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How will the Mental Capacity Bill work in practice?

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Key points

- The Mental Capacity Bill will introduce, for the first time anywhere, 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 themselves.
- It starts with a presumption that all persons (aged 16 or over) have capacity to make decisions for themselves and that they should be supported to do so.
- However, if a person lacks capacity and hasn't put in place alternative decision making arrangements (such as a Lasting Power of Attorney) important safeguards must be put in place for that person before intervening.
- Under the Bill a person "lacks capacity" if he/she is unable to make a specific decision for him/herself, at a particular time, because of an impairment of, or disturbance in, the functioning of their mind or brain so across dementia, learning disability, mental health and brain injury
- It will enable a wide range of decisions to be made relating to a person's health, welfare and financial issues
- Education and training, from public awareness to specialist roles, will be needed to ensure the Bill is effectively implemented

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Introduction

This briefing paper, and the associated presentation, will use case examples to demonstrate how the proposed Mental Capacity Bill will provide a comprehensive 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 themselves. The case examples will cover both civil and criminal justice aspects of the new law across a range of levels and settings. This applied approach will allow the proposed assessment, intervention and review aspects of the Mental Capacity Bill to be explored. It will also facilitate consideration of: the scope of the new law; the proposed safeguards; compulsion in non-hospital settings; advance care planning; and addressing public safety issues. The discussion of the case studies, and how the new law would apply to them, will be based on the views of a range of key stakeholders. This briefing will also highlight education, training and research priorities for implementing the Bill.

The need for a new legal framework

The Mental Capacity Bill will create a new, comprehensive and progressive legal framework to enable decisions to be made when a person lacks the capacity to do so. This is needed due to limitations of the current Mental Health (Northern Ireland) order 1986; the gap in statute law to enable the full range of health, welfare and finance decisions; and developments in theory, research and literature on this area. The current mental health law was drafted at a time when care was more hospital focused. Services are now mainly community based with hospital usually only being used for acute crises. This more positive, inclusive approach requires a more flexible legal framework that can facilitate care across settings. The criteria for compulsory intervention in the current law is also that the specified thresholds of mental disorder and risk are met and so, even if a person has the capacity to decide about intervention, they could still be compelled. Another issue with the current law is that people with a diagnosis of 'personality disorder' are specifically excluded from compulsory intervention which has been identified as an issue in practice. The current law also only address mental health care and treatment and there is no statute law to provide a framework for all health, welfare and finance decisions. Further drivers for change have been judgements on the European Convention on Human Rights, especially the Bournemouth case, and the United Nations Convention on the Rights of Persons with Disabilities which have reinforced the need for a comprehensive legal framework that protects people's autonomy and, when they lack the capacity to make a decision, provides appropriate safeguards.

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Over past 15 years new mental health and mental capacity laws developed in Scotland, England/Wales and the Republic of Ireland. The approach in those jurisdictions has been to retain a specific mental health law and add a new capacity law. This has created overlaps and complexities in practice. It has also been argued that having a separate framework for people with mental health problems is potentially discriminatory as it allows compulsory intervention even if a person retains decision making capacity which is not allowed under the capacity laws. In Scotland this has been addressed by having a capacity criterion in their mental health law but, a possibly more comprehensive, fair and straightforward approach, sometimes call the fusion approach¹ is to provide a capacity based legal framework for all supports, decisions and safeguards that are needed.

These arguments were considered by the Bamford Review of Mental Health and Learning Disability (2007) that concluded that “having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust” and so “.....the Review considers that Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory” (p.49).

The process of developing the new law

The process of developing the new law has been long, inclusive and careful. It formally began in 2002 with the start of the Bamford Review and the comprehensive approach was recommended by the Bamford Review’s Legal Issues Committee. That report was published for public consultation in August 2007. In response the Department of Health, Social Services and Public Safety published plans for a new framework in January 2009 and there was a further public consultation. In September 2009 it was announced that the DHSSPS had decided to develop a new capacity based law which would provide a comprehensive legislative framework which would no longer need a separate mental health law.

This is a progressive and ground breaking approach and it has taken considerable efforts across a range of groups to develop the new law. This process is lead by a Project Board which includes the DHSSPS, Department of Justice, the Court Service and Prof Roy McClelland who chaired the

¹ Dawson J, Szmukler G. (2006) Fusion of mental health and incapacity legislation. *Br J Psychiatry* 188:504-9.

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Bamford Review. It provides strategic direction and oversight. There is then a Project Team, sometimes referred to as the Bill Team, which is responsible for most of the work to produce the Bill. This includes: exploring the wide range of complex issues that need to be addressed by the Bill; the possible implications for other laws; instructing Legislative Counsel on the drafting of the Bill itself; and working out the detail of how the Bill will work in practice; and the guidance needed to ensure this happens as intended. The Bill Team has also used two Reference Groups, one focused on civil society, the other on criminal justice issues, to explore proposals for the Bill as they have been developed. These Reference Groups are made up of a range of professionals, service users, carers voluntary organisations and have continued the open and inclusive approach to developing this law.

In July 2010, there was a further public consultation to examine the equality impact of the new Bill and then in June 2011 the first set of instructions were provided to the Office of Legislative Counsel to enable them to draft the Bill itself. In July 2012 the Department of Justice also had a public consultation on how this approach could be applied to the criminal justice aspects of the legal framework. It is now planned that the civil aspects of the new Bill and a policy paper on the criminal justice aspects of the new Bill will be published for consultation in March 2014. It is hoped that the Bill will then be enacted within the current Assembly mandate.

The key points of the Bill

The Bill will be founded on and include some key principles. The central one is respect for personal autonomy which means that if a person has the capacity to make a decision, about their health, welfare and finances, then that decision should be respected. The starting position is to assume that everyone, aged 16 and over, has decision making capacity and, if there are concerns identified about a person's ability, this has to be considered on a decision specific basis. In other words people may have the ability to make some decisions but not others and so there should be no global assumptions of incapacity based on factors such as diagnosis or disability. The Bill also recognised that often people need support to make decisions and so all practical help and support should be given to enable the person to make their own decision before establishing that the person lacks capacity. If a person, with support or not, has the ability to make a decision then this should also be respected no matter how unwise this may appear to others. If a decision is needed then it has to be made in the person's best interest which will be determined by a process including, as far as possible, what the person's past and present wishes and feelings are thought to be, including their beliefs and values.

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The assessment of whether someone is able to make a certain decision is therefore central to how the Bill will work in practice. The assessment will involve considering if person is unable to make the decision because of an impairment of, or disturbance in, the functioning of, the mind or brain, and, if they can understand, retain, appreciate, use and weigh and communicate the necessary information for the relevant decision.

It is also proposed that this capacity based approach to health, welfare and finance decisions be applied across settings including to those in the criminal justice system. Although people in the criminal justice system may not be free to make certain decisions, such as whether to leave prison or meet with their probation officer, if they have the necessary capacity, their decisions about health, welfare and finance should be respected. For those in the criminal justice system whose decision making ability is impaired there will be police, court and transfer powers to ensure they receive care and treatment in the most appropriate setting.

The table on the next page provides a brief overview of the key points of the Bill. In terms of the safeguards: across all levels there should be a reasonable belief that the person lacks capacity and that the intervention proposed would be in the person's best interests; the level of assessment and other safeguards increases with the seriousness of the proposed decision/intervention.

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Range of causes of impairment	Types of decision	Levels of intervention	Safeguards
Dementia Learning disability Brain injury Mental health Personality disorder Physical health Alcohol and drugs	Decisions in relation to care, treatment or personal welfare	Routine	Reasonable belief the person lacks capacity and the intervention proposed is in their best interests
		Serious (surgery, pain, distress, consequences)	And Formal assessment of capacity Nominated person Second opinion (for certain treatments)
		Authorised (compulsory treatment with serious consequences, deprivation of liberty, community attendance for treatment and community residence order)	And Independent advocate Authorisation (generally by Trust Panel or in the case of short term detention for examination, by an ASW) and medical recommendation) Tribunal
			High Court

In general the process of how the Bill will work in practice will involve: the need for a decision arising; concern being identified about the person's ability to make the decision; assessment of the person's ability to make the decision; support provided to try to enable the person to make the decision; the provision of appropriate safeguards; if necessary, decision making (by carers, relevant professionals, Lasting Powers of Attorney, Court Appointed Deputies, High Court); and authorisation, review and appeal processes. Three examples are outlined below to give a sense of the how the new framework could work in practice – the cause of why a person might lack capacity is relatively unimportant.

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The first example focuses on how the Bill will enable intervention when necessary. Mrs A is a 75 year old woman with dementia who lives with her husband. Her ability to make certain decisions is impaired by her dementia. For routine decisions Mr A and other carers, assuming that Mrs A doesn't resist or object, can proceed on the basis of a reasonable belief that Mrs A lacks the capacity to make that decision, for example to dress, eat and wash, and that it is in her best interests to do so. For serious interventions, for example if Mrs A required life sustaining/threatening surgery, a formal assessment of capacity by an appropriately trained professional and consultation with Mrs A's nominated person or default primary carer/nearest relative would be required. If Mr A objected to the proposed serious intervention or, in certain circumstances Mrs A resisted and/or it involved deprivation of liberty then an independent advocate would be provided. If objection continued an application would have to be made to the Trust Panel for authorisation by an Approved Social Worker (regulations may also prescribe other suitable persons) which must include a medical report This decision could then be appealed to a Tribunal and/or eventually would be automatically referred to a Tribunal.

The second example focuses on how the Bill will protect autonomy. Mr B is a 25 year old man with learning disabilities who lives with his parents. Mr B's ability to make certain very complex decisions (for example involving long term consequences, specialist knowledge, probability) may be impaired by his learning disability. Mr B is able, with appropriate supports, to make a wide range of decisions, including some unwise, about what to wear, who to go out with, how to spend his money, what to do with his time. His parents are very concerned about some of these decisions and feel that he should be required to reside in supported housing. Mr B does not agree and so this proposed intervention would involve compulsion. The process would then again include: assessment of Mr B's ability to make this decision; the provision of any appropriate supports; the involvement of an independent advocate.

The third example demonstrates how the Bill will facilitate the management of risk. Mr C is a 45 year old man with a diagnosis of schizophrenia who lives alone. He has some delusional paranoid beliefs that impair his ability to make certain decisions such as whether to harm himself or other people. The new framework would continue to allow emergency intervention, if it was necessary and proportionate, based on the reasonable belief that Mr C lacked capacity and the intervention proposed would be in his best interests. So, for example to prevent him harming himself and/or others. If, even with support, Mr C's mental health problems also impair his ability to make some specific decisions, such as whether to attend for treatment and reside in supported housing then,

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with the appropriate safeguards in place, the new framework would allow those interventions to be required. If physical force was necessary, however, then that should continue to be in an appropriately staffed and safe setting. If Mr C's relevant decision making ability was not impaired then any identified risk would have to be managed through alternative approaches such as assertive community treatment, forensic services, probation, the Public Protection Arrangements NI and MARAC (domestic violence). This is also the case at present for those who do not meet the criteria for the Mental Health (Northern Ireland) Order 1986.

It is important to acknowledge that the new framework will not fully resolve all the current complexities involved in assessment, engagement, professional judgements, managing risk and fluctuating circumstances. There are also some ongoing issues which will be considered in the ongoing development of the Bill. The title and wording of the Bill needs to be as clear and accessible as possible. The Bill does not apply to those under 16 but they also need a comprehensive legislative framework for decisions to be made in certain circumstances. The application of the capacity based approach to the criminal justice system is positive and progressive and it also offers the opportunity to harmonise, clarify and update other aspects of that system such as fitness to plead, insanity and diminished responsibility. The process of implementation will also require education and training across levels including public education, health and social care staff, key staff, capacity assessors and those in other specialist roles such as Approved Social Workers, doctors, Trust panel members, advocates and Tribunal members. There will also be a need for research about how the Bill works in practice including: the prevalence of impaired decision making; what supports work for whom; a comparison with the current and other frameworks; the qualitative experiences of those involved; and the identification of any other issues in practice.