity Act 2005: post-legislative scrutiny, House of Lords, 13th March 2014, p.7.

liberty as protected by Article 5 of the ECHR. **Consequently the proposed exclusion of under 16s will, in CLC's opinion, inevitably lead to legal challenge.**

7.9 Clauses 45 – 51 of the Mental Capacity Bill provide for the renaming of the Mental Health Review Tribunal to the Review Tribunal and outlines how the new system will operate. The DoJ had previously begun a consultation process into the reform of the Tribunal system in Northern Ireland. CLC received notification that the Minister for Justice has decided to delay the reform of Tribunals and therefore the functions, roles and powers of the Review Tribunal will not be revised prior to the commencement of the Mental Capacity Bill. The system in England under the Tribunals, Courts and Enforcement Act gives a right to challenge the decision of the Mental Health Review Tribunal to the Upper Tribunal, Administrative Appeals Chamber. Appeals against decisions of the Upper Tribunal can be made to the Court of Appeal. This provides for a faster, more accessible review mechanism for patients than the current system in Northern Ireland. **Consideration should be given to the improvement of the Review Tribunal system to ensure a faster, fairer method of hearings for individuals, given that the Review Tribunal will have its remit extended to cover decisions of capacity as well as detention.**

8. Part 3 – Nominated Person

8.1 The nominated person has a key role within the Mental Capacity Bill. The nominated person clauses of the Bill will replace the nearest relative provisions of the Mental Health (NI) Order 1986 for those aged 16 and above and will permit a person aged 16 and over who has capacity to nominate a person to act for a time in the future when they loose capacity. The Bill, at clauses 67 - 83 sets out the procedure for the selection of the nominated person and the procedure to be followed in the event of a person failing to nominate a person or for the removal of the nominated person. However, for under 16s it is intended to retain the system of nearest relatives with some amendments. **The nearest relative provisions of the Mental Health Act 1983 in England and Wales have been found to be incompatible with the rights of the patient under Article 8 ECHR as incorporated into domestic law by the Human Rights Act 1998.[39] As a result of this, the corresponding provisions of the Mental Health (Northern Ireland) Order 1986 require substantial amendment in order to make them compliant with the Human Rights Act 1998.** The DHSSPS has proposed that the nearest relative provisions of the Mental Health (NI) Order 1986 will be amended by:

1. Adding the "patient" to the list of persons with a right to apply to the County Court for displacement of their nearest relative;

2. Continuing the position that any person listed by the Mental Health Order who can make an application to the County Court can be appointed acting nearest relative, but that the patient cannot be appointed as his or her own acting nearest relative;

3. Adding a new ground of "unsuitability" to the existing grounds on which an application to displace the existing nearest relative and appoint a new acting nearest relative can be made.

[39] See for example *JT v UK* 26494/95 (2000) ECHR 133.

8.2 CLC has a number of concerns in relation to current proposals with regard to the nearest relative as we do not believe that the proposed amendments will ensure ECHR compliance. **CLC wishes to see applications by under 16s to displace an unsuitable nearest relative being brought to the Mental Health Review Tribunal, rather than to the County Court, as this will be faster and will also be in line with the similar provisions in the Mental Capacity Bill for over 16s. In addition we wish to see a young person being able to choose an appropriate person who is not on the current statutory list as their nearest relative if they are suitable and willing to act.** The term, '*any other person deemed suitable by the Review Tribunal*' should be inserted into the default list. (the current default list is spouse, parent, brother or sister grandparent, grandchild, uncle or aunt, nephew or niece in that order) The displacement of the nearest relative should not systematically follow the default list, as it currently does, but should be as a result of the child choosing a suitable person from within the list. Whilst the first person available from the statutory list may be suitable, they may not be the most suitable person from within the list. The ability of the child or young person to choose an appropriate person to act as a nearest relative, regardless of their position in the default list, should extend to the ability to choose '*any other person deemed suitable by the Review Tribunal*'.

8.3 CLC also wishes to see specific provisions being put in place for looked after young people that would provide them with an ability to displace a Health and Social Care Trust (employee or agent) as their nearest relative in favour of another suitable person of their choosing. Similarly, in the case of a young person resident in the JJC, we would wish to see young people detained there being given the ability to displace the Director of the JJC as their nearest relative in favour of a suitable person of their choosing. It is worth noting that under this proposal the suitability of the nearest relative would be determined by the Mental Health Review Tribunal, which would be a quicker and more cost effective process, or as is currently proposed, by the County Court.

9. Part 4 – Independent Advocates

9.1 Part 4 of the Mental Capacity Bill covers the appointment, role and functions of Independent Advocates. **Advocacy is a key safeguard within the Mental Capacity Bill and should be available to all regardless of age.** When an act under part 2 of the Mental Capacity Bill requires authorisation, or where an act although serious in nature does not require authorisation, an independent advocate must be put in place. **CLC is concerned that no definition has been provided as to what an independent advocate is within the Bill.** Further given the centrality of the role of the independent advocate to the Mental Capacity Bill we do not think the Committee has all the information it requires to thoroughly scrutinise this Part of the Bill in the absence of a clear definition of an independent advocate

9.2 Clause 35(3)(b) of the draft Mental Capacity Bill only places a duty on the person who wishes to carry out the intervention to **consult with** and take into account the views of the independent advocate. **In CLC's view, this is not the recognised function of an advocate. The advocate should be in place so that the person who lacks capacity can be assisted in making their views known. This is critical to the principle of autonomy upon which the Bill is premised.**

9.3 The wording of clauses 84(1) - (4) suggests that any advocate supplied will either be in the direct employment of a Health and Social Care Trust or will be contracted into

the service by the Trust. This CLC would submit is incompatible with the concept of independence. Further it suggests that **the choice of advocate available to the person will be significantly limited and that the person may not be able to select an advocate from a service of their choosing under the terms of the Bill.** This calls into question the availably of truly independent advocates under the Bill and raises significant questions regarding the strength and integrity of the safeguard of advocacy. The Mental Capacity Bill also provides the DHSSPS with the power to make regulations regarding the arrangements and functions of advocates. Only limited information has been made available as to what these regulations will contain and the impact that they may have upon the availability of advocacy services. Again noting the centrality of independent advocate to the principle of autonomy and the premise on which the Bill has been brought forward we are concerned that critical details as to the arrangement for and functions of independent advocates will not be subject to Committee scrutiny as part of this Bill process.

9.4 The Mental Capacity Bill also sets out the procedure for ensuring that an independent advocate is instructed in clause 86. It is important to note and concerning, that the appointment of an independent advocate cannot be triggered by either P or by their nominated person. Instead, the appointment of an independent advocate must be carried out by, "*appropriate healthcare professionals,*" who are not clearly defined in the Bill. P or their nominated person therefore cannot request the services of an advocate in order to assist them with the decision which is being made**. A young person aged 16 or 17 should be able to request the services of an advocate of their choice to assist them with the decision making process. CLC has long argued for the availability of statutory advocacy services for all children and young people who require such services. CLC believe that the provision of statutory advocacy services should mean that all young people, regardless of age, should be able to request the services of an advocate of their choice to assist them with the decision making process.**

9.5 The fact that under clauses 35 and 36 of the Bill advocacy is only available when a serious intervention is being proposed, and where both the patient (p) and their nominated person are objecting and where a health care professional has requested the relevant Trust to instruct an advocate, means that there are a large number of hurdles to be crossed before an advocate is available to the patient (p). This suggests that part of the role of the independent advocate is to encourage the patient, or their nominated person, to accept the intervention that is being proposed. This and the number of hurdles to be crossed before an advocate is available to the patient causes grave concerns as advocacy is recognised as having a key role under the Mental Capacity Bill. The earlier an advocate is involved with a patient (p), the better the chance they will have in understanding and expressing their views about a particular intervention. Whilst the Bill makes no provision for the patient (p) themselves to request an independent advocate, clause 88 provides that the patient (p) has the right to declare that no independent advocate is to be instructed and clause 91provides that a person has the right to discontinue their involvement with the independent advocate. It is an essential right of the person to be able to declare that they do not wish to have the services of an advocate or to dispense with those services if they so desire. However, whilst the Bill allows for the ability to decline advocacy services it does not allow for the right for advocacy to be reinstated.

9.6 It would also appear that the independent advocate will be instructed only for the single decision being considered in the patient's best interests and that once that intervention has been adjudicated upon, the access to the advocate will cease. The person, even if they wish to continue using the services of the independent advocate, will have no statutory right to access the service. The right to access an advocate

under the Bill is therefore linked to one decision only, but the right of the person under the Bill to dispense with advocacy services relates to all future decisions without an appropriate mechanism to re-engage with the service. There also appears to be no duty in relation to continuation of service. **If a person has an independent advocate appointed to them with whom they have built a relationship of trust, they may wish to use the same advocate in future matters. The wording of clause 91 of the Bill provides no guarantee that the person can request the same advocate for future decisions. The role of the advocate, their appointment and their continuing duties require both detailed clarification and serious reconsideration**. This we believe needs to happen as part of the Bill scrutiny process and cannot be left to DHSSPS regulations.

10. Advocacy for under 16s – Amended Mental Health (NI) Order 1986

10.1 In relation to under 16s, the DHSSPS/DoJ have provided little or no information as to what it is intended that advocacy services for under 16s will look like. Again we are concerned at the lack of information available to the Committee to enable it to fully scrutinise the adequacy of this critical safeguard. It was suggested that there would be a duty to consult with an independent advocate in a similar way to the duty under the Mental Capacity Bill. However this does not amount to a statutory duty to provide under 16s with an independent advocate of their choosing.

10.2 The Bamford Review recognised the need for children and young people who lack capacity to have equal access to the protections and safeguards of any new mental health and capacity legislation.[40]

CLC believes that access to independent advocacy for children is vital in the community when detention is being considered as an option, prior to the test for detention being applied, as this from our experience could prevent the need for detention. It is also vital that both voluntary and detained patients have a statutory right to advocacy in a hospital setting. **In compliance with both Departments international obligations, CLC wishes to see as effective a statutory right to advocacy as possible, intervention at the earliest possible stage and the provision of advocacy for under 18s in the community where required and in particular, post discharge.**

10.3 Under an amended Mental Health Order it is unclear if under 16s will be provided with an independent advocate of their choosing or have the right to continuity of service and therefore access to a familiar advocate should they require appointment of an advocate in respect of a range of separate issues. **It is essential that young people are able to choose and indeed to revisit their own independent advocate once they have established a relationship of trust with an individual advocate or advocacy service.** This is critical given the particular vulnerabilities of children and young people. Young people who have formed relationships with independent advocates from working with a particular advocacy service on a previous occasion may feel that that a particular service is best suited to meet their needs.

10.4 No information has been provided by either department as to the type of training that will be required for independent advocates for under 16s. It is necessary that this

[40] A Comprehensive Legislative Framework, August 2007, p.47

training is accredited and is in line with Articles 4 and 42 of the UNCRC which stress that all professionals working with children and young people should be aware of, and receive training about the UNCRC and children's rights. Training for independent advocates for under 16s should include, as a minimum, training on children's rights, on determining the capacity of the child, on how to listen to and communicate effectively with children and equality training. It is also unclear as to how training for advocates will be funded.

11. Part 5 – Lasting Powers of Attorney

11.1 Part 5 of the Mental Capacity Bill sets out the procedures for the appointment of a lasting power of Attorney, the powers of Attorneys' and the procedure for removal of Attorneys'. The Mental Capacity Bill as it is currently will apply generally to persons aged 16 and over, with some exceptions one of which are the clauses governing the appointment of Lasting Powers of Attorney from which 16 and 17 year olds are specifically excluded from under the Bill. Clause 99(1) of the Mental Capacity Bill states:

"A person appointed as an attorney by an instrument executed with a view to creating a lasting power of attorney (a "relevant instrument") must be
(a) an individual who is aged 18 or over at the time the instrument is executed"

Therefore a lasting power of attorney can only be made under the Mental Capacity Bill by a person aged 18 and over. This is similar to the situation in England and Wales. CLC notes that there are a number of hazardous occupations in which 16 and 17 year olds are employed and it may be beneficial in those limited circumstances for those young people to have the ability to make a lasting power of attorney e.g. being a member of the armed forces.

12. Future Decision Making Arrangements - Advance Decisions

12.1 Clause 11 of the Mental Capacity Bill deals with the issue of advance decisions.

The Mental Capacity Act 2005 in England and Wales codified the common law on advance decisions. The Mental Capacity Bill however does not codify the law on advance decisions and leaves the common law position in place. Whilst it is recognised that the law in the area of advance decisions continues to develop thorough case law, the Mental Capacity Bill provides an opportunity to codify the law and to prevent some of the problems service users and practitioners in England and Wales experienced with the use of advance decisions. When both Departments carried out their consultation in 2014 the consultation document did not state that 16 and 17 year olds would be excluded from making advance decisions under the Bill. It now appears that it is the intention of both Departments that advance decisions may not be executed by a capacitous 16 or 17 year old, in line with the common law position. The Bamford Review of Mental Health and Learning Disability recommended that a person from the age of 16 should be able to make a valid advance statement.[41] The Departments current proposals regarding advance decision making is in direct conflict with this recommendation of the Bamford Review.

12.2 For a person aged 18 and above a doctor will in theory not be permitted to override an advance decision to refuse treatment for a mental illness. The wording of clause 11 of the Mental Capacity Bill is somewhat obscure and the fact that the Bill refers to

[41] A Comprehensive Legislative Framework, August 2007, p.47

a valid decision made under the common law leaves room for uncertainty. It is essential that both the DHSSPS and DoJ take the opportunity available through the Mental Capacity Bill to define what is meant by a valid advance decision, to clarify who can make such a decision and the degree to which such a decision must be followed and respected by all professionals in relation to both the physical and mental health treatment of an individual **aged 16 and over**. It is further essential that both Departments educate the general public about the availability and purpose of advance decisions.

12.3 The House of Lords Select Committee on the Mental Capacity Act 2005 made specific recommendations in relation to advance decisions which should be addressed through the Mental Capacity Bill. These included that the Government must urgently address the low level of awareness among the general public of advance decisions to refuse treatment; that there is a need to promote better understanding among health care staff of advance decisions, in order to ensure that they are followed when valid and applicable; that there is a need to promote early engagement between health care staff and patients about advance decisions to ensure that such decisions can meet the test of being valid and applicable when the need arises and that there is a need to promote the inclusion of advance decisions in electronic medical records to meet the need for better recording, storage and communication of such decisions.[42]

The Ad Hoc Committee now has an opportunity to take into account the findings of the review of the Mental Capacity Act 2005 in relation to advance decisions and to codify the law on advance decisions in Northern Ireland, taking account of the lessons learned from the experiences of service users and professionals in England and Wales. Advance decisions should therefore be codified within the Mental Capacity Bill and be elaborated on in Guidance and in the Code of Practice which should be made immediately available and publicly consulted on as a matter of urgency.

13. Part 6 – High Court powers: Decisions and Deputies

13.1 It is not proposed that Northern Ireland will have a separate Court of Protection similar to that in England and Wales. Part 6 of the Mental Capacity Bill outlines the powers of the High Court, which will in essence carry out the functions of the Court of Protection in relation to the determination of an individual's capacity, personal welfare, care and treatment. The House of Lord's Select Committee in its post legislative scrutiny on the Mental Capacity Act 2005 raised concerns with regards to the ability of individuals to access the Court of Protection in England:

"*Restrictions in the availability of legal aid, and practical difficulties in accessing it, were a strong theme in concerns over access to the Court of Protection."*[43]

It is vital for the effective operation of the Mental Capacity Bill with regard to making determinations of an individual's capacity, personal welfare, care and treatment through the High Court that legal aid is made available on a non-means tested basis to allow young people to challenge matters to the High Court when necessary. We believe that the Ad Hoc Committee should seek assurances that in such instances, legal aid will be made available.

[42] Mental Capacity Act 2005: post-legislative scrutiny, House of Lords, 13th March 2014, p.15.
[43] Mental Capacity Act 2005: post-legislative scrutiny, House of Lords, 13th March 2014, p.87.

14. Part 9 – Places of Safety

14.1 The Mental Capacity Bill contains a power for the PSNI to remove a person from a public place to a place of safety. CLC acknowledges that this is a necessary power and the value of it is recognised for some young people. As currently drafted, the place of safety power as contained within the Mental Capacity Bill contains a requirement upon the police to establish a lack of capacity in the individual before applying the power to remove them to a place of safety. This is contrary to the place of safety power described in the DHSSPS/DoJ consultation on the Mental Capacity Bill in 2014 which stated that the exercise of the power would not require a determination by PSNI Officers on the ground, as to the age of the person they are considering bringing to the place of safety, as the determination of capacity was to be unnecessary as part of the criteria to exercise the power. This appears to be a return to a previous proposal by the DoJ which was made in 2012, when it was proposed to have two separate place of safety powers, a capacity based approach for over 16s and a non-capacity based approach for under 16s. CLC pointed out in its consultation response to the DoJ in 2012 the practical difficulties especially for police of having this twin track approach and the proposal in the 2014 consultation to have one place of safety power for everyone regardless of age was welcomed. This would now appear to not be the case.

14.2 CLC has some ongoing concerns regarding the use of places of safety powers. It is intended to retain the current list of places of safety, including hospitals and police stations. CLC believes that police stations and the JJC should never be used as a place of safety for a child. The Mental Capacity Bill will allow for the transfer of people from one place of safety to another within a 24 hour period. The ability to move persons from one place of safety to another is welcome, provided that the power is used to move persons from unsuitable places such as police stations to more suitable environments such as hospitals and not to move persons from suitable environments to unsuitable ones. CLC welcomes the approach by the Departments to have the period of time for a place of safety restricted to 24 hours. This reduction to 24 hours is in line with the current situation in Scotland and is more compliant with the UNCRC requirement that a deprivation of liberty should be for the shortest appropriate period. We would suggest that a clause be inserted into the Mental Capacity Bill (and into the amended Mental Health Order) which places an obligation on the PSNI to record statistics on the use of place of safety powers for young people, including the ultimate disposal of the young person under the place of safety power as currently accurate statistics regarding the use of the place of safety power are not available.

15. Part 10 – Criminal Justice

15.1 The Mental Capacity Bill will create a capacity based model for treatment within the criminal justice system for persons aged 16 and over. It appears that a person over the age of 16 who has capacity will be able to make a decision about their care, treatment, or personal welfare, and that decision will be respected. Where a person aged 16 and over is deemed to lack capacity, interventions will be carried out by implementing the principles and safeguards of the Mental Capacity Bill. It is unclear from the information which has been provided by the DoJ as to how this will work in practice and further detail is required in relation to arrangements for those under the age of 16. Details are also required as to how the capacitous decision of 16 and 17 year olds will be respected within the criminal justice system. It is also unclear how

the JJC, which has residents that are both under 16 and over 16 will operate in a dual system. Again we are deeply concerned by the lack of detailed information available in the Bill and consequently available to the Ad Hoc Committee to enable proper parliamentary scrutiny. This is especially so in respect to under 16s.

15.2 Courts will be required to take account of the capacity of the defendant when making certain determinations. The criminal courts can currently make disposals such as decisions to remand or sentence a person to a treatment based disposal (such as a hospital order) without any requirement to consider capacity or consent. The DoJ's proposals for the Mental Capacity Bill will mean that courts will be required to take account of the capacity and best interests of a person aged 16 and over before they exercise their powers and where a person aged 16 and over who has capacity refuses treatment based disposals the courts will not be able to make such a disposal. This has implications for both the courts and the young person and again further details as to how this capacity based system will operate in practice is required. Further scrutiny of the sentencing powers and procedures that the courts will have when dealing with 16 and 17 year olds under the Mental Capacity Bill is also required.

15.3 It is also unclear as to how young people will transition from one legislative framework to another, for example a person who is charged with an offence when they are 15, but who is found guilty and sentenced at 16. It is totally unclear whether such a young person will be governed by the provisions of the Mental Health (NI) Order 1986 or the Mental Capacity Bill. We would suggest that the Ad Hoc Committee seeks detailed clarification from the DoJ in relation to young people transitioning from one legislative framework to another.

15.4 Under the Mental Capacity Bill a court, when making a treatment based order for a person aged 16 and over will be required to consider not only the persons capacity, but also the likelihood of serious harm to the person or to others and the availability of appropriate suitable treatment. It is important that a list of 'suitable treatments' are provided and that funding is in place for such treatments so that courts are not fettered by the unavailability of such treatments.

15.5 The DoJ in their 2014 consultation document stated their intention to remove the stigmatising term of "mental disorder" from the criminal justice system in relation to persons aged 16 and over. However the term "disorder" appears throughout the Mental Capacity Bill. As the Mental Health (NI) Order 1986 will be retained for under 16s this stigmatising term of mental disorder will continue to be used in relation to young people under 16. CLC would wish to see all stigmatising language removed from an amended Mental Health (NI) Order 1986 and from the Mental Capacity Bill.

15.6 The Mental Capacity Bill creates a new suite of court disposals that will be unavailable to under 16s. This places under 16s at a considerable disadvantage, as even if a court were to believe that one of the new disposals was suitable, it would be prohibited from making such an order by virtue of the age of the defendant alone. The DoJ in its previous consultation document stated that persons who retain capacity would be able to request treatment and consent to treatment within the criminal justice system. This does not appear in the Mental Capacity Bill as is currently before the NI Assembly for consideration. The Ad Hoc Committee may wish to seek clarification from the DoJ as to why this provision has been removed.

15.7 The Mental Capacity Bill permits the courts, as they do now, to have two remand powers for examination to obtain a report, and for treatment. If the court remands the

accused person, they will be taken to a hospital, admitted and detained there for 28 days initially and up to a maximum period of 12 weeks. The person themselves will also be able to obtain a report at their own expense on their health from a medical practitioner and apply to the court for a termination of the remand. It is essential that Legal Aid is available to fund such reports. Whilst it can be seen how the remand for treatment option could work in practice for the adult population, it is difficult to envisage how the new power would work in practice for 16 and 17 year olds, as they would have to be remanded for treatment to an unsuitable adult facility, which would not be in their best interests and could raise serious child protection issues. There is currently no inpatient forensic treatment facility for young people in Northern Ireland. Therefore it is difficult to see how a court could remand a young person aged 16 or 17 to hospital for treatment. This could potentially result in young people who either lack capacity or that have a mental illness being refused bail and sent to the JJC as no alternative is available to the courts. The JJC is clearly unsuitable for young people who lack capacity or who have mental illness. This would clearly not be in the best interests of the young person.

15.8 It is proposed by the DoJ that there will be an expanded range of healthcare based disposal options open to the court when they are dealing with a person aged 16 and over. It would appear that this new suite of court disposals will not be available to courts when sentencing under 16s. **Amendments to the Mental Health Order must take account of this new suite of disposals and they must be available to courts when sentencing under 16s.** A court should not be faced with a young person whom it believes would benefit from one of these new disposals but be prohibited from making such an order. Under 16s with mental ill health within the court system should not be disadvantaged or be subject to inappropriate disposals as a result of their exclusion from the Mental Capacity Bill.

15.9 Unfitness to plead is currently determined by the common law through what is known as the Pritchard Test, which relies upon mental impairment, comprehension, and decision making. The test requires the person to be able to understand the charges, decide whether to plead guilty or not, exercise their right to challenge jurors, instruct solicitors and counsel, follow the course of proceedings and give evidence in their own defence. The current situation regarding unfitness to plead at Magistrates Court level is different from that in the Crown Court. The term fitness to plead is not one which is currently used in Magistrates' Court, and instead District Judges (Magistrates) must rely on the provisions of Articles 42 and 44 of the Mental Health (NI) Order 1986. This provides the Magistrate's Courts and Youth Courts with the power to make a Hospital Order if this is deemed to be suitable.

The Northern Ireland Law Commission (NILC) carried out a review and consultation on unfitness to plead in 2013. CLC responded to this consultation, and copies of our response are available upon request. The NILC[44] considered that elements of a mental capacity approach could enhance the test for determining unfitness to plead and recommended that, in order to be unfit to plead, the accused must be shown to be unable to make a decision for themselves in relation to a matter because of an impairment or disturbance in the functioning of the mind or brain and must be unable to:

a) understand the charges brought against them;

[44] NI Law Commission, Report Unfitness to Plead 2013

b) follow the course of proceedings; and

c) make certain decisions that they are required to make in relation to the trial.

The NILC recommended the adoption of the above test to the Magistrates' Courts. It would appear that it is not intended to apply the test of unfitness to be tried to under 16s or even to persons aged 16 and 17 within the Youth Court. If it is intended to apply the test of unfitness to be tried to persons aged 16 and 17 only within the Youth Court setting, this may create difficulties for the Youth Courts if they are faced with a defendant who is under 16 but clearly unfit to be tried.

If it is intended that the Mental Health (NI) Order 1986 will no longer apply to 16 and 17 year olds, then the new capacity based approach under the Mental Capacity Bill must apply, otherwise there will be no unfitness be tried (to plead) option available for 16 and 17 year olds in the Youth Court system. The Ad hoc Committee may wish to seek clarification in respect of this matter.

15.10 The Mental Capacity Bill creates public protection orders to provide a model that would allow an unfit person who retains capacity, remains ill, refuses treatment and is a serious risk, to be detained for protection rather than for treatment. Whilst it is recognised that this particular situation must be legislated for, the concept of a protection order has implications for the rights of the person under the ECHR as incorporated by the Human Rights Act 1998. Such an order will mean that a person is being deprived of their liberty without either having been the subject of a court disposal or being compulsorily detained in hospital in compliance with the law for the purposes of treatment of a mental illness. Such an intervention has the potential to impact upon a person's rights under Articles 5, 6, 8 and 14 of the ECHR and will undoubtedly be the subject of legal challenge.

16. Part 12 – Duties of hospital managers owed to children

16.1 Clause 254 of the Mental Capacity Bills relates to the duties hospital managers owe to 16 and 17 year olds and states that:

254 (1) This section applies in relation to a person who-

(a) is 16 or over, but under 18; and

(b) is an in-patient in a hospital for the purposes of the assessment or treatment of mental disorder under this Act.

(2) The managing authority of the hospital must ensure that (subject to the person's needs) the person's environment in the hospital is suitable having regard to his or her age.

(*3) For the purpose of deciding how to fulfil the duty under subsection (2), the managing authority must consult a person who appears to that authority to have knowledge or experience which makes that person suitable to be consulted.*

Clause 254 merely places a duty on the managing authority of a hospital to ensure that the hospital environment is "suitable" having regard to the 16 or 17 year olds age. This does not place a statutory duty on hospital managers to ensure that no young person is detained on an adult psychiatric ward. While the proposed obligation on the managing authority of a hospital to ensure that any person under 18, either a

detained or voluntary inpatient, should be in a suitable environment having regard to his or her age is welcome, further clarification is required as to what this accommodation is and when and how it will be provided. We have serious concerns about the use of the term "suitable" and wish to see a clear legislative duty on hospital managers to ensure that no young person is ever detained on an adult psychiatric ward.

16.2 It is a matter of serious concern to CLC that children and young people are presently not always treated in age appropriate facilities as required by Articles 37(c) and 3 of the UNCRC. When the Bamford Review looked at this issue it recommended that child and adolescent mental health services should ordinarily cover children and young people up to their 18th birthday and that at all times children and young people should be located in developmentally appropriate settings.[45] CLC expressed serious concerns regarding the approach advocated by the Northern Ireland Executive in its Response to Bamford[46] with regard to the issue of age appropriate services, where the Executive stated that there should be flexibility when deciding whether young people should be admitted to adult wards.

16.3 It is CLC's view that the detention of children with adults in non-appropriate age and developmental facilities fails entirely in ensuring the best interests of children and young people is a primary consideration. **It is our view that at all times, without exception, children and young people under 18 should be treated in developmentally and age appropriate settings. The accommodation of children and young people as in-patients on adult wards is completely unacceptable as there are serious implications for child protection.** Healthcare professionals working on adult wards are unlikely to have been trained in child protection procedures, adult patients are unlikely to have been vetted, children may not be given the same opportunities to express their views on adult wards, particularly if staff are untrained in effective methods of communication with vulnerable children and children in adult wards may not receive the most appropriate and highest standard of treatment where staff are trained and experienced in treating adult patients only.

16.4 The treatment of children on adult psychiatric wards was also a matter of concern for the United Nations Committee on the Rights of the Child in its Concluding Observations following its examination of the UK Government's compliance with its obligations under the UNCRC in 2008.[47] CLC wishes to see a clear statutory duty placed on hospital managers within the Mental Capacity Bill to ensure that no young person is detained on an adult psychiatric ward and to guarantee that **all** children and young people in need of inpatient mental health services at **all** times will be located in developmentally and age appropriate settings.

16.5 Clause 254(3) places a duty on the managing authority to consult a person who appears to that authority to have, "…*knowledge or experience which makes that person suitable to be consulted.*" In CLC's view such consultation should not be required in relation to the detention of children on adult psychiatric wards, as the statutory provision should be that such detention is not allowed. In any event, clause 254(3) does not state the purpose of consulting with the suitable person or define the

[45] A Vision of a Comprehensive Child and Adolescent Mental Health Service, July 2006, paras 4.43 and 4.44

[46] Delivering the Bamford Vision – The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability, Draft for Consultation, June 2008

[47] United Nations Committee on the Rights of the Child, Concluding Observations United Kingdom, CRC/C/GBR/CO/4, 20th October 2008, para. 56.

necessary knowledge or experience that is required to make a person suitable to be consulted with. Given the wording of Clause 254(3) CLC is unclear about whether the 'knowledge and experience' which makes a person suitable to be consulted with refers to the knowledge or experience of the young person or knowledge and experience of the particular hospital that it is intended to place the young person in. In addition, the issue of conflict of interest is potentially engaged here especially in respect of children who are in the care of the state, either as a looked after child or in the criminal justice system. CLC would suggest that clause 254(3) be deleted and a clear statutory duty making it unlawful to admit under 18s to an adult psychiatric ward be inserted.

17. Amendment of the Mental Health (NI) Order 1986 for under 16s

17.1 Given the potential impact upon under 16s of the retention of the Mental Health (NI) Order 1986 it is concerning that the Ad Hoc Committee have not been provided with sufficient detail in order to fully scrutinise the proposals for the amendment of the Mental Health (NI) Order 1986 for under 16s. The amendments that have been proposed by both Departments are discussed in detail below, however we would submit that these are the absolute minimum amendments required to the Mental Health (NI) Order 1986. CLC suggested a number of amendments to the Mental Health (NI) Order 1986 both before and during the 2014 consultation as an attempt to bring this piece of legislation into the 21st century however none of these amendments have been taken on board. The failure to do so will result in under 16s not having access to fundamental safeguards and protections.

Clause 255 of the Mental Capacity Bill provides for Schedule 8 of the Bill to amend the Mental Health (NI) Order 1986 so as to make provision for independent advocates for children, and to require persons making certain decisions to have a child's best interests as their primary consideration, as well as making other amendments to the Order. A child here is defined as any child under the age of 16. The proposed amendments to the Mental Health (NI) Order 1986 are at best minimal and they are not as a result of a full and comprehensive review of the Order. We would suggest that the Ad Hoc Committee scrutinise the amendments that are proposed for the Mental Health (NI) Order 1986 to ensure that they are in the best interests of children and young people under 16.

As we have highlighted above, **the Bamford Review noted that the Mental Health (NI) Order 1986 was not human rights compliant and did not recommend its retention. It is very concerning therefore that it is now proposed that it should be retained for under 16s. CLC has serious concerns that rather than being afforded special rights and protections, children and young people aged under 16 will not have access to the protections and safeguards outlined in the Mental Capacity Bill.**

17.2 In their consultation on the Draft Mental Capacity Bill in 2014 the DHSSPS and the DoJ outlined some amendments which both Departments' were considering making to the Mental Health (NI) Order 1986 for under 16s. While CLC maintains its position that under 16s should be included within the scope of the Mental Capacity Bill, in our response to the consultation we made a number of detailed recommendations regarding what we believe are necessary changes to the Mental Health (NI) Order 1986 to ensure ECHR compliance and that sufficient safeguards and protections for under 16s would be provided, based on our extensive casework and policy

experience in the area of children's mental health. We have provided comment on the suggested amendments to be Mental Health (NI) Order 1986 below.

17.3 Schedule 8, paragraph 3A inserts a best interests clause into the Mental Health (NI) Order 1986 and whilst CLC generally welcomes this proposal, it is our view that the text of the proposed best interests clause is not fully compliant with the UNCRC. In order to ensure compliance with the UNCRC, the best interests clause should clearly reflect the wording of Article 3 of the UNCRC, which provides that in all actions concerning children, the best interests of the child shall be a primary consideration. While this is reflected in Schedule 8, paragraph 2, paragraph 3B which sets out the determination of a patient's best interests is wholly unclear. The Committee on the Rights of the Child is clear that any assessment of a child's best interests must include respect for the child's right to express his or her views freely, with due weight given to these views in all matters affecting the child, in line with another general principle of the Convention, Article 12. The Committee states that Articles 3 and 12 have complimentary roles, the first aims to realise the child's best interests and the second provides the methodology for hearing the views of the child and their inclusion in all matters affecting the child, including the assessment of his or her best interests. The Committee is clear that Article 3 cannot be correctly applied if the requirements of Article 12 are not met.[48] States must also ensure appropriate arrangements, including representation, when appropriate, for the assessment of best interests; the same applies to children who are not able or willing to express a view.[49] The fact that the child is very young or in a vulnerable situation (e.g. has a disability, belongs to a minority group, is a migrant, etc.) does not deprive him or her of the right to express his or her views, nor reduces the weight given to the child's views in determining his or her best interests.[50]

While CLC appreciates that the Departments are attempting through Schedule 8, paragraph 3B(5) to ensure that the views of young people are sought in the determination of what is in their best interests, it is unclear whether this will apply to both voluntary and detained patients. The term "so far as is reasonably practicable" should be deleted from paragraph 3B(5) and the term "so far as is practicable and appropriate" should be deleted from paragraph 3B(7). The duty on Government under Article 12 of the UNCRC includes not only an obligation to facilitate young people to express their views but also to take the views expressed into account in making decisions which impact on the child. This is not strongly enough reflected in Schedule 8. Currently there is not enough emphasis on taking into account the views of young people in decision making, which falls short of what is expected under Article 12 of the UNCRC. CLC wishes to see this being addressed under the legislation to give full and proper effect to the obligations under Article 12 of the UNCRC.

[48] General Comment No.14 (2013) on the right of the child to have his or her best interests taken as a primary consideration' United Nations Committee on the Rights of the Child, CRC/C/GC/14, 29th May 2013, para 43.
[49] General Comment No.14 (2013) on the right of the child to have his or her best interests taken as a primary consideration' United Nations Committee on the Rights of the Child, CRC/C/GC/14, 29th May 2013, para 44.
[50] General Comment No.14 (2013) on the right of the child to have his or her best interests taken as a primary consideration' United Nations Committee on the Rights of the Child, CRC/C/GC/14, 29th May 2013, para 54.

17.4 Schedule 8, paragraph 3C puts in place regulations for the instruction of advocates for those under the age of 16. It appears that in limited circumstances advocacy services may be available to all young people in hospital regardless of whether or not they are detained patients. This is a welcome development from the previous position of advocacy being available only for detained under 16s. However, we wish to see the provision of advocacy for all under 16s at the earliest possible stage and have some concerns about when advocacy services will become available and for what purposes. CLC believes that it is vital that advocacy services are available in the community when detention is being considered as an option for a child, prior to the test for detention being applied, as this could we believe, based on our experience, prevent the need for detention. Whilst it now appears that both voluntary and detained patients will have a statutory right to advocacy in hospital settings only, it remains unclear as to the level of service that will be available.

In compliance with both Departments international obligations, CLC wishes to see as broad a statutory right to advocacy as possible, intervention at the earliest possible stage and the provision of advocacy for under 18s in the community where required and in particular, post discharge. CLC has a number of concerns about the dilution of the commitment to independent advocacy more generally within the Mental Capacity Bill which will now only be made available at the point of serious intervention. It appears that under 16s will not be provided with an independent advocate of their choosing, nor have the right to continuity of service and therefore access to a familiar advocate should they require the appointment of an advocate in respect of a range of separate issues. We would urge both Departments' to make a commitment to young people being able to choose and indeed to revisit their own independent advocate once they have established a relationship of trust with an individual advocate or advocacy service. This is critical given the particular vulnerabilities of children and young people to whom this legislation will apply. Young people who have formed relationships and trust with independent advocates from working with a particular advocacy service on a previous occasion may feel that that a particular service is best suited to meet their needs which will ultimately deliver better outcomes for the young people.

17.5 Information is required as to the type of training that will be required for independent advocates for under 16s. It is necessary that this training is accredited and is in line with Articles 4 and 42 of the UNCRC which emphasise that all professionals working with children and young people should be aware of, and receive training about the UNCRC and children's rights. The Committee on the Rights of the Child's General Comment No.5 provides a detailed account of children's rights training requirements that are placed on Governments. It notes that the Government's target audiences for training must include *"...all those involved in the implementation process - Government officials, parliamentarians, judiciary, and for all those working with and for children."*[51] Training for independent advocates for under 16s should include, as a minimum, training on children's rights, on determining the capacity of the child, on how to listen to and communicate effectively with children and equality training. We would seek clarification as to the type of training that will be required and whether or not there will be funding available for this training.

17.6 Schedule 8, paragraph 63B inserts a requirement for consent and a second opinion for electroconvulsive therapy (ECT) for detained patients aged under 16. CLC has serious concerns about the use of ECT on children and young people and its

[51] 'General Comment No.5 (2003) General measures of implementation of the Convention on the Rights of the Child' CRC/GC/2003/5, 27th November 2003, para.53.

compliance with human and international children's rights standards. As an absolute minimum we wish to see an amendment to the Mental Health (NI) Order 1986 to reflect the National Institute for Health and Care Excellence (NICE) Guidance on the use of Electroconvulsive Therapy which recognises that the risks associated with ECT may be enhanced in children and young people and states that clinicians should exercise particular caution when considering ECT treatment.[52]

17.7 Schedule 8, paragraph 3D amends the nearest relative provisions of the Mental Health Order, which provide for a person, generally a family member, to have certain rights and responsibilities in relation to a detained patient. As already highlighted above the nearest relative provisions of the Mental Health Act 1983 in England and Wales have been found to be incompatible with the rights of the patient under Article 8 of the ECHR and as a result of this, the corresponding provisions of the Mental Health (NI) Order 1986 are also incompatible and require substantial amendment in order to ensure compliance with the Human Rights Act 1998.

Schedule 8, paragraph 3D will amend the nearest relative provisions by adding the "patient" to the list of persons with a right to apply to the County Court for displacement of their nearest relative and by continuing the position that any person listed by the Mental Health (NI) Order 1986 who can make an application to the County Court can be appointed acting nearest relative, but that the patient cannot be appointed as his or her own acting nearest relative.

17.8 CLC has a number of concerns regarding the proposals to amend the Mental Health (NI) Order 1986 with regard to the nearest relative as we do not believe that the proposed amendments will ensure ECHR compliance. CLC wishes to see applications by under 16s to displace an unsuitable nearest relative being brought to the Mental Health Review Tribunal, as this will be faster and more cost effective, and will also be in line with the similar provisions in the Mental Capacity Bill for over 16s. In addition we wish to see a young person being able to choose an appropriate person who is not on the current statutory list as their nearest relative if they are suitable and willing to act. The term, '*any other person deemed suitable by the Review Tribunal*' should be inserted into the default list. The displacement of the nearest relative should not systematically follow the default list, but should be as a result of the child choosing a suitable person from within the list. Whilst the first person available from the statutory list may be suitable, they may not be the *most* suitable person from within the list. The ability of the child or young person to choose an appropriate person to act as a nearest relative, regardless of their position in the default list, should extend to the ability to choose, '*any other person deemed suitable by the Review Tribunal*'.

As indicated above CLC also wish to see specific provisions being put in place for looked after young people that would provide them with an ability to displace a relevant Health and Social Care Trust as their nearest relative in favour of another suitable person of their choosing. Similarly, in the case of a young person resident in the Juvenile Justice Centre (JJC), we would wish to see young people detained there being given the ability to displace the Director of the JJC as their nearest relative in favour of a suitable person of their choosing. It is worth noting that under this proposal the suitability of the nearest relative could then be determined by the County Court as currently proposed, but CLC would like to see this being amended to the Mental Health Review Tribunal for the reasons given above.

[52] Guidance on the use of Electroconvulsive Therapy, Issued April 2003, Modified October 2009, para 1.3.

17.9 Schedule 8 paragraph 3D places a similar duty on hospital managers in respect of age appropriate accommodation as that for 16 and 17 year olds under Part 12 of the Mental Capacity Bill, outlined above. CLC has repeatedly highlighted the admission of children to adult wards as a serious and ongoing concern and breach of the UNCRC. This was also highlighted as an issue of serious concern by the Committee on the Rights of Child following its examination of the United Kingdom's compliance with the UNCRC in 2008. Almost 200 children in Northern Ireland were detained on adult psychiatric wards between 2007 and 2009[53] and from January 2012 until December 2012 there were 91 admissions of children to adult psychiatric wards in Northern Ireland.[54] The duty on hospital managers in respect of age appropriate accommodation is potentially a welcome one but the same issues arise as for 16 and 17 year olds. An obligation is placed on the responsible authority of a hospital to ensure that any person under 16 should be in a suitable environment having regard to his or her age. We have highlighted above the weaknesses with this duty that it is insufficient, not compliant with international children's rights standards or the Bamford Review and must not be replicated in relation to under 16s. **CLC wishes to see a clear statutory duty on hospital managers to ensure that no young person is ever detained on an adult psychiatric ward. CLC wishes to see both Departments giving effect to a clear statutory duty within the context of the amendments to the Mental Health (Northern Ireland) Order 1986 so as to guarantee that all children and young people in need of inpatient mental health services at all times will be located in developmentally and age appropriate settings.**

18. Access to educational provision

18.1 The right of children and young people with mental ill health to an effective education was recognised in the Bamford Review's Human Rights and Equality of Opportunity report.[55]

In the consultation on the Mental Capacity Bill in 2014, and indeed from the first consultation on a Framework for New Mental Health and Capacity Law in Northern Ireland in 2009, an assurance was given by the DHSSPS that any new legislation would include clauses in relation to access to education for children and young people in mental health hospital settings. Neither the Mental Capacity Bill nor the amended Mental Health (NI) Order 1986 as proposed contain any clauses relating to education for children and young people. This is disappointing given the recognition of the need and the commitment by the Department to insert such clauses. In compliance with the Bamford recommendations CLC believes that both pieces of legislation should contain strong education provisions that allow young people to have equal access to the level of education that their peers receive in the community. Provisions should be made for children with special educational needs, including children who have statements of special educational needs. For those who are already statemented, statements must include specific and quantifiable provisions to support them in education. As part of discharge planning from hospital, children should be referred to the Education Authority for any necessary educational assessments so that they may return to education with the least possible delay and

[53] RQIA's Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland Updated 23rd February 2011
[54] Response to CLC Freedom of Information Requests to the five Health and Social Care Trusts.
[55] Human Rights and Equality of Opportunity – The Bamford Review, October 2006, p.21.

with any additional special educational provision required put in place as a matter of priority once they leave a hospital environment.

In order to comply with the UNCRC, particularly Articles 2 (the right of the child to non-discrimination), 23 (the right of a disabled child to a full and decent life), 28 & 29 (the right to education) Protocol 1, Article 2 of the ECHR and Article 24 of the UNCRPD (the right of persons with a disability to education), both the amendments to the Mental Health (NI) Order 1986 and the Mental Capacity Bill should ensure that all children with mental ill health or a learning disability continue to receive a practical and effective education, particularly if the child is detained, up to the age of 18.[56]

19. Other amendments required to the Mental Health (NI) Order 1986

19.1 CLC has provided both the Departments with detailed suggested amendments to the Mental Health (NI) Order 1986, based upon our work with children and young people in the field of mental health. The amendments proposed by CLC would have increased the levels of protections and safeguards available for under 16s and would have went some way towards making the Mental Health (NI) Order 1986 fit for purpose. Unfortunately none of the suggested amendments proposed by CLC have been incorporated in Schedule 8. CLC are happy to speak about these proposals in oral evidence and to provide additional papers to the Ad Hoc Committee on our concerns.

Based on its considerable experience of working with children with mental health needs CLC has engaged in detail with the DHSSPS and the DoJ since January 2014 in relation to amendments to the Mental Health (NI) Order 1986 and it is disappointing to note that none of these have been included in Schedule 8 of the Mental Capacity Bill. We have been afforded no explanation as to why these proposed amendments have been rejected. We would request that the Ad Hoc Committee explore in detail the following areas of serious concern when it is scrutinising this part of the Bill. We are happy to provide additional information in respect of each aspect if that would be useful.

19.2 Other areas which CLC have already raised in detail with the DHSSPS and which we believe are required to be amended in the Mental Health (NI) Order 1986 include:

- The language of the 1986 Order needs to be reviewed and amended, with phrases which are stigmatising, such as ‘mental disorder’ being removed. This would be in keeping with the Bamford Vision;

- Conditions caused by personality disorder, drugs and alcohol need to be included with the list of conditions currently covered by the term ‘mental disorder’ to ensure that children are not prevented from having access to inpatient assessment and treatment for these conditions;

- The test for detention for assessment/treatment should be amended to reflect the test proposed for over 16s under the Mental Capacity Bill, as was previously proposed for under 16s in earlier consultations;

- There must be a right of access to the Mental Health Review Tribunal at the earliest possible stage. The 1986 Order should be amended to allow under 16s the ability to apply to the Tribunal during the assessment period and a tribunal should be

[56] Or possibly up to the age of 19 where there is a statement of Special Educational Needs in force

constituted within the assessment period, rather than after 6 weeks as is the case currently;

- Article 13 of the Mental Health (NI) Order 1986 refers to renewal of authority for detention for treatment. CLC believes this article should be amended to state that a review of detention must be carried out by two doctors and the renewal of authority for detention for treatment must be authorised by a Trust Panel (as available under the Mental Capacity Bill). While CLC does not support the introduction of Trust Panels, if they are introduced it is essential that renewal of authority for detention for treatment should require authorisation as is proposed for those over 16. Children under 16 should not have less safeguards than those over 16 when it comes to renewal of authority for detention for treatment There must also be a right of appeal to the Mental Health Review Tribunal;

- Article 73 of the Mental Health (NI) Order 1986 relates to the automatic referral mechanism to the Mental Health Review Tribunal. This should be amended to ensure that applications are made in time to allow the Tribunal to hear the case within one year. Our experience currently would suggest that automatic referrals are often made at the last possible time allowed and given the time it takes to list a Mental Health Review Tribunal more than six weeks will have passed since the year of detention has expired;

- Currently the Mental Health (NI) Order 1986 only permits a young person to apply to the Mental Health Review Tribunal once every 6 months. This is an extremely long time in the life of a child under the age of 16. CLC wants to see this restriction being removed and the inclusion of a provision to allow for multiple applications to be made, if necessary, with the leave of the Mental Health Review Tribunal;

- Article 121 relates to the offence of ill treatment of patients. This needs to be amended to mirror the offence of ill treatment or neglect of those who lack capacity in the Mental Capacity Bill. Children under 16 should have at least equal protection from ill treatment and neglect as those over 16;

- Article 130 relates to places of safety for those in need of immediate care or control. CLC believes that the Juvenile Justice Centre or a PSNI station is not a suitable option as a place of safety for a mentally ill young person. We wish to see these locations removed from the legislation;

- The legislation should include a list of safeguards and protections which are at least equivalent to those over 16s will be afforded under the Mental Capacity Bill, including those safeguards which have not been addressed elsewhere, such as a statutory recognition of the views of carers and restraint safeguards. These safeguards and protections should apply to both detained and voluntary patients equally;

- Article 127 of the Mental Health (Northern Ireland) Order 1986 which provides for voluntary patients must be substantially amended to ensure that the safeguards and protections for children who are voluntary patients, including a statutory right of access to advocacy services, are at least as robust as those for voluntary patients under the Mental Capacity Bill.

19.3 The amendments suggested by CLC are the **minimum** required to bring the Mental Health (NI) Order 1986 closer to being Bamford compliant. The Mental Health (NI) Order 1986 was found by the Bamford Review to be non-human rights compliant and the Order will require substantial amendment in to address this situation. Children

and young people under the age of 16 must have access to the level of protections and safeguards that are at least equivalent to those over the age of 16 under the Mental Capacity Bill and we would urge the Ad Hoc Committee to take these proposed amendments into consideration.

20. Extension of the Disregard Provision in Article 10 of the Mental Health Order to include periods of detention for treatment

20.1 An amended Mental Health (Northern Ireland) Order 1986 will still allow for the compulsory detention for assessment or treatment of mental ill health for those under the age of 16, and it some cases it may be easier to detain under 16s as it will not be necessary to first establish a lack of capacity as in the Mental Capacity Bill for over 16s. For many young people a detention under the Order has a stigmatising effect. In its consultation in 2014 the DHSSPS stated its intention to amend Article 10 of the Mental Health Order, which contains the obligation to declare periods of detention for treatment for a mental illness for insurance and driving purposes, travel, to employers and for jury service, as this has an extremely detrimental impact on the child's life and future. The proposal was to amend Article 10 so that no under 16 would ever have to declare a period of treatment in hospital for mental ill health, which CLC very much welcomed. **However, this extension of the disregard provision is not included anywhere in Schedule 8.** Again we have been provided with no satisfactory explanation for this.

20.2 Given that the UNCRC defines children as, *"…every human being below the age of eighteen"*[57] CLC had advocated that the disregard provision should have been extended further to include 16 and 17 year olds under the Mental Capacity Bill and to operate retrospectively to include all persons who have been detained in childhood under the 1986 Order since its enactment. It is extremely disappointing that it now appears that the extension of the disregard provision will not be included in the Bill. CLC has acted in numerous cases of children and young people who, as a result of the obligation to declare periods of detention for treatment for a mental illness, have been unable to take up opportunities including travel and employment. We believe that it is vital to safeguard the futures of young people who have suffered mental illness in childhood and to include the disregard provision in the Bill for all under 18s and for anyone detained for treatment of a mental illness while under the age of 18. We would request that the Ad Hoc Committee consider this issue in detail during its consideration of this section of the Bill.

21. Offences

21.1 The Mental Capacity Bill makes provision for a new offence of ill-treatment or neglect (clause 256).

This new offence of ill-treatment or wilful neglect will apply to anyone caring for a person who lacks capacity or is believed to lack capacity, in relation to all or any matters concerning their care. It also applies to attorneys and deputies. Penalties include a fine or imprisonment for up to 5 years or both. The wording of clause 256, which is similar to that in the Mental Capacity Act, would suggest that the new offence of ill-treatment or neglect applies only to persons aged 16 and over and that under 16s will not benefit from this added protection. **It is essential that this new**

[57] Article 1, UNCRC

criminal offence should provide equal protection to those under the age of 16 as well as to those aged 16 and over.

21.2 Section 44 of the Mental Capacity Act 2005 (England and Wales) created an offence of ill-treating or wilfully neglecting a person who lacks capacity, or whom the offender reasonably believes to lack capacity. The offence may only be committed by certain persons that have a caring or other specified responsibility for the person who lacks capacity. The penalties are, on summary conviction up to 12 months imprisonment, a fine not exceeding the statutory maximum, or both, or on conviction on indictment up to 5 years imprisonment or a fine, or both. The Code of Practice of the Mental Capacity Act 2005 makes it clear that the offence of ill-treatment or wilful neglect of a person who lacks capacity under article 44 **also applies to children under 16 and young people aged 16 or 17**. However, the offence only applies if the child's lack of capacity to make a decision for themselves is caused by an impairment or disturbance that affects how their mind or brain works.[58] It therefore follows that a determination of the lack of capacity in under 16s as caused by an impairment or disturbance that affects how their mind or brain works is possible and is legislated for under the Mental Capacity Act 2005. This calls into question the rationale for the exclusion of under 16s from the Bill.

21.3 It is essential that the offence of ill-treatment or wilful neglect under the Mental Capacity Bill applies to under 16s as well as to those aged 16 and above, however consideration must also be given to the ongoing review of this offence in England. It has been recognised that the offence in section 44 of the Mental Capacity Act 2005 is flawed, in that it is possible that a situation could arise where two patients, one with full capacity and one without could be subjected to the same type of ill-treatment, by the same person with the same intent, but a prosecution for ill-treatment or wilful neglect could only be brought in respect of the patient without capacity. This has required the law to be revised. This situation is being replicated for over 16s in this proposed Bill; offences committed against persons aged 16 and over who retain capacity will not result in a prosecution under clause 256 of the Mental Capacity Bill if the alleged victim retained capacity at the time the offence was committed. Consequently the proposed wording of clause 256 should be amended to address this inconsistency.

21.4 The Department of Health in England launched a public consultation in February 2014 on a new offence of ill-treatment or wilful neglect, which will not be based on the victim having a lack of capacity. The consultation document considers, and asks for the views of consultees, on whether existing safeguards for children are suitable and whether the new offence should apply in all formal health settings in both the public and private sector used by children, including in services used by both children and adults. It is therefore entirely possible to have an offence of ill-treatment or neglect within the Mental Capacity Bill which is not capacity based and which applies to everyone in society regardless of age.

22. Part 15 – Supplementary

22.1 Under clause 276 the Department must prepare and issue codes of practice for the Mental Capacity Bill. The DHSSPS and the DOJ's Consultation on Proposals for the Draft Mental Capacity Bill in 2014 repeatedly stated that the Codes of Practice would elaborate upon and provide detail about matters such as what additional protections the Bill will provide for 16 and 17 year olds, details as to what is meant by an impairment or disturbance in the functioning of the mind or brain, and what

[58] Code of Practice, Mental Capacity Act 2005, para.12.5

circumstances may amount to a deprivation of liberty, among other matters. This view has been repeated in oral briefings to the Ad Hoc Committee on the Mental Capacity Bill by Departmental representatives in June 2015. The Codes of Practice have not yet been published. Given the intention to include such a level of detail pertinent to the Bill in the Code of Practice, it is highly regrettable that the Ad Hoc Committee does not have access to the Code of Practice to enable it to fully appreciate what the implications of some of the proposed provisions will be.

22.2 A delay in the publication of the Codes of Practice will have a detrimental impact upon the Mental Capacity Bill, as delays in the publication of the Codes of Practice for the Mental Health (NI) Order 1986 had. The detrimental effect of this delay in publication was recognised by the Bamford Review in its Comprehensive Legislative Framework report.[59]

22.3 It is essential that the Codes of Practice are immediately published and considered at the same time as the Mental Capacity Bill. Given the importance of the Codes of Practice, **it is essential that they are subject to full parliamentary and public consultation in a timely manner and are assessed for their impact on the promotion of equality of opportunity, through screening and if necessary EQIA, at the earliest possible stage as part of the policy development process.**

23. Conclusion

23.1 The Children's Law Centre is grateful for the opportunity to submit evidence on the Mental Capacity Bill and we hope that the Committee finds our comments helpful in examining the contents of the Bill. We would very much welcome the opportunity to provide oral evidence to the Committee on the contents of the Bill, and are happy to further discuss or clarify anything within this written evidence in advance of this.

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[59] A Comprehensive Legislative Framework, August 2007, p.5.