Northern Health and Social Care Trust

NHSCT RESPONSE TO MENTAL CAPACITY BILL
As Requested by the Ad Hoc Committee of the NI Assembly

July 2015

The Northern Health and Social Care Trust (the Trust) thanks the Ad Hoc Committee of the NI Assembly for the opportunity to comment on the legislation during the current process.

This response is based on the extensive clinical experience of delivering services and Service User participation, thus the Trust believes it is well placed to consider the impact of the proposed Bill on issues relating to implementation, culture and practices.

The Trust believes that Draft Mental Capacity Bill (the Bill) provides a progressive, positive and comprehensive framework with regard to capacity and best interest providing explicit principles and clear guidance for putting these into practice. It has clarified the legal position and the role of the law within capacity issues. It has clearly illustrated the need to balance care and protection against empowerment and the individual's human rights. The Trust welcomes the emphasis within the Bill to ensure that an individual must be given all practicable help and support to enable him or her to make a decision. The Bill addresses the discrimination implicit in separate Mental Health Legislation by bringing together all decision making into the same legislative framework – this is welcomed by the Trust. However, it must be recognised that the concept of a single statutory framework covering all decisions relating to care, treatment for physical or mental illness and personal welfare for persons deemed to lack capacity is a major step change for all those responsible for delivering care and will require careful planning and comprehensive training including awareness training. In particular, it is vital that a code of practice governing the operation of the legislation is developed and consulted upon and that service users, carers and staff are fully versed in the implementation of the legislation prior to the legislation going live. This requires the development of the code of practice and consultation on that code before the legislation can be enacted.

Title of the Legislation:
The Trust proposes that the title of the legislation should be changed to the Capacity Bill.

Part 1: Principles: Best Interests

The Trust welcomes inclusion of principles but would recommend that the principle of least restrictive option is stated clearly at the front as in the Capacity Act 2005. We would advocate that there should be further clarification of these principles within the Code of Practice.

Part 2: Chapter 1; Clause 9 Protection from Liability:

Acts of omission should be addressed in this section.

Part 2: Chapter 1; 11 (b) Advance Decisions:

There needs to be further clarity on this as follows:

If a person who has made an advance decision that they never again want a specific treatment or to be admitted to hospital, what happens if they subsequently become so ill as to meet criteria for treatment under this legislation? Which would take precedent the advance decision or the treatment deemed necessary and proportionate under the Mental capacity Bill? Does 11 (b) mean that such a treatment would not be carried out?

Part 2: Chapter 1; 12: Acts of Restraint:

It is noted that there is no grounds for restraint in response to risk to others – rather it is only 'risk of harm to P'. Consideration should be given to provision of grounds for restraint when there is 'substantial likelihood of risk to others'. Clear guidance will be required to inform the threshold of unacceptable risk.

Part 2: Chapter 2; 14 Section 13: Formal capacity assessments and statements of incapacity

14(4) It is welcomed that Regulations will be in place regarding who is best placed to make assessments of capacity. It is proposed that the following terminology may be helpful: '*all suitably trained professionals receiving on-going supervision should be considered to be appropriate to make such assessments'*. There is some concern that Independent Service Providers may not have the same training/supervision or regulation in this area of practice; this will inevitably lead to an increased demand on HSC Trust staff.

Part 2: Chapter 3; 18 Second Opinion: relevant certificates

It is noted that a 'medical practitioner' is considered to be required to provide the second opinion in cases of serious interventions. Within current HSC services the predominant theoretical model informing assessment, formulation of issues and intervention is a bio psychosocial model. Within this framework there can be a greater emphasis on some occasions on a medical / biological approach and on others it may be a more psychological approach -albeit on all occasions focussing on integration of these strands. Indeed within NICE Guidance on many occasions the predominant evidence base is for a psychological intervention. Thus in light of the growing evidence base for effectiveness of interventions other than medical approaches, and in order to future proof the Bill, it is recommended that the professional with lead responsibility for delivery of the assessment or intervention would be best placed to make those recommendations for treatment as they will lead

on the delivery. Thus it is suggested that *the second opinion should be completed by the profession with lead responsibility for the delivery of the relevant treatment*.

Part 2: Chapter 4; 24 Deprivation of Liberty:

The Trust is keen to ensure that the definition of deprivation of liberty as defined within the review of the Cheshire West case has been fully integrated into the legislation.

Part 2: Chapter 4; 29 Duty to Revoke requirement where criteria is no longer met:

It is noted that a 'medical practitioner' is considered to be required to revoke the requirement. As described in earlier sections, in light of the growing evidence base for effectiveness of interventions other than medical approaches, and in order to future proof the Bill, it is recommended that the professional with lead responsibility for delivery of the intervention in P's case, would be best placed to make those recommendations for treatment and revoking any earlier requirements. It is recommended that the *'lead clinician'* may be a more appropriate term.

Part 2: Chapter 7; 48 Duty of HSC to refer case to the Tribunal

The Trust recommends that review within 1 year should be enhanced to 3 monthly reviews for 16 and 17 year olds.

Part 2: Chapter 8; 52 -53 Medical Reports

Rather than a 'a medical report' the Trust proposes that a clearer description of the report is a '*clinical report'*; as while there are many occasions that this may be completed by a medical practitioner, on other occasions it may be completed by other professional groupings.

Part 4: Independent Advocates: 84

The Trust is unsure how 'independent' the independent advocate is, if their services are commissioned directly by the Trust. As such it is recommended that provision is made for an alternative commissioner of such a service.

Implementation of Legislation:

It is suggested that the magnitude of culture and practice change which is required across multiple areas of health and social care, justice and beyond is such that considerable emphasis must be placed on the implementation framework. It is crucial to differentiate between an expression of a preference, or a 'want', as being an indication of capacity (leading to, for example, people without capacity being allowed to become hugely obese, to the point of health risks). In other settings, particularly general medical inpatients wards, it will be important to ensure staff do not act in a paternalistic/authoritarian fashion and make decisions based on the staff's perception rather than going through the procedures of implementing best

interests. Services in general may well struggle with the person's right to make unwise decisions, especially where risk is involved, leading to people's rights being restricted. Such issues would clearly limit the impact of the change in personal autonomy delivered by the Bill.

The draft bill establishes that capacity test is 'issue and time specific'. Mental disorder is, by nature, dynamic and can change within short time frames and is why current mental health legislation recognises both the nature and degree of mental illness.

It will be essential to ensure that adequate resources are available for implementation – to ensure that staff are available to complete the necessary reports within the specified timeframes across the breadth of decision making that is required.

The requirement for a focus on development of capacity to enable people to make autonomous decisions and to need to evidence efforts to do this is in keeping with recommendations on best practice and is to be welcomed. The Trust fully supports this approach and highlights that such an approach is resource intensive and will impact on staffing resources.

The need to create panels within Trusts to review and authorise decisions will require to be adequately resourced with individuals of sufficient skill, expertise and experience to ensure the role is meaningfully carried out.

It is likely that infrastructure requirements will include additional access to medical practitioners, social workers (in particular ASWs), psychologists and speech and language therapists for tasks closely associated with the implementation of the Bill (in particular production of clinical reports and supporting and enhancing development of capacity).

In addition any professional or care staff who recommend or deliver any element of care or treatment (albeit not meeting criteria for serious treatment) will require additional training and support to ensure they are compliant and working within the culture of legislation.

Leading the Changes:

Learning from the House of Lords Review of the Implementation of the MCA 2005 would suggest that implementation has worked well when key people were identified within the organisation and there was a clear lead from within an organisation and especially if **there was a multi-agency lead group.**

It is further proposed that while a focus on supporting cultural change with qualified professionals is important, it remains crucial to also focus on service users themselves, families and informal carers. The Trust is keen to work in partnership with the DHSSPSNI to support this change.