Southern Health and Social Care Trust

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Submission to the Joint Ad Hoc Committee on the Mental Capacity Bill

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The Southern Health & Social Care Trust welcomes this opportunity to provide a written submission to the Ad Hoc Joint Committee having considered the Mental Capacity Bill (as introduced) , and the Explanatory and Financial Memorandum , 8th June 2015 .

The consultation on the Bill closed on the 2nd September 2014 and the Trust's response at that time reflected views of a range of professionals. The response detailed positive comments, concerns and recommendations.

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The Trust is keenly aware of the need for legislative change in Northern Ireland as we do not have assisted capacity legislation in this jurisdiction and the Mental Health (Northern Ireland) Order 1986 does not take account of the growing recognition of the right to personal autonomy. We also urgently require a process and structure for providing community care and treatment to individuals who lack capacity, particularly in light of the Supreme Court judgement regarding the deprivation of liberty of individuals in the Cheshire West case.

Financial Effects of the Bill: 40, 41, 45, Page 82

At the outset the Trust wishes to express its concern with regard to the total estimated financial implications to DHSSPS and DOJ which for the year one implementation costs are in the range of £75.8m to £129.2m. The recurrent costs are in the range of £68m to £102.7m. Given the current financial challenges in Health & Social Care, Trusts need to be assured that we can deliver what this Bill sets out to achieve. Legal Aid for cases brought under the legislation has been considered as a factor in the costings. Do the authors of the Bill consider that the language used in the legislation will be open to broad interpretation and therefore open to legal challenge? Will the outworkings of the Bill in some key areas be decided by Case Law? Crucially it is noted that the commencement of the Bill can be delayed or phased, pending the resolution of the financial issues; however it must also be noted that should the Bill not progress through the Assembly, the region does have a lacuna in the law specifically with regard to deprivation of liberty referred to above.

Short Title: Clause 295. Page 82

All law, policy and guidance should be as clear as possible and the scope of this Bill makes the title of particular importance. The current working title of Mental Capacity Act (Northern Ireland) 2015 may not convey to many people the focus of this law which is about assisting people who lack capacity with making decisions about their care and treatment in all areas of health and social care. It may still be considered by some professionals and the public as a replacement of the current mental health law, and may fail to de- stigmatise those who suffer from mental illness which is one of the objectives of the new legislation. The language in the Bill needs to be accessible as possible to the reader.

Part 1: Principles

The Trust welcomes that Part 1 takes account of developments following the Bamford Review such as the ratification of the UN Convention on the Rights of Persons with Disabilities, by placing greater emphasis on the requirement to take steps to support people to take decisions for themselves, including unwise decisions. As they are key concepts in the Bill, Part 1 also defines what ‘’lacks capacity’’ means and sets out steps to be followed when determining what is in a person’s best interests. The best interests principle is a complex subject and Clause 7 provides a list of factors to be considered but must all be balanced in order to comply with Clause 2 –the best interests principle. This may require further clarity.

Clause 3 –this clause sets out the definition of ‘’lacks capacity’’ for the purposes of the Bill. It states that a person can ‘’lack capacity’’ even if the loss of capacity is only temporary and it does not matter what the cause of the impairment or disturbance is. The misuse of drugs and alcohol may cause a loss of capacity and this will have a significant impact on our current service models for the treatment and support offered to people with addiction problems.

Part 2: Lack of Capacity: Protection from Liability, and Safeguards

Chapter 1

In broad terms, it provides protection against civil and criminal liability but only if you act in the person’s best interests. Part 2 introduces the concept of Trust Authorisation Panels for the most serious interventions; the operation and powers of such Panels may be open to legal challenge. There will also be increased access to Review Tribunals.

Clause 9 sets out the general safeguards for considering and undertaking an intervention with the person. These general safeguards attract the principles around capacity and best interests and are framed in a way so as to be workable in practice. However, there is use of the word ‘’reasonable ‘’, i.e. when it is reasonable for D to intervene. The codifying of the common law doctrine will have a significant impact on the practice of health and social care staff ; assessing capacity, consulting with relevant people , supporting decision –making with the person , recording and review. Health and social care staff will be even more mindful of liability while carrying out their duties. This could potentially have both positive and negative effects on day to day practice. Training and support will be vital to successful implementation.

Chapter 2

Clauses 13-14: Formal capacity assessments. Again the use of language will need to be clear in this section. For example in Clause 13 it states “…in addition, the formal capacity assessment must be carried out recently enough so as to be relevant

and meaningful." The regulations will need to assist health and social care staff to carry out their roles without fear of liability.

Clause 24 –Deprivation of liberty. The Trust welcomes that the deprivation of liberty concept now has a wider scope and includes deprivation in places other than hospitals and care homes. This takes account of the UK Supreme Court judgement in Cheshire West case and clause 24 states that Part 2 of the Bill can be used to authorise deprivations of liberty that would otherwise have required the authorisation of the court under Part 6.

Clause 30-34: Community residence requirements. These residence requirements are intended to replace guardianship currently within the Mental Health Order. It clearly states that community residence requirements are not to be regarded as a deprivation of liberty (or restraint). Historically there has been limited use of guardianship; however the memorandum refers to current case law evolving from its use. Guardianship under the Mental Health Order cannot be used to deprive a person of their liberty and on occasion has been applied for in complex cases when the individual lacks capacity to protect themselves and provide for their welfare. With the closure of long-stay facilities many people require care and treatment in community settings which amount to deprivation of liberty. Such intervention can now be sought from HSC Authorisation Panels, Clause 24.

Chapter 7

Clause 45- and 48: Right to Appeal to Tribunal and Duty of HSC Trust to refer case to Tribunal.

Clause 45 sets out the clarifying periods for application to Tribunals and duty of Trusts to refer. This seems to mirror the automatic review to Mental Health Review Tribunals under the Mental Health Order. However should greater access to Tribunals be considered as indicated in the DHSSPS Circular 15th September 2014 (c) where Trusts are asked to consider referrals to Tribunals under the Mental Health Order for those patients who lack capacity?

Part 9: powers of police constables for people in need of care or control

Clause 137 mirrors the current powers under Article 130 of the Mental Health Order. However it does not seem to cover other circumstances available in that Order, viz. Articles 129(1) and Article 129 (4). Article 129(1) is concerned with persons, not currently subject to the Order but who, an officer of an authorised Trust believes to be, suffering from a mental disorder and who: has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or being unable to care for himself, is living alone. Again Article 129(4) is concerned with those patients for whom an application for admission (compulsory detention in hospital) has been completed but it has not been possible for the patient to convey or acquire the necessary assistance to convey the patient to hospital.

Additionally, the Trust's Approved Social Workers currently have the responsibility of ensuring the safe transportation of a person being admitted for compulsory assessment and they often require the support of the Ambulance service and PSNI in this role. The Approved Social Worker delegates responsibility for safe transport to NIAS and/or PSNI. The police are also required to physically remove the person to the hospital and to protect the person and others, based on a risk assessment by the Approved Social Worker .The Trust would recommend that this be explicit in law.

Part 11: transfer of detained patients across UK jurisdictions

Clauses 248 --250: These clauses deal with removal and transfer of detained patients between UK jurisdictions. Both Western and Southern Trusts have a border with the Republic of Ireland and it would be useful to consider practical arrangements between Northern Ireland and the Republic of Ireland.

Part 15: Supplementary section

Clauses 278 and 279 with regard to Warrants: The Trust would recommend consideration of Articles 129 (1) and (4) of the Mental Health Order as referenced above at Part 9 –Powers of Police. The wording of Article 129(1) reflects the type of safeguarding concerns Trusts may have with persons living alone who lack capacity to care for themselves.