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COMMENTS ON MENTAL CAPACITY BILL 2015

Some introductory remarks

The Northern Ireland Mental Capacity Bill is a ground-breaking step which I strongly support. My comments will amplify some of the points I made when giving evidence to the Ad Hoc Joint Committee on the Bill on 29th June 2015. My comments will be mainly about how the law would work out for persons with 'mental illness'.

The solution to the discrimination that is inherent in conventional mental health legislation is a 'fusion' law such as is proposed for Northern Ireland. Involuntary treatment would only be permitted – arguably with rare exceptions in some forensic criminal cases - firstly, when the person has an impairment of 'decision-making capacity' (DMC) and, secondly, if treatment would be in the person's 'best interests' (BI). What is especially important is that the impaired DMC could be of any cause, in any person, in any setting – a head injury, post-epileptic confusion, schizophrenia, confusion due to an adverse drug reaction or infection, Alzheimer's Disease, and so on - in any kind of hospital ward, or care home, or in the community. The 'fusion' proposal builds on the complementary strengths of two existing regimes. Existing capacity-based legislation's strength in giving due weight to self-determination is nearly always counterbalanced by a number of weaknesses. These lie in the lack of sufficient attention to emergency treatment, non-consensual treatment and detention in hospital. But these are exactly those areas in which civil commitment schemes are strong; detention and the use of force are clearly authorised and regulated.

Specific comments

Clause 7 (9) Best interests.

This states that a person "must, in relation to any act that is being considered, have regard to whether failure to do the act is likely to result in harm to other persons with resulting harm to P".

I am not entirely sure what this means. I take it to mean that *the interests and preferences of other people can be considered only insofar as they affect the*

interests of the person without capacity. If this is indeed the case, I suggest that 7(9) be redrafted along these lines.

Relationship with Criminal Justice System

Part 9 and the clauses dealing with remand to hospital, transfer from prison to hospital, and Interim detention orders look fine.

However, I am not clear about some aspects of the role of Public Protection Orders. There is here an element of discrimination against persons with an impairment or disturbance of the functioning of mind – most of whom would be people generally known as mentally abnormal offenders.

Here I would like to briefly reiterate the way in which current mental health law discriminates against persons with (in the conventional terminology) a 'mental disorder' in relation to detention and treatment 'for the protection of others'. People with mental disorders are unusual in being liable to detention (albeit usually in hospital but often in police cells) because they are assessed as presenting a *risk* of harm to others, but before they have actually committed an offence. This constitutes a form of preventive detention, restricted to those with a mental disorder. However, if we were to take all people in a community at any time who commit serious violent offences, only a small proportion – around 5% will be constituted by persons in recent contact with mental health services (less than 2% by those with a 'serious mental illness' such as a psychosis). Yet it is that small percentage who are liable to preventive detention on the basis of risk alone – not the much larger numbers who present a risk of serious offences but who do not have a mental disorder.

Fairness demands that all people who present an equal level of risk should be equally liable to detention. If preventive detention is to be allowed for for those with a mental disorder on account of their risk to others, if we are to avoid discrimination, so should it be for all of us – or we should have no preventive detention for anyone, including those with mental disorder. At present persons with mental disorder do not receive the protections from preventive detention that the rest of us do. Mental health legislation denies such protection, thus reinforcing an underlying stereotype that the mentally ill are inherently dangerous.

This does not mean that a person's potential dangerousness is unimportant. If it is reliably linked to an individual's mental disorder for which there is treatment, then if the person lacks DMC, involuntary treatment may be justified if it is in their 'best interests'. What if the person *has* DMC – and rejects the offer of treatment where there is one? If involuntary treatment is to be imposed under these circumstances, protection of the public becomes the sole interest. Such a person should be managed in the same way as an offender who does not have a mental disorder.

Clauses 165 – 170 Public Protection Orders (PPO)

I am not clear about the intention lying behind the construction of PPOs. I have not seen any background information. The principle that I have stated above is that persons with an impairment or disturbance of the functioning of mind, when it comes to protection of the public, should be treated on an equal basis with those who do not have such an impairment. A Hospital Direction (Clause 172) does this – in the sense that the period of detention is proportionate to the seriousness of the offence and is in line with the duration of the sentence imposed on a person without a mental impairment.

The PPO on the other hand seems to me to have two problems. First, although it is reviewable, it does not have a maximum term attached. It can be renewed at 6 months and then annually. The detention is thus indeterminate and could go on for a very long time, much longer that a person convicted of the same offence but who does not have a mental impairment. Second, there are three groups of persons who can be detained, but treatment is - under Clause 238 – to be on the same basis as a non-detained patient :
1. involuntary treatment is allowed if P lacks DMC and it is in P's BI;
2. treatment is allowed if P has DMC and treatment is accepted voluntarily;
3. that leaves a third group of detained persons, those who have DMC but refuse treatment (which is nevertheless available). Where is the health interest that is being served these cases? Why should they be in a treatment facility, and not under another form of custody? (This problem also seems to exist with the Hospital Direction – *Clauses 172-174; Clause 238*)

I suggest that for such an arrangement to be non-discriminatory, there would need to be a similar reviewable, but indeterminate, detention for those without a a mental impairment which is based on a similar level risk posed to other persons, and which is assessed in a comparable manner for those with or without a mental impairment. (In fact, factors specifically associated with a mental illness contribute very little to the assessment of risk - the major predictors of risk of violence are the same for offenders with or without a mental impairment). From my reading of the option of longer than normal sentences under the Northern Ireland Criminal Justice Order 2008, the PPO could be brought into alignment – depending on the seriousness of the offence and the assessed level of risk - with an indeterminate sentence, a discretionary life sentence or a fixed-term extended sentence. Apart from the argument based on 'fairness', this also would arguably be compliant with the UN Convention on the Rights of Persons with Disabilities. The PPO as it stands would not.

In thinking through the issues in the past with my colleagues, John Dawson and Rowena Daw[1], we proposed for those with a conviction for a serious offence, two major options for disposal by the court:
1. A hospital order for those who lack DMC and where treatment is in their BI or for those with DMC and accepting treatment voluntarily; the conditions would

[1] Szmukler G, Daw R, Dawson J. A model law fusing incapacity and mental health legislation & outline of the Model Law. Journal of Mental Health Law. 2010; Special Issue Ed 20:11-24; 101-128.

be the same as for those detained on a civil order, with discharge determined by the responsible consultant;
2. A range of hospital orders: this could be a fixed term order commensurate with the seriousness of the offence in line with a sentence for non-mentally impaired persons. Treatment could be involuntary or voluntary as for option 1. above. Or the order could be for one of the longer than normal sentences – an extended sentence, an indeterminate sentence or a life sentence. These could comprise a period of detention in an institution offering treatment or care, followed by a period of supervision on licence. Again involuntary and voluntary treatment would be determined as for option 1. Later transfers from prison could be made where appropriate, for instance, where a person with DMC decides that they now accept treatment voluntarily. While under supervision, involuntary treatment could not be given under these hospital orders if the person had regained DMC, but a referral for an assessment for a Part 2 order could be promptly made as the person will be regularly seen. At termination of a fixed term, if criteria were met, the person could be detained under the Part 2 civil provisions.

Under this set of principles it is possible to offer desired levels of public protection and treatment where appropriate, while at the same time treating all offenders on an equal basis.

Clause 205 Powers to deal with person unfit to be tried or not guilty by reason of insanity

This group of persons present a major challenge. When such a person has DMC but is assessed as presenting a serious risk to others it becomes clear that they somehow fall between the criminal justice system - not being convicted means that a prison sentence is impossible – and the health system – where retaining DMC and refusing treatment (where there is one) means that involuntary treatment would not ordinarily be possible. The options under *Clause 205* are probably the best one can achieve at the moment, until some kind of 'third way' is developed. If a PPO is to be an option, the considerations above should be taken into account.