

## **Mental Capacity Bill**

### **Submission to the Northern Ireland Assembly Ad Hoc Joint Committee from the Royal College of Nursing**

#### **Introduction**

- 1 The Royal College of Nursing [RCN] represents nurses and nursing, promotes excellence in practice and shapes health policy. The RCN represents registered nurses, health care assistants and nursing students across all care settings throughout Northern Ireland.
- 2 The RCN welcomes the opportunity to provide written evidence to the Northern Ireland Assembly Ad Hoc Joint Committee on the Mental Capacity Bill.
- 3 This submission builds upon the RCN's response to the joint DHSSPS and Department of Justice consultation on the draft legislation, conducted in 2014. The response was informed by the expert professional views of RCN members working in a range of care settings within both the HSC and the private and independent sectors across Northern Ireland. The response was subsequently endorsed by the RCN Northern Ireland Board, the elected body responsible for the governance of the RCN in Northern Ireland.
- 4 The RCN has consistently supported the concept of the single Act covering capacity and, in common with a wide range of other health organisations in Northern Ireland, lobbied for its introduction as far back as 2009 as an essential component of delivering the Bamford vision. We are pleased to see this commitment explicitly re-stated in **paragraph 7 of the Explanatory and Financial Memorandum**.

- 5 At the time of the Health Minister's announcement later that year, the Director of the RCN in Northern Ireland stated: "We are pleased that the Minister has listened to the views of nurses and of professional and service user organisations on this issue. The RCN believes that a single Act covering both mental health and mental capacity will avoid stigmatising patients and will stop placing practitioners in the difficult position of labelling patients according to their mental health status or their mental capacity. We also welcome the Minister's commitment to ensuring that human rights principles and improved safeguards for patients are incorporated in the legislation. This announcement is good news for people with mental health issues and those with learning disabilities, their families, carers and the health professionals who provide care for them. It will help to provide the legislative basis for a new service that truly respects the human rights, autonomy and needs of vulnerable patients." This remains the position of the RCN and, as such, we are pleased now to be able to comment on the wording of the Bill itself.
- 6 When the Bill is passed, Northern Ireland will become the first jurisdiction in the world to combine mental health, mental capacity and criminal justice legislation within a single Act. Uniquely, there will be a single statutory framework governing all decision-making in relation to the care, treatment or personal welfare of a person aged 16 or over who lacks capacity to make a specific decision for himself or herself.
- 7 The RCN believes that the new legislative framework will help reduce the stigma often associated with separate mental health legislation and provide an opportunity to strengthen protection for people who lack capacity to make decisions for themselves. While the existing Mental Health Order has worked well in many respects, it does not reflect a growing recognition of the right to personal autonomy on the part of service users. The Bill, in contrast, encompasses a vision and framework that would apply to everyone in society, including those subject to the requirements of the criminal justice system.
- 8 The RCN believes that securing the support of the nursing profession in Northern Ireland for the new legislation is vital to its success. As well as being the largest single professional group within the health and social care

workforce, nurses also have the greatest volume of direct patient and client contact and are therefore well-placed to act both as ambassadors and advocates for the legislation if they are appropriately and supportively engaged by the DHSSPS and Department of Justice. The RCN would welcome the opportunity to work in partnership with both Departments and other relevant organisations in order to help build and secure this support.

- 9 The remainder of this submission outlines the key issues that the RCN would wish to bring to the attention of the Ad Hoc Committee. As requested, it is themed in accordance with the structure of the legislation.

## **Part 1: Principles**

- 10 The RCN believes that the implications of this legislation extend far beyond the confines of the mental health and learning disability fields of practice. They will have implications for all areas of health and social care practice and service provision in Northern Ireland. People may lack capacity to make a decision for many reasons. It may be, for example, because of a stroke, an acquired brain injury, a learning disability or mental ill health.
- 11 The successful implementation of the legislation will also require a significant change in attitudes throughout society, particularly in respect of how the human rights are respected and upheld of those people with capacity who may choose to make decisions about themselves that others may consider unwise or even potentially dangerous.
- 12 Accordingly, the RCN urged the DHSSPS and Department of Justice to consider renaming the draft legislation as the Capacity Bill or perhaps the Best Interests Bill (see **section 7 on pages 4-5**). We believe that this will underline the point made in paragraph ten above and help to build a broad consensus of support for the legislation and its underlying ethos across the health and social care services, and society more widely. The RCN reiterates this suggestion and wishes to bring it to the attention of the Ad Hoc Committee.

- 13 The starting point for the legislation is a presumption of capacity. **Section 4 on page 2** makes it clear that people will be supported to exercise their own capacity to make decisions where they can. The main provisions will apply where a person lacks capacity (due to, for example, a stroke, mental ill health, or a learning disability) and where no alternative decision-making arrangements (such as a power of attorney) have been put in place. The safeguards being provided reflect the nature and seriousness of the intervention. The more intrusive the intervention in the life of the person lacking capacity, the greater the safeguards required.
- 14 The RCN endorses in general terms the principles governing capacity and best interests defined at **sections 1 and 2 on pages 1 and 2**. We also endorse the definitions of lacking capacity, inability to make a decision, and best interests as set out in **the remainder of Part 1**.

## **Part 2: Lack of capacity, protection from liability, and safeguards**

- 15 The RCN believes that the term “restraint”, as employed and described at **section 12 on page 8**, is outdated and possibly pejorative. We advocate the use of the term “restrictive interventions” or “restrictive practices”. The RCN was recently commissioned by the Department of Health in England to develop guidance for health professionals that will reduce the need for restrictive interventions in health and adult social care. The key principles of this work are: that human rights must be protected and honoured at all times; that the involvement and participation of service users, their families and carers is essential; that people must be treated with compassion, dignity and kindness at all times; and that health and adult social services must keep people safe and free from harm. The RCN would be pleased to share the outcomes of this work with the Ad Hoc Committee.
- 16 In particular, the RCN is concerned about the specific wording of **section 12, paragraph 4**, whereby “an act restraining P” is defined as act that “is intended to restrict P’s liberty of movement, whether or not P resists” or “a use of force or a threat to use force and is done with the intention of securing the doing of an

act which P resists”. The use of restraint should be the last resort within an escalating series of restrictive interventions that are designed primarily to protect the safety of the patient and/or others. The current wording appears erroneously to equate restrictive practices with restraint and implies that restraint is an appropriate means to seek compliance, rather than a means to safeguard the patient and/or others. The RCN recommends that this wording should be replaced by that used in the English code of practice (26.37) whereby: “Where a person restricts a patient’s movement, or uses (or threatens to use) force then that should: be used for no longer than necessary to prevent harm to the person or to others; be a proportionate response to that harm; and be the least restrictive option”. The key difference is that force (or the threat of force) is not referred to in this definition as a means to seek compliance, as it is in the Northern Ireland Bill.

- 17 The RCN believes that the subordinate legislation and code of practice must include a robust definition of what is meant by restrictive interventions and some practical case studies to help disseminate and promote good practice in this respect. These should cover a range of care settings and encompass issues such as alcohol and drug dependence, or eating disorders, for example. Where restrictive interventions are used, there must be documented evidence of a lack of capacity, that it is being conducted in the best interests of the individual, and that the least restrictive option is being used.
- 18 The draft legislation refers (see, for example, **section 13, clause 14, paragraph 2 on page 9**) to the assessment of capacity by a “suitably qualified person” but does not specify precisely whom this will be.
- 19 In our response to the previous DHSSPS and Department of Justice consultation, the RCN stated that nursing must be formally and specifically designated within the definition of suitably qualified persons. It is essential that capacity assessment is conducted by appropriately trained, qualified, experienced and accountable individual practitioners, and that it embraces the full range of care settings in which such assessments may need to take place, not just secure environments. **Chapter 2, section 13, clause 14, paragraph 4**

**on page 9** states that: “regulations may prescribe the description of persons who are suitably qualified for the purposes of this section”. The RCN welcomes this statement but recommends that the word “shall” be substituted for the current “may”. The same point applies in relation to community residence requirements as defined at **chapter 4, section 24, clause 31, paragraph 3 on page 18**. A key part of the related work will involve the development of a capacity assessment tool for nursing and, again, the RCN would welcome the opportunity to help develop, pilot and promote such an assessment tool, as well as to help share and promote examples of nursing innovation and excellence in relevant fields of practice that could, ultimately, form part of the code of practice and its associated explanatory material.

- 20 With reference to the wording of **chapter 2, section 13, clause 14, paragraph 4 on page 9**, the RCN believes that the regulations must include nursing within the description of persons who are “suitably qualified” for the purposes of this section. The same point applies to the wording of **chapter 4, section 31, clause 3 on page 18** in relation to community residence requirements. The RCN believes that such an amendment would not only be in the best interests of patients but would also be a more efficient use of professional resources.
- 21 The Bill defines (**chapter 2, section 13, paragraph 13, page 8**) the formal assessment of capacity. This raises the issue of whether there is such a thing as an informal assessment of capacity (by a suitably qualified person) and, if so, how this should be defined, if at all. From an accountable professional and legal point of view, is there any appreciable difference in the likely consequences for a registered nurse (or any other registered practitioner) who knowingly breaches the terms of a capacity assessment (formal or informal) on the one hand, and one who simply ignores the current established process(es) for seeking informed consent on the other?
- 22 The key to this is planned and co-ordinated training and development, commencing at pre-registration education level, embracing not just capacity assessment but a range of associated issues such as best interests, deprivation of liberty and the role of the nurse within trust-appointed panels.

Again, the RCN would welcome the opportunity to work in partnership with the DHSSPS and other relevant parties in order to help secure appropriate nursing involvement and support in respect of these issues.

- 23 The RCN believes that the process for assessing capacity must be robust, yet as simple and straightforward as possible, avoiding making further demands upon the nursing workload through excessive paperwork and bureaucracy. It must also be responsive to immediate patient or client need, particularly in respect of emergency care settings, for example.
- 24 RCN members have, in general terms, welcomed the Bill's move away from an emphasis upon the traditional holding power towards a more sensitive range of interventions. However, they have also expressed concern that the current six hour holding power does at least provide a simple and widely-understood framework for intervention and that a considerable amount of work will need to be undertaken in order to secure the confidence of nurses and other health and social professionals in respect of this change of emphasis.
- 25 For higher or more serious interventions and the associated proposed safeguards, it appears that the Bill provides reasonably robust processes. However, the highest proportion of treatment or care is delivered in more fundamental settings such as supported living accommodation, domiciliary care settings, or GP surgeries and treatment rooms. How will the application of the principles be policed in these settings? Has consideration been given to the impact of this throughout the independent, voluntary and community sectors? Who, for example, will manage or authorise the required processes in areas such as supported living?
- 26 The RCN is concerned about the wording of **chapter 6, section 42, paragraph 2(a) on page 23**. The RCN does not believe that it is in the interests of the patient or client to stipulate in legislation that the "responsible person" must always be the approved social worker in charge of the case. In many circumstances, the role could be performed by a registered and appropriately qualified nurse. The RCN recommends that this wording be revised accordingly.

## **Part 9: Power of police to remove person to place of safety**

- 27 The RCN is concerned about how a place of safety is defined (**section 158, paragraph 1, page 86**) and how this would affect, for example, a patient who absconded from a nursing home and was placing himself or herself in a potentially hazardous position. We believe that this issue needs to be thought through with great care and we do not believe that the current definition is sufficiently flexible.
- 28 In general terms, the RCN is concerned about the police making decisions to move someone to a place of safety and we believe that this must be undertaken in collaboration with relevant nursing and other clinical expertise following a nursing assessment. The police are not nurses and should not be expected to make such decisions without accessing and acting upon professional nursing input and expertise, including safety and public protection risk assessments. Lessons can be learned, the RCN believes, from the experience of liaison and diversion modelling in England.

## **Part 10: Criminal justice**

- 29 The RCN notes that the term “unfit to be tried” is deployed in the Bill, rather than “unfit to plead” as in the previous DHSSPS and Department of Justice joint consultation. The RCN questions the suitability of this term and the communications methods that are to be used in order to determine whether someone, particularly a person with a learning disability, is in some sense “unfit to be tried”. Appropriate training for magistrates and other members of the judiciary will be particularly important in this regard.

## **Summary**

- 30 The RCN hopes that the comments above will provide helpful to the Ad Hoc Committee in its consideration of the Bill. The RCN recognises that the passage of the legislation represents just one further stage in the process of adopting and implementing the important principles that it embodies. We look



forward to continuing to work in partnership with Departmental colleagues and others to ensure that this process is able to command the full support of the nursing profession in Northern Ireland.

### **Further information**

- 31 For further information about the work of the RCN in support of nursing and patient services in Northern Ireland, please contact Dr John Knape, Head of Communications, Policy and Marketing, at [john.knape@rcn.org.uk](mailto:john.knape@rcn.org.uk) or by telephone on 028 90 384 600.

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