Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Mental Capacity Bill: DHSSPS Briefing

22 January 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Seán Holland	Department of Health, Social Services and Public Safety
Ms Alison McCaffrey	Department of Health, Social Services and Public Safety
Mr Paul McConville	Department of Health, Social Services and Public Safety
Ms Lisa Trueman	Department of Health, Social Services and Public Safety

The Chairperson: Folks, you are all very welcome. We have Seán Holland, deputy secretary, social services policy group; Lisa Trueman, principal, mental capacity legislation unit; Alison McCaffrey, principal, mental capacity legislation unit; and Paul McConville, social services officer, the office of social services. You know the procedure, folks. We ask that you make a 10-minute presentation, and then we will open it up to members' questions.

Mr Wells: I want to be at the top of the queue. *[Laughter.]*

The Chairperson: Fair enough. I thought that you wanted in at this point.

Mr McCarthy: I will go second.

The Chairperson: I will hand over to you, Seán.

Mr Seán Holland (Department of Health, Social Services and Public Safety): Thanks very much, Chair. Good afternoon, and thanks for the opportunity to discuss the draft Mental Capacity Bill with the Committee. Members will have our short paper, which provides an outline of the updated legislative timetable along with the Department's plans for further public consultation. To begin with, I would like to give the Committee a brief overview of the Bill's key provisions by way of a recap.

As members will be aware, the Bill aims to give effect to the major recommendations arising from the Bamford review. It will introduce, for the first time anywhere, a single statutory framework governing all decision-making on the care and treatment of a physical or mental illness or the personal welfare, including financial matters, of a person aged 16 or over who lacks capacity to make specific decisions for themselves.

The scope of the Bill is, therefore, very broad, covering routine matters such as helping to wash and dress a person right up to the most serious issues such as depriving someone of their liberty. It therefore includes a compulsory assessment in the treatment of a mental disorder, which is currently captured by the Mental Health (Northern Ireland) Order 1986. That order will therefore be revoked by the Bill when enacted in respect of persons aged 16 or over.

Importantly, the Bill is based on a number of key principles that underpin all its provisions. It starts by enshrining in statute what is referred to as the common-law presumption of capacity. That is the general rule that adults are presumed to have capacity to make decisions for themselves unless it is established otherwise. The Bill also promotes the need to help and support people to exercise their capacity and to make their own decisions when they can. That means that, if a person has capacity to make a specific decision, the Bill respects their right to make that decision for themselves, even decisions that others, including their clinicians, may consider to be unwise. To be explicit, it includes, for example, a decision to refuse treatment for cancer, such as chemotherapy or surgery — even life-saving surgery. It will also include decisions about the treatment of a mental disorder. That means that it will no longer be possible to detain a person who retains capacity against their will for the purposes of treatment.

In keeping with respectful personal autonomy, the Bill will enable people who have capacity to put in place a new lasting power of attorney to make not only financial decisions but health and welfare decisions on their behalf should they lack capacity to do so themselves at some point in the future. Where it is established that a person lacks capacity using the test provided in the Bill, and where no alternative decision-making arrangement has been put in place, but where a decision about a person's care, treatment or personal welfare needs to be made, the Bill puts in place a new statutory decision-making mechanism. That is at the heart of the Bill.

Rather than giving certain people statutory powers to intervene in a person's life, which is what happens under the Mental Health Order, the Bill adopts a different approach: it puts on a statutory footing the common-law doctrine of necessity in so far as it applies to acts in relation to care, treatment or personal welfare. That doctrine is relied on by many people who work with or care for people who lack capacity to make decisions for themselves. In broad terms, it provides protection against civil and criminal liability, as long as you are acting in the person's best interest.

That approach is not unique; it follows what has taken place with the Mental Capacity Act 2005 in England and Wales. What is unique, however, is that those core provisions have a wider application than those in England and Wales. They apply to all Acts in connection with persons, treatment or personal welfare. They therefore cover the compulsory assessment and treatment of mental disorder that, in other jurisdictions, continues to be dealt with by separate powers under separate mental health legislation. I suppose that, when you are doing something that is unique, it is reasonable to ask why you are taking that approach. In this case, it is an outworking of the Bamford vision to reduce the stigma associated with separate mental health legislation. That is what makes this legislation ground-breaking and eagerly awaited by stakeholders and commentators, not just locally but in other parts of the world as well.

What is also unique about the Bill is that it goes well beyond equivalent legislation elsewhere by requiring additional safeguards to be put in place where the intervention is serious. Those safeguards are designed to protect the person who lacks capacity; importantly, if they are not complied with, the person intervening can be held liable for the actions that they are taking.

Let us move on, briefly, to the legislative timetable. Over the past number of years, considerable time and effort has been applied to developing the key aspects of the Bamford review proposal for a single new legislative framework. As reflected in the Minister's letter of 9 December 2013, the core civil provisions of the new framework have now been drafted, and significant progress has been made on the criminal justice aspects of the framework. That progress has been informed by the outcomes of two previous consultations by the Department in 2009 and 2010, and a public consultation on the criminal justice issues by the Department of Justice in 2012. Indeed, getting to this point has been a collaborative effort involving many people and organisations. The corollary of that progress, however, is that more drafting time has had to be built into the Bill's legislative timetable.

Members will be aware of the recent decision by the Health Minister and the Justice Minister to bring forward the public consultation on the draft Bill to March of this year. It is intended that the consultation papers will include the core civil provisions of the Bill as drafted and a further policy statement by the Department of Justice on criminal justice issues. There will also be an update on children's issues. The revised timescale will ensure that stakeholders are given the earliest opportunity to consider the core provisions of the new framework and should also allow the drafting of the remaining sections to be finalised, thereby maintaining progress towards the introduction of the Bill to the Assembly in early 2015, with a view to enactment before the end of the current mandate.

Finally, I would like to turn to the issue of under-16s and why the Department's position has not changed in relation to them. As I said earlier, the Bill enshrines in statute the common law presumption of capacity in adults. That presumption, on which the entire Bill relies, simply cannot be applied to all children. It is important to explain to the Committee what a presumption of capacity in children would mean. For example, a doctor would have to assume as a starting point that a two-year-old would be competent to consent to treatment. A social worker would have to assume that an eight-year-old had capacity to decide that he no longer wished to live with his parents. A dentist would have to assume that a 10-year-old had the capacity to decide whether or not to have a filling. Not only would that not make sense, but it would fundamentally undermine the role of parents in making decisions for their children, which is central to the working of the Children's (Northern Ireland) Order1995 and reflected in our age-of-majority legislation as well. We need to be clear: the Bill is targeted at adults who lack capacity because of an impairment or disturbance in the functioning of the mind or brain. For children, capacity questions are more about development, lack of maturity and, indeed, the absence of life experience to help to inform their decision-making.

Therefore, although we hold dear the rights of adults to make decisions that may not be in their best interests, the position is fundamentally different for children, and this Bill simply will not work for them. That is not to say that the views of children should not be heard or that they should not be able to participate in making decisions. Children are children, and we owe them a greater duty of care because of that status. That position is in keeping with the UN Convention on the Rights of the Child.

Put simply, there is a different and much more complex legal framework in place for children. That is why the capacity legislation in other parts of the UK does not apply to under-16s. In fact, the Republic of Ireland has gone even further by not applying their draft Mental Capacity Bill to under-18s.The Department believes that emerging capacity in children should be given careful consideration but in the context of a separate project. Such a project would be a substantial undertaking in its own right, and, given the Department's current focus on this Bill, it is therefore likely to be a commitment for inclusion in a wider Children Order-related review for the next Assembly mandate. The Children Order is the right context in which to consider those complex issues, as that is where the concept of parental responsibility is currently enshrined. Also, let us not forget that the Children Order will continue to apply to all children, defined under that order as persons under the age of 18. Importantly, the order requires the child's welfare to be given paramount consideration. It also recognises that children should be given a voice in what happens to them and gives opportunities for working in partnership with children as far as their age and development allows.

In addition, under common law, a child who is Gillick-competent can consent to medical treatment. However, that is diluted because parents can consent on the child's behalf where they do not consent. That is another example of just how complex this area of law is and why any changes to the existing legal framework should be given careful and separate consideration.

Pending the outcome of that separate project, legislative cover is, however, required for the small number of under-16s who require compulsory assessment and treatment for a mental disorder. As the Mental Health Order already provides important safeguards for those children, the Minister has decided that it should be retained as a temporary measure for that purpose. In addition, the Department is currently working closely with children stakeholder groups to inform the proposed amendments to that order in order to enhance the safeguards in it, drawing, where appropriate, on those available in the mental capacity legislation for children aged 16 and over who are subject to the same intervention. Indeed, put simply, we are open to consider any proposal brought forward by any stakeholder group that would better protect children under the retained provisions of the Mental Health Order.

In conclusion, I hope that our presentation and briefing paper have helped to outline our way ahead. We are now obviously very happy to answer questions.

The Chairperson: Thank you for that, Seán. It is important legislation, and I think that all of us are actively trying to get a correct, robust and protective fit. The Bamford review very clearly indicated that the Mental Health Order was not fit for purpose and highlighted a number of the order's failings, including the fact — you alluded to this — that it does not comply with human rights standards. How, then, can the Department justify a proposal to retain that order for under-16s, given that that conflicts with Bamford's recommendation?

Mr Holland: It is important to place the Bamford work in context. It was a large piece of work that pointed to the direction of travel that it felt should be taken on a number of issues. Things move on. We considered the issues raised by Bamford in greater detail than could have been done at the time when the Bamford vision was set out.

When it comes to under-16s, we are proposing to retain the Mental Health Order. You are right to say that there are flaws in that order, which is why we are undertaking the wider exercise. However, we are retaining it on a temporary basis until we can reach a more permanent review of the situation for children within the context of the Children Order. I think that that has been welcomed by a lot of interested parties, particularly rights groups, which recognise that there are advantages to gathering together issues that relate to children in a single piece of legislation.

We are looking at ways of introducing additional safeguards, not currently available, in the period when the provisions of the Mental Health Order are retained. That will address some of the reasons why the Mental Health Order was identified as having deficits in respect of human rights. As I say, we have no fixed views about that. If anyone comes to us with a concern about how a vulnerable young person needs additional protection and has a suggestion for how, during the period of retaining the Mental Health Order, we can enhance protection for those young people, we have said that we will do whatever can be done. If you can demonstrate to us that that protection is required and can be provided for, we are very open to that.

The Chairperson: My concern is twofold. The Children Order, which you referred to, is almost 20 years old, and that in itself brings challenges. When we are looking at, in particular, the horrific issues around such things as child sexual exploitation, we question whether the order is out of date. Now, we seem to be saying that the Department is placing a lot of emphasis back on it. Secondly, you have admitted that the order is flawed, yet we are going to enact this in some sort of temporary measure to provide legislative cover. What do we mean by "temporary"?

Mr Holland: The Children Order goes back to 1995; it has been around for some time. Many aspects of the Children Order remain fit for purpose, and we should recognise the many children's lives that have been enhanced and protected by the use of the Children Order and also the greater voice that it has given to parents and family members in some very difficult circumstances that were not allowed for in the legislation that preceded it. However, it does require a change. You referred to child sexual exploitation, and that is one of the issues that we would like to consider in reviewing the Children Order. That same issue of child sexual exploitation is one of the things that would be of great concern were you to extend the mental capacity legislation to under-16s. We already know that we have had significant difficulty with young people who are definitely capacitous putting themselves in very dangerous situations against the advice of people who are there to care for them. If you were to extend the mental capacity legislation to under-16s, they would have a legal right to place themselves in certain situations without parental or care intervention, and I think that that would be a really concerning situation.

The Chairperson: What does "temporary" mean?

Mr Holland: The work to address a reform of the Children Order would be substantial, particularly because this would be the first time that we had not simply followed England's lead on children's legislation. The 1995 Children Order in Northern Ireland was more or less a case of us taking a piece of legislation that had previously been enacted in England and "Northern Irelandising" it. That is not the current position in our proposal to look at a review of the Children Order. It would not be following an English situation, and we would be starting from scratch.

The Chairperson: If something is temporary, does the Department have a preferred, permanent solution?

Mr Holland: The permanent solution would be to introduce, in the next Assembly mandate, a new Children Order. That will be a complex task requiring significant resources. I am aware, as the

Committee will be, of the time and resources that have had to be dedicated to the mental capacity legislation. That has been difficult because it is groundbreaking, but, in scope, reviewing the Children Order would be as big or a bigger undertaking. It would take time to do it.

The Chairperson: Is there a risk that, for under-16s, we are using a piece of legislation that, in your own words, is flawed?

Mr Holland: That is why we have said that we will enact in the retention any additional safeguards that people feel are necessary to protect the interests of vulnerable children. You are right to say that there is a risk, and the action that we are taking to mitigate that risk is to put in place additional safeguards for under-16s.

The Chairperson: It is still a risk.

Mr Wells: Your colleagues are clearly quite offended that they have not had a chance to speak at all, Seán.

Mr Holland: They will get plenty of chances, Jim, as we get into the technical detail.

Mr Wells: I can see the angst on their faces. Maybe they will want to take this on. I use the adage that, if I absolutely commit myself to something, I will offer £500 to your favourite charity if I do not deliver by a certain date. Are your prepared to give £500 to your favourite charity if you do not deliver this by the end of February?

Mr Holland: If I were able to control all the variables, I would happily make it £1,000, Jim. Unfortunately, there are a number of things that are not within my control. Although there are many charities that I would very happily support, I would not want to make that contingent on this Bill.

Mr Wells: Can I suggest that the Jim Wells benevolent fund be added to that list?

Mr Holland: Is that a regulated charity, Jim?

Mr Wells: Seán, we have had quite a few dates and quite a few false dawns, and you have sat on that chair on many occasions and said, hand on heart, that it will come. Those dates have all passed. You have given us a commitment that you will have a written ministerial and Executive agreement — the word "Executive" worries me, because it is like a black hole when stuff goes in there — to consult on the core provisions by January or February 2014. This is January 2014; where is it?

Mr Holland: I will have to check Hansard, but, as far as I am aware, the commitments that I have given when I have sat in this chair are that this legislation will be brought forward in this mandate. I know that timetables have been provided previously, but I think that that is the only commitment that I have given. Yes, January/February. We hope to commence consultation in March. At this point, I will hand over to Lisa, who can take you through the detail of the legislative timetable.

Mr Wells: She looks delighted by the way.

Mr Gardiner: It gets you out of it. *[Laughter.]*

Ms Lisa Trueman (Department of Health, Social Services and Public Safety): As Seán said, we intend to consult in March on the core civil provisions of the Bill and an update on children. I know that the Department of Justice will also issue a further policy statement on criminal justice provisions. That takes us to March. It is then our intention to analyse responses in early summer and to introduce the Bill to the Assembly in 2015.

Mr Wells: That is January 2015. That is cast in stone and cannot be moved.

Ms Trueman: That is our intention.

Mr Holland: It is cast in stone in that we have to get it to that point for the legislation to be brought forward in this mandate.

Mr Wells: Yes, because enactment is March 2016. If there is any slippage on that at all, you will be in real trouble.

Mr Holland: Yes.

Mr Wells: In fact, you would be in deep trouble had the Assembly mandate not been extended for a year. You would not have met the target at all.

Mr Holland: I acknowledge that.

Mr Wells: You will not get an extra year in the future. It would be an awful pity to go through all this procedure only for the whole thing to collapse because we did not get it through in time. I realise that a lot of the donkey work will have been done and that you would not be picking it up from fresh in a new mandate. I accept that an awful lot of work will have been done by that stage and it would not be entirely lost. However, I see this as the most important piece of legislation that the Committee is dealing with in this mandate. I also see it as one of the most complex. I would not like to think that Ms Trueman will be back at some stage in the future saying, "Sorry, but it has slipped by another six months."

Mr Holland: Neither would I. That is why the Department has committed significant resources to the Bill team bringing forward the legislation; more resources than I have ever seen placed behind a piece of legislation. However, I have to be honest with you: there are some things that are beyond our control. This is a cross-departmental initiative. We are working with two Departments. The Department of Justice is dependent on us, and we are dependent on it. At various stages, we require the involvement of the Executive. I would not describe it in the terms that you did, Jim, but getting things through the Executive within a certain time frame certainly provides challenges sometimes. The other thing, as illustrated by the Chair's opening questions, is that this is really complex. A broad range of stakeholders had to be involved in this work, and it has been slow.

Mr Wells: Is part of the problem that Justice is lagging behind Health?

Mr Holland: I would not say that. We are working very well with Justice. Both of us are committed to this time frame.

Mr McCarthy: I am delighted to hear your commitment once again. As you said, this is groundbreaking legislation that we want to see before the end of the Assembly term. I have a couple of quick questions. How will the Department ensure ongoing engagement with key stakeholders during the drafting and advancement of the Bill? Does the Department have a clear legislative window in which to complete the Bill, given that other legislation builds up towards the end of an Assembly term?

Mr Holland: I will answer the first question and then ask Lisa to address the second. You asked about engagement with stakeholders throughout the process. This process has been characterised by the engagement of stakeholders. Going back to the Chair's opening remarks again, that probably relates to the fact that it came out of the Bamford work. Bamford was a very inclusive and wide-ranging process. That engagement was set up and has flowed from there.

Consultation is part of the engagement. As part of the consultation exercise, we intend to do targeted consultation exercises. Stakeholders will have specific events within the consultation period. Then, when we get to the drafting stage, I am sure that the Committee will play its role in ensuring that stakeholders are engaged. When we are at that stage of amendments and questions, stakeholders can use Committee members to have a voice and engage with the Bill.

Your second question related to the legislative window.

Ms Trueman: May I just clarify that question? Do you mean the legislative window within this mandate?

Mr McCarthy: Yes. Do you have a legislative window in which to complete the Bill, given that other legislation builds up towards the end of an Assembly term? That is the problem. We want to make sure that we do not fall at the last hurdle.

Mr Wells: It is tradition in this place that legislation suddenly arises from nowhere and has to be rushed through. This is normally an awful place in the last few months of a mandate, because so much stuff has to be got through. Are you going to get caught up in that?

Ms Trueman: I am sure that members will be aware that we have suggested to the Health and Justice Committees that we have an Ad Hoc Joint Committee. It is the intention to begin consultation with that Committee after the consultation process. However, it might be prudent to bring that consultation with the Committee forward. We would be more than happy to brief the Committee as soon as possible to ease the passage of the Bill. However, you are right: we have from January 2015 to the end of the mandate. It will be challenging.

Mr McCarthy: But you are committed to getting it through.

Ms Trueman: We are committed.

Mr McCarthy: We will give you 100% support and hope that it comes through.

Mr Brady: Thanks for the presentation. I have a few points to make. Do you accept that the Department's decision to exclude under-16s from the proposed Bill leaves arguably the most vulnerable group — children aged under 16 — and their primary advocates, their parents, outside the scope of what might be considered progressive legislation? The Department has decided that children and their parents are best served by retaining what is considered to be, and what you have admitted is, archaic legislation.

You can correct me if I am wrong on the figures. Less than 0·5% of children being treated in mental hospitals are formally detained. Therefore, 99·5% of children are inpatients on a voluntarily basis without legislative cover. Surely that cannot be considered satisfactory. At paragraph 11 of your briefing paper, the Department says that it is seeking legislative cover:

> *"for the small number of under 16s who require compulsory assessment/treatment of mental disorder."*

I assume that that "small number" is the 0·5%. That means that the majority of children will not be subject to that additional legislative cover. There are going to be children left without that legislative cover for quite a long time while you are doing a review.

I was working in the voluntary sector when the Children Order came in in the mid-1990s. It was a huge piece of legislation that took a long, long time to come to fruition. Even now, it is still regarded as fairly complex legislation. That decision seems to leave the most vulnerable group outside the scope of progressive legislation. I do not understand why that has not been addressed. You are really saying that you are putting this in place and that it will cover x number but leave out a number of people who are probably the most vulnerable. That cannot be right. It cannot be satisfactory whatever way you want to dress it up.

Mr Holland: First, I do not believe that it would be progressive legislation if it were extended to under-16s. It would be dangerous legislation. It would be against the will of most people in Northern Ireland who have a very strong commitment to family values and, in particular, respect the role of parents in decision-making for children that is appropriate to age and stage. We are not alone in that position. No jurisdiction anywhere in the world has tried to extend this kind of legislation to under-16s; I believe, for the very reasons that we do not wish to.

That does not leave children without any protections. The Children Order, which applies to all children under the age of 18, affords them protections. There are protections in the Mental Health Order, albeit that that is flawed currently. In retaining the specific provisions of the Mental Health Order, we are willing to look at any additional safeguards that anyone can point us to and say, "We think that there is a gap for this vulnerable child, so you need to do this." We are anxious to have those conversations, and we are having those conversations. That extends to those children, Mickey, who, as you rightly point out, are very vulnerable and are not covered by the legislation. In our discussion with children stakeholders, we have said that we will also consider looking at what we can do to enhance safeguards relating to children who are detained on a voluntary basis. So, we will try to address that issue in whatever way that people come to us with practical suggestions. Paul, is there anything that you wish to add?

Mr Paul McConville (Department of Health, Social Services and Public Safety): In the existing system, there are examples of good practice where safeguards are in place for children who are voluntary patients. There is consultation with their parents and, indeed, with the young people themselves. If there is a conflict of interests or a perceived conflict of interests between children and parents' positions, independent advocates can be used to represent the views of children and young people. Those who are in inpatient facilities would be consulted very regularly about their experiences on ward rounds. Indeed, any child who resides in hospital for three months or more must be notified, and the provisions for looked-after children, including the looked-after reviewing process, are then enacted. So, there are a number of existing safeguards in the Children Order. However, if it is a question of detention, the Mental Health Order would apply.

Mr Brady: I have another point on consent and under-16s being voluntary patients. It seems that compliance with the wishes of adults, even when those adults believe that they are acting in the child's best interest, is not necessarily consent. Obviously, parents and doctors have a role in decision-making for children, but it seems that there have to be safeguards, whether the patients are classified as voluntary or involuntary. Compliance with the wishes of adults is not necessarily consent.

Mr Holland: No, as this Committee is only too well aware, an adult or a parent can, unfortunately, act in ways that are not in the best interests of a child. It is important that safeguards are in place to prevent that. That is why we are engaged with the children stakeholders to identify any measures that can be introduced that would mean that no child under the age of 16 is in any way less well protected than a young person over the age of 16.

Mr Brady: The purpose of changing the legislation is because it is inadequate. So, inadequate legislation will still apply to those children until the Children Order and all of that is reviewed. So, there will still be a vulnerable group left without the same protection. Obviously, there must be some sort of inequality issue there as well because there is a group of children who do not and will not have the same protection as the majority of children.

Mr Holland: There are a couple of points on that. Firstly, there is a choice. The choice is one of whether you try to extend this legislation to under-16s, with all the consequences that we have outlined. Clearly, that is not a choice that is acceptable to the Department. Then you say what is practical, and it would not be practical to undertake a review of the Children Order simultaneously with introducing mental capacity legislation. It just physically could not be done. You rightly say, Mickey, that there are vulnerabilities there, so you put in place whatever safeguards are required to address those vulnerabilities. That is what we intend to do. I am looking to Lisa and Alison, and they have nothing to add.

Mr Brady: I remain to be convinced and will leave it at that.

The Chairperson: Thank you for that information. From the Committee's point of view, this is something that we will closely and actively work through in whatever Ad Hoc Committee is formed post the consultation. I think that the issue remains around the under-16s and the fact that we are still ultimately talking about a Mental Health Order that is recommended to be flawed and to be non-compliant with human rights in some regard. So, there are real challenges there. The Department, while saying that it will look at whatever suggestions or protections are brought from sectors, needs to do much more in relation to, in particular, vulnerable children, especially under-16s.
I will leave it at that. You have heard our questions today, and we will continue that engagement and work through the scrutiny process. Thank you for your time.