Mental Capacity Bill – Royal College of Psychiatrists in Northern Ireland Submission to the Ad Hoc Joint Committee to Consider the Mental Capacity Bill

The Royal College of Psychiatrists in Northern Ireland welcomes the opportunity to submit evidence to the Ad Hoc Joint Committee to consider the Mental Capacity Bill. This follows on from our response to the public consultation in September 2014. The submission will reiterate the main points in that response and make further comments on the Bill's recent draft which we hope will inform the Committee's on-going discussions.

The Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.

The College has 370 members in Northern Ireland, including doctors in training. These members provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

This submission is made on behalf of the Royal College of Psychiatrists in Northern Ireland Executive Committee.

Introduction

The College welcomes the Mental Capacity Bill (MCB) and is in strong agreement with a principles based approach that emphasises respect for autonomy and non-discrimination. The current Mental Health (Northern Ireland) Order 1986 (MHO) is outdated, and while it has some strengths, there is a need for new legislation. It is also necessary to pass capacity legislation in order to protect those in Northern Ireland who lack capacity and fall into the

'Bournewood Gap', thus complying with the European Convention on Human Rights, and bringing Northern Ireland into line with other UK jurisdictions.

Currently there are two strands of law dealing with treatment without consent – common law (or capacity legislation elsewhere in the UK), which largely relates to physical treatment, and mental health law relating to psychiatric treatment. Anyone with a physical disorder has the absolute right to refuse treatment unless they lack decision making capacity, in which case a best interests principle applies. But those with a mental disorder can be treated against their wishes, and without reference to their capacity or best interests. This is a profound difference in the principles governing treatment of physical and mental disorders.

The MCB moves away from what has happened elsewhere in the UK, with a fusion of mental health and capacity legislation which is largely in line with the changes suggested in the Bamford Review's Comprehensive Legislative Framework, 2007. We are strongly supportive of the principle behind the proposals. However, we recognise that it is a novel approach and inevitably will encounter some challenges. Indeed we regard it as wise to anticipate and identify difficulties at this stage. This submission will highlight what the College regards as the strengths of the MCB, and also the areas we see as problematic.

We consider the bill advantageous for the following main reasons:

1 Having separate legislation dealing with compulsory treatment of psychiatric disorder, when a different legal standard applies to others, is profoundly discriminatory and perpetuates the stigmatization of those with mental illness.

2 The MCB recognises the importance of individual autonomy by making capacity central to decisions about compulsory treatment and by promoting supported decision making. This reflects a tendency towards a greater emphasis on patient autonomy seen in recent medical case law. It is also consistent with the aims of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) to which the UK is a signatory (although we are aware that there is much controversy surrounding the Convention, particularly with respect to best interests which is mentioned below).

3 Unified legislation avoids having an unclear and potentially complex interface between two strands of law. We are aware of the experience in England and Wales, whereby the interface between the Mental Health Act 2007 (MHA) and the Mental Capacity Act 2005 (MCA) is legally complex and has led to significant difficulties, particularly relating to the law on deprivation of liberty. By contrast the MCB gets rid of this unclear interface, with capacity as the starting point for all compulsory intervention.

The remainder of this submission highlights our main areas of concern, and also those measures which we particularly welcome.

Principles (Clauses 1 and 2)

The Royal College of Psychiatrists is strongly in favour of principles based legislation in line with the original recommendations of the Bamford review.

Definition and Assessment of Capacity (Clauses 3 and 4)

Under the MCB, capacity assessment becomes the basis of decisions about compulsory treatment, and therefore its definition is of central importance to the daily work of psychiatrists. Moving from the current standard of compulsion (the "nature and degree" of mental disorder, combined with "risk of serious physical harm") is a paradigm shift for psychiatrists and it is essential that the concept of capacity as outlined in clauses 3 and 4 is applicable and workable in everyday clinical situations.

Decision making capacity currently comes into play when a person refuses physical treatment, and is already in use in this circumstance, although not to date codified in statute. We strongly welcome that the MCB fills a well recognized gap in the current law. The MCB also subsumes the function of the MHO, and in doing so needs to provide a new standard for detention in psychiatric settings that is robust and reliable. There is therefore much to be said about the appropriateness of the capacity test for this purpose. The following sections highlight some issues.

Risk Issues

The recognition that decision making capacity is important as a factor in psychiatric detention is not new. All of the committees set up to review mental health legislation in the three UK jurisdictions (the Bamford Review in NI, the Millan Committee in Scotland, and the Richardson Committee in England and Wales) strongly recommended that capacity be considered in decisions about compulsory intervention. In England and Wales the government did not take their committee's advice (a decision which attracted much criticism) and updated the old MHA with little change to the criteria for detention. Scotland, on the other hand, brought in the Mental Health (Care and Treatment) (Scotland) Act 2003 which requires that a patient has "significantly impaired decision making" as a condition for involuntary detention and treatment.

However, moving to a framework of decision making capacity and best interests is open to criticism that risky individuals will fall outside the remit of the MCB. People with mental disorders are often perceived as dangerous to others, and it could be argued that this is sometimes exaggerated, leading to stigma and misunderstanding. However, it is undoubtedly true that some mentally unwell people are a risk – sometimes to others, and more commonly to themselves. The MCB needs to provide a legislative framework whereby this risk, when present, can be effectively dealt with, and while maximizing patient autonomy, protects others when necessary.

It is noteworthy that for those who lack capacity, the concept of best interests includes preventing P from harming him/herself or others, and also that the process of Authorization includes consideration of risk. However, in the case of a capacitous person who presents a risk, it is possible that detention could proceed under the current MHO, but not under the MCB. It is our view that the number of such individuals will be small. We note the experience in Scotland where detention depends on significantly impaired decision making and the presence of risk (among other things). Those who are capacitous and present a danger to others fall under the remit of the criminal law. We believe that in practical terms this is not materially different from the MCB, and we take reassurance from the fact that the Scottish legislation has been in operation successfully for more than ten years.

Reliability

A capacity test also has to be reliable with consistency in application of the standard by many different assessors. There is some research evidence that this is the case[1] (although these studies did not include the 'appreciation' element in the capacity test). It could be argued that some elements of the test are quite subjective, including the new element of appreciation (see below). We regard it as important that terms are well defined to avoid either under or over-inclusiveness in the capacity test. A broad definition of mental impairment, plus inclusion of terms in the capacity test that are subjective and open to interpretation could mean inadvertently 'widening the net' of detention. Caution is needed therefore, particularly in the way terms are defined, and in the guidance in the Code of Practice which needs to be clear and backed up by adequate training.

Fluctuating Capacity

We recognise the importance of not using a person's status to make inferences about their decision making capacity, and that the functional nature of the capacity test is central to the Bill. On one hand this is helpful when one considers that capacity, if lost temporarily, can be regained. It is very important that individuals are not labelled as incapacitous, and decisions about a person's capacity are subject to review. Also, a functional test maximises autonomy by recognizing that even if capacity for some decisions is lost, it can still be present for others. But on the other hand, a time specific assessment may not capture the long term, fluctuating nature of some mental disorders.

In particular, the process of regaining capacity could present a challenge if a person deemed to have regained capacity refuses treatment and rapidly deteriorates back to incapacity. We would suggest that regaining capacity is regarded as a process, with a sustained improvement demonstrable before a person is again deemed able to make treatment decisions. We believe this would be ultimately more protective of patient autonomy. However, this needs to be balanced against the fact that according to the principle of least restrictive alternative, restriction of liberty should not apply for longer than necessary. Therefore review

[1] Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M, 'Mental capacity in psychiatric inpatients', *British Journal of Psychiatry*, 191 (2007): 291-297, and also Cairns R, Maddock C, Buchanan A, David A S, Hayward P, Richardson G, Szmukler G, Hotopf M, 'Reliability of mental capacity assessments in psychiatric in-patients', *British Journal of Psychiatry* (2005) 187:372-378

arrangements need to be in place to avoid unnecessary delay in identifying resumption of capacity, but that are sufficiently flexible to allow time to elapse so that resumption of capacity is likely to remain stable. We anticipate that the Code of Practice will provide further practical guidance.

Appreciation (Clause 4 (c))

We note that in addition to the widely used elements of the capacity test (as in the MCA), there is a requirement that a person "appreciates" relevant information in coming to a decision. We recognise that this goes some way to addressing the criticism that the MCA test does not lend itself well to the assessment of psychiatric disorders, where cognitive processes and understanding may be intact, but the influence of factors such as delusional thinking, lack of insight and emotional colouring may not be taken into account. In particular, lack of insight is an important symptom of psychiatric illness which can affect a person's judgement. There is no clearly agreed definition of insight, but it has been described as the ability of a person to appreciate the relevance of information to their own situation.[2] It is our view that this is an important part of the process of making a decision, and that the inclusion of appreciation reflects this, and makes the test more applicable to the everyday work of psychiatrists. However, neither insight nor appreciation have clear definitions and there is potential to introduce a degree of subjectivity into the capacity test, again risking over-inclusiveness. It is essential in the context of the capacity test that appreciation has a specific and clearly understood definition. We would welcome further clarification of this in the Code of Practice.

Best Interests (Clause 7)

The College supports the principle that intervention in the life of an incapacitous person should be in their best interests, and that in determining this P's wishes should be respected and given "special regard" (Clause 7 (6) (a)) wherever possible. We acknowledge that some

[2] Grisso T et al, 'The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment', *Law and Human Behavior*, 19 [2] **(**1995):128

commentators regard best interests as potentially paternalistic (deciding for a person 'for their own good'), and contrary to the UNCRPD. However, the clinical reality is that in some situations P's views cannot be ascertained e.g. an unconscious or very confused patient. While it is very important that people with mental disorder (especially those with lifelong conditions such as intellectual disability) are not excluded from making decisions about their own lives, there are also clearly situations where a very ill or incapacitated person is unable to make their preferences known, and a degree of beneficent intervention is required. Our view is that the best interests formulation in the Bill gives sufficient regard to a person's wishes, but also that it is flexible enough to accommodate the range of situations encountered in clinical practice.

Protection from Liability (Clauses 9 – 12)

We recognize the centrality of clause 9 in protecting staff in their dealings with those who lack decision making capacity. We welcome the acknowledgment of the difficulties of emergency situations where immediate intervention is required. What is 'reasonable' in such circumstances will be different from circumstances of less urgency.

We have some concern about advance decisions (Clause 11). We recognize their value in allowing a person to make a capacitous decision about how they wish to be treated when ill. This can be a useful basis for mental health professionals and patients to work together. Some clinical situations may prove difficult however. The case of a person refusing lifesaving treatment on the basis of an advance decision is a concern. We welcome that the Bill appears to allow that an advance decision does not prevent provision of treatment to save life or prevent serious deterioration (Clause 11 (4) (a and b)). This gives some reassurance to those working in emergency situations. However, we are aware, and concerned by, the case of Kerrie Woolterton who refused lifesaving treatment following self-poisoning. Doctors abided by her wishes which had been expressed in advance, and found their action in doing so the subject of much criticism and controversy.

We suggest also that there should be some exclusions to what can be directed in advance. For example we do not believe it is reasonable for a person to stipulate that they never wish to be admitted to hospital. Also flexibility is required to deal with future advances in

treatment which may alter a person's wishes. Again, practical guidance will be required in the Code of Practice.

Second Opinion (Clauses 16 – 18)

There are good aspects of the current MHO in terms of safeguards, such as the requirement for a second opinion in some circumstances. Mental capacity legislation in other places often lack these checks and balances[3]. We welcome the fact that the MCB preserves these strengths, and extends them to others who lack capacity. This also applies to other safeguards such as involvement of the nearest relative, and the right to review by a Tribunal.

However, we see no reason for electro-convulsive therapy to be specifically singled out from other "treatment with serious consequences" (Clause 16 (1) (b)). Many physical treatments are equally, if not more, serious. Mentioning ECT in this way does not seem to be in the spirit of the Bill's aim to reduce stigma and consider mental and physical interventions by the same standard.

Deprivation of Liberty (Clauses 24 – 27)

Many people in NI who lack decision making capacity are deprived of their liberty but are not legally protected due to the lack of capacity legislation. This should not continue. In this sense, those under the provision of the MHO are better protected by the safeguards inherent in this legislation, as discussed above. All deprived of liberty should come under similar protection. We note the change in the recent draft Bill (in light of the *Cheshire West* case) to define Deprivation of Liberty (DOL) as detention "in a place in which care or treatment is available" (Clause 24 (2) (a) (i)). The College has concerns about this very broad definition. Given the potentially large numbers that it applies to, the system of safeguarding against DOL needs to be efficient and workable in practice. We are aware of the experience in

[3] Szmukler G, Daw R, Dawson J, 'A model law fusing incapacity and mental health legislation', *Journal of Mental Health Law*, Special Edition (2010): 11-22

England and Wales where the DOL safeguarding procedure is seen as excessively bureaucratic and complex. This relates in part to legal complexity at the MHA / MCA interface, which under the MCB would not arise, but also is due to a system over burdened with very large numbers of DOLS applications.

Authorisation (Clauses 19 – 34)

The requirement for authorisation of certain serious interventions is clearly key in the on going process of compulsory detention / treatment. Practical detail is required as to this process. We anticipate that this will appear in the Code of Practice. We foresee challenges in the timeframe for Trust panels to be convened and have concerns that unless adequately resourced patient care could be compromised.

Prevention of Serious Harm (Clause 21)

We note that this clause refers to "serious harm to P or serious physical harm to other persons". This appears to exclude psychological harm to other persons, and we see no reason why this should be the case. It is the level of harm (physical or psychological) that determines whether or not compulsory intervention is warranted, and in this context we regard the key word as "serious", therefore requiring a clear definition.

Criminal Justice Provisions

The College supports the extension of capacity principles to the care of mentally disordered offenders. An overarching theme of the MCB is that everyone is dealt with under the same standard, thus reducing discrimination. We strongly believe that this should be inclusive of mentally disordered offenders. We also acknowledge that public protection is an important part of mental health legislation. The MCB needs to rise to the challenge of striking an appropriate balance between respect for autonomy and protecting the public. We welcome

the joint work that has been done by the Departments of Health and Justice, and we acknowledge that this is a difficult area.

The College recognises that the criminal justice provisions make reference to the incarceration of mentally disordered offenders by the Courts only, and that all other treatment decisions are dealt with as any other patient.

The criminal justice provisions in the Bill make mention of mental disorder and risk, but there is no clear reference to capacity principles. We acknowledge that tying the courts to a best interests concept in dealing with disposal of offenders is problematic for them. As such Public Protection Orders are grounded in public protection rather than best interests considerations. On one hand this allays anxieties about the use of a capacity standard with mentally disordered offenders. On the other hand it is difficult to see how the civil and criminal provisions can interface coherently. Currently the operational criteria, which are clearly relevant to the everyday work of forensic psychiatrists, are unclear. Again, we anticipate clarification in the Code of Practice.

Regarding Public Protection Orders it appears to be the case that a person with decision making capacity could be detained even though they refuse treatment. We accept that on a practical level there are difficulties when applying the MCB principles to an offender population, but this situation is little different from preventative detention which causes us concern.

Further Considerations

Children and Young People

The College is concerned that children under 16 will be excluded from the Bill, although we understand that a separate piece of work is needed to deal with the particular issues raised by this group. This should proceed as a priority with the aim of having a robust rights based legal framework for children.

The issue of emerging capacity in young people obviously makes this group particularly complex. A capacity framework needs to be developmentally congruent and take into

account emotional maturity as well as the other familiar elements of the capacity test. In a situation of emerging capacity there will be an interplay between the child, their parents and the state in terms of the extent to which a child's decision is respected or overridden to prevent harm. This is a matter of current debate and will need to be considered fully. The College recommends this is done by an expert group with representation from a wide range of stakeholders.

The College cautions against the modification of the MHO as a long term solution for children, as we regard the existing legislation as out of date. However, we accept that in the interim the MHO will be maintained for those under 16, and we advocate strengthened safeguards, particularly with respect to deprivation of liberty.

Education and Training

There is a clear need for a comprehensive programme of education and training prior to the introduction of the new legislation, and on an on-going basis. This will apply to a wide range of professionals, service users and other stakeholders. This has an obvious resource implication. We are aware that this has already been highlighted by those responsible for drafting the Bill, and by various members of the Ad Hoc Joint Committee, but we make no apology for reiterating this important need.

We would highlight the recent House of Lords report into the MCA[4] which found that the aims of the MCA to boost autonomy and give incapacitous people legal protection are laudable, but are being frustrated by a lack of understanding of the legislation, and of capacity principles in general. This should serve as a warning. If adequate funding is not provided for training the result could be ignorance of the legislation or even misuse, as the House of Lords report has identified.

As psychiatrists we often encounter the attitude that capacity issues 'belong' within mental health, and we are concerned that outside psychiatry there is a generally poor understanding of capacity principles. This is concerning because assessment of an individual's capacity is an important element in the provision of care or treatment by many other professionals.

[4] House of Lords Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: post-legislative scrutiny, March 2014

Indeed it should be the person proposing the intervention who should carry out the capacity assessment, and in complex situations joint assessment with other disciplines, for example Occupational Therapy, Psychology, Speech and Language Therapy, can be helpful. It is important that the MCB is understood to be widely relevant, not least because the inevitable increase in assessments would lead to unmanageable workload if it fell to psychiatrists alone, but more importantly that 'ownership' of the new legislation needs to be taken by all those affected by it for it to work effectively.

Governance

Another difficulty highlighted by the House of Lords report into the MCA has been the failure to give overarching responsibility for the outworking of the Act to a single authority. The result has been ineffective implementation. Clear governance arrangements for the MCB need to be in place to avoid the same thing happening in NI.

Transitional Arrangements

Many people will be detained under the MHO when the new legislation comes into force. Clear arrangements are required with respect to their transition from the old to the new legislation.

Code of Practice

Much reference has been made by the DHSSPS to the forthcoming Code of Practice which we expect will contain more detail, especially with respect to the practical outworking of the Bill. There are some elements of the Bill that are still unclear as to definitions and practical processes. In particular this applies to guidance on definition of "appreciation", fluctuating capacity, advance decisions, process of Authorization, and criminal justice provisions, as already highlighted. We regard the Code of Practice to be an extremely important piece of work, and it is essential that this is made available as soon as possible.

Summary and Conclusion

Our current mental health legislation treats those under its remit by a different standard to that which applies to others. Excluding a group of people from principles considered fundamental for everyone else is unjustified, discriminatory and should come to an end. Indeed this situation has been called "a harmful anachronism".[5] In addition, the standard for compulsion under conventional legislation i.e. detention on the basis of illness and risk, is stigmatising and can feed into harmful misconceptions.

Moving to capacity and best interests as the standard for compulsory intervention is a significant change. For those currently under the provision of the MHO it will reduce stigma and allow people with mental disorder the autonomy in decision making that everyone else enjoys as a matter of course. Those who lack decision making capacity and currently have little legal protection will have their rights laid down in statute. It also eliminates the difficult interface between mental health and capacity law, thus avoiding unnecessary complexity.

However with any new legislation difficulties are inevitable. The capacity test itself needs to accommodate a range of disorders, but caution is required to avoid making it too open to interpretation, with inadvertent over inclusiveness as a result. Even legislation with laudable aims can fail in implementation, as the House of Lords report has shown in respect of the MCA. We take heed of this and are of the view that unintended consequences can be avoided if caution is exercised. In particular we suggest that clear guidelines in the Code of Practice and comprehensive training are ways to ensure that the Bill achieves its aims. We also acknowledge that dealing with mentally disordered offenders under capacity principles is a particular challenge.

Nonetheless we believe the MCB represents a progressive and ground breaking change in the law. It is our strong view that capacity principles should be central to mental health legislation, and that the MCB maintains a better balance between autonomy and paternalism

[5] Szmukler G & Holloway F, 'Mental health legislation is now a harmful anachronism', *Psychiatric Bulletin*, 22 (1998):662-665

than the current MHO. Practical implications need to be considered, and pitfalls anticipated, but overall we regard this as a workable bill.