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DRAFT

MENTAL CAPACITY BILL

Principles Framework

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In anticipation of the introduction to the Assembly of a Mental Capacity Bill, this paper provides background to the development of the core principles framework which underpin the legislative provisions contained within the draft Bill which was published for consultation in 2014. The paper includes an overview of the range of consultation responses which addressed the principles framework contained in Part 1 of the draft Bill.

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Key Points

- In 2007, the Bamford Review concluded that ‘There should be a single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland’. To use the terminology which was emerging around that time, it was recommending the ‘fusion’ of mental health law (primarily concerned with the reduction of the risks flowing from mental disorder to the patient and others) and mental capacity law (designed to empower people to make decisions for themselves wherever possible, and to protect people who lack capacity) into a single piece of legalisation.
- The draft Mental Capacity Bill, which is the product of significant post-Bamford policy development, contains the legislative framework implementing the Bamford Review recommendation highlighted above. The draft Bill, therefore, moves Northern Ireland one step closer to becoming the first jurisdiction in the world to enact a single legislative scheme which, on the basis of incapacity principles, governs non-consensual treatment of both physical and mental illnesses. Whilst other jurisdictions (for example the province of Victoria in Australia) have relatively recently considered enacting such legislation, none have yet proceeded to do so.
- The Bamford Review stated that the single legal framework it proposed should be based on ‘...agreed principles, explicitly stated in legislation and supplemented, if necessary in supporting Codes of Practice’. The principles it identified closely resembled those considered by many to be the standard theoretical framework used to address ethical situations in the field of medicine.
- Rather than directly transposing the Bamford principles onto the face of the draft Bill, Part 1 of the draft Bill seeks to capture the substance of these principles, albeit using different terminology. Some consultation responses expressed concern with this approach.
- Taken as a whole, consultees views on the principles framework set out in Part 1 ranged from an unconditional broad welcome - through concern for potential difficulties and unforeseen consequences arising from novel aspects of the draft legislation - to the view that the model upon which the Bill was based was conceptually ill founded.
- The latter views were framed within the post-Bamford entry into force in 2008 and UK ratification in 2009 of the United Nations Convention on the Rights of People with a Disability. The UNCRPD it was argued required a paradigm shift away from substitute to supported decision making. It was, however, also recognised that, given the emerging law and practice relating to supported decision making, ensuring compliance with the UNCRPD would be complex and challenging.
- The Mental Capacity Bill, once introduced in the Assembly, will proceed through the law making process within this developing legal and policy environment.

Executive Summary

On 11 May 2015, the Assembly passed a motion to establish an Ad Hoc Joint Committee to consider the Mental Capacity Bill and to submit a report by 28 January 2016. This paper focuses on the principles framework set out in Part 1 of the draft Bill as, at the time of writing, the Bill itself had not been formally introduced into the Assembly.

The draft Mental Capacity Bill is the product of a process which began in 2002, when the DHSSPS initiated a review of the law, policy and provisions affecting people with mental ill-health or a learning disability. The review, which published its report on legislative reform in summer 2007, was named the Bamford Review in recognition of the contribution made to it by the late Professor Bamford, Chair of the steering committee

Within its overarching recommendations, the Bamford Review stated that ‘There should be a single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland’ and ‘the framework should be based on agreed principles. The principles which the Bamford Review recommended should underpin the new legislation and ‘support the dignity of the person’ were:

Autonomy – respecting the person’s capacity to decide and act on his own and his right not to be subject to restraint by others.

Benefit – promoting the health, welfare and safety of the person, while having regard to the safety of others.

Least Harm – acting in a way that minimises the likelihood of harm to the person.

Justice - applying the law fairly and equally.

The principles identified by the Bamford Review reflected the existing standard theoretical framework used to analyse ethical situations in the field of medicine. The fusion of mental health law (primarily concerned with the reduction of the risks flowing from mental disorder to the patient and others) and mental capacity law (designed to empower people to make decisions for themselves wherever possible, and to protect people who lack capacity) into a single piece of legalisation, however, represented a significant innovation.

The DHSSPS and DoJ have both undertaken significant consultation during the development of the policy recommend by the Bamford Review, albeit that DoJ activity initially lagged behind that of their colleagues in the DHSSPS. A significant outcome, following this consultation, has been that children (those aged under 16) largely fall outside of the scope of the Bill and will continue to be dealt with under existing legislation, particularly the Children’s Order. Those in criminal justice system, however, will be included within the scope of the Bill.

In May 2014, a consultation document, which included the draft provisions of the Bill relating to civil society and set out the proposed approach for those subject to the

Criminal Justice system, was published. The consultation document stated that the draft Mental Capacity Bill would ‘...introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a physical or mental illness) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision’.

The Departments received one hundred and twenty one responses to the consultation, with forty five percent of these commenting on the principles in Part 1 of the draft Bill. The information provided in this paper is designed to provide an illustrative, rather than a representative, summary of the range of views expressed in consultation responses, on these principles. These views ranged from unqualified support for the principles and approach adopted in the draft Bill to the view that the model upon which the Bill was based was conceptually ill founded, particularly within the framework of the UK’s post-Bamford ratification of the United Nations Convention on the Rights of People with a Disability.

Contents

Key Points

Executive Summary

1	Introduction.....	9
2	Background.....	9
3	The Bamford Review Principles Framework.....	11
4	Post-Bamford Policy Development.....	13
5	Consultation on draft Mental Capacity Bill.....	17
6	Conclusion.....	28

Appendix 1 Draft Mental Capacity Bill – Part 1 Principles

1 Introduction

On 11 May 2015, the Assembly passed a motion to establish an Ad Hoc Joint Committee to consider the Mental Capacity Bill and to submit a report by 28 January 2016.

The Ad Hoc Joint Committee held its first meeting on 19 May and at that meeting agreed a forward work programme in anticipation of the introduction in the Assembly of a Mental Capacity Bill. It should be noted that, at the time of writing, a post consultation final version of the Mental Capacity Bill had yet to be formally introduced in the Assembly.

This paper is intended to provide Members with a broad overview of the policy development leading up to publication of the consultation on the draft Mental Capacity Bill and an overview of the consultation responses relating to the principles framework contained in Part 1 of that Bill. The paper does not, however, address the significant detail that was contained in some of the consultation responses. Rather, selected extracts have been included to orientate Members to some of the issues which were raised in the consultation and which they are likely to consider in detail, once the Ad Hoc Joint Committee begins its own consultation.

For ease of reference, Part 1 of the draft Bill is included as Appendix 1 to this paper.

2 Background

The Mental Capacity Bill is the product of a process which began in 2002, when the DHSSPS initiated a review of the law, policy and provisions affecting people with mental ill-health or a learning disability. The review, which concluded with the publication in 2007 of its report on legislative reform (one of 11 reports), was named the Bamford Review in recognition of the contribution made to it by the late Professor Bamford, Chair of the steering committee.

The length of this policy development and legislative drafting process perhaps reflects both the inclusive, structured approach taken by the DHSSPS (and more recently the DoJ) to policy development and the complexities involved in drafting a bill which, for the first time in any jurisdiction, seeks to fuse together mental capacity and mental health law.

In the UK context, it has been observed that mental health law is ‘...primarily concerned with the reduction of the risks flowing from mental disorder to the patient and others’ whereas mental capacity legislation is ‘...designed to empower people to make decisions for themselves wherever possible, and to protect people who lack capacity’. A key challenge faced by the Departments, therefore, as they sought to address any stigma and inequality resulting from specific mental health legislation, has been the need to minimise the potential for unforeseen consequences in the move

away from separate legal structures relating to risk of harm to self and others on the one hand and to capacity on the other.¹

Given the Bamford Review's fundamental assertion that those who have decision-making capacity should be free to make their own decisions (however unwise or imprudent these decisions may be) the inclusion within the scope of the Bill of children and those within the criminal justice system presented particular policy development challenges to both the DHSSPS and the DOJ. The outcome of their consideration of options has been that those in criminal justice system have been included within the scope of the Bill. Children (those aged under 16), however, will largely fall outside the scope of the Bill and will continue to be dealt with under existing legislation, particularly the Children (Northern Ireland) Order 1995. In addition, some parts of the Bill will not apply to young people (16 and 17 years olds).

In line with the approach advocated by the Bamford Review, the draft Bill seeks to resolve the inherent tensions arising from the existing separate legal structures for mental health and capacity by adopting a principles based approach; an approach whereby protection is afforded to all those falling within the scope of a new legislative framework by adherence to underlying core values or principles.

The Executive Summary which accompanied the full final report of the Bamford Review provided the following guide to the principles and human rights based approach to development of a new legislative framework for mental health and learning disability that it advocated:

A rights-based approach is proposed as the guiding principle for reform of legislation, which should respect the decisions of all who are assumed to have capacity to make their own decisions. Grounds for interfering with a person's autonomy should be primarily based on impaired decision making capacity. New legislative solutions are, therefore, required for issues posed by the effects of disorder of the brain or mind on and individual's decision-making capacity and which affect his/her own personal health, the need for care and treatment, safety and the welfare or the safety of others.

A principled, human-rights approach moves from public protection as the priority towards safeguarding the rights and dignity of people with mental disorder and ensuring their access to appropriate care and treatment. It will be necessary in some situations to balance these individual rights with the rights of others who may be placed at risk through the individual's behaviour. Adequate and proportionate protections must be ensured within legislation.

Mental health legislation considered from a principles base also requires a comprehensive approach which recognises the overlap with capacity issues,

¹ Unlike the rest of the UK, there is no specific mental capacity legislation in Northern Ireland. Instead and mental capacity is currently governed by common law (case law).

the needs of children and of those within the Criminal Justice System, including the interfaces with other relevant statutes.²

This paper provides background to the development of the core principles framework which underpins the legislative provisions contained within the draft bill, which itself was subject to a consultation exercise in 2014. The paper also provides information on the responses made to this consultation exercise. As has already been stated, however, it should be borne in mind that the paper was prepared before formal introduction to the Assembly of a Mental Capacity Bill.

3 The Bamford Review Principles Framework

In their classic textbook 'Principles of Biomedical Ethics', first published in 1971, Beauchamp and Childress set out four principles which are now considered by many to provide the standard theoretical framework from which to analyse ethical situations in the field of medicine. The four principles are:

Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.

Beneficence: this considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.

Non maleficence: avoiding the causation of harm; the healthcare professional should not harm the patient. All treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment.

Justice: distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner.³

Whilst the scope of the draft Bill extends beyond the field of medicine, the influence of this framework on the work of the Bamford Review is clear and likely to reflect the professional medical backgrounds of key members of the review group.

Within its overarching recommendations, the Bamford Review stated that 'There should be a single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland' and 'the framework should be based on agreed principles, explicitly stated in legislation and supplemented, if necessary in supporting Codes of Practice'. The principles underpinning new legislation, the overarching recommendations stated, should support the dignity of the person and have regard to: autonomy, justice, benefit and least harm.⁴

² DHSSPS (2007) A Comprehensive Legal Framework for Mental Health and Learning Disability –Executive Summary <http://www.dhsspsni.gov.uk/legal-issues-executive-summary.pdf> (accessed April 2013)

³ http://www.ukcen.net/index.php/ethical_issues/ethical_frameworks/the_four_principles_of_biomedical_ethics

⁴ The Bamford Review of Mental Health and Learning Disability (Northern Ireland) A Comprehensive Legal Framework (DHSSPS) August 2007 (accessed May 2015) para 8.7 <http://www.dhsspsni.gov.uk/legal-issue-comprehensive-framework.pdf>

Autonomy: respecting the person's capacity to decide and act on his own and his right not to be subject to restraint by others

- There should be an assumption of capacity and provision of care and treatment should be on a partnership and consensual basis, as far as possible. Respect for capacitous decisions should extend to those decisions made legally in advance and where the person grants specific decision-making powers to another on his behalf, for the time when he loses capacity himself.
- Participation – users of services should be fully involved to the extent permitted by the person's capacity, in all aspects of their care, support or treatment. Users of services should be provided with all the information and support necessary to enable them to participate. This may include the involvement of advocates and/or carers. Account should be taken of past and present wishes in so far as these may be ascertained.

Justice: applying the law fairly and equally

- Non-discrimination – persons with a mental disorder or a learning disability should retain the same rights and entitlements as other members of society.
- Equality and respect for diversity – persons should receive treatment, care and support in a way that accords respect for, and is sensitive to their individual abilities, qualities and cultural backgrounds. The legislation should not discriminate on grounds of age, gender, sexual orientation, ethnic group, disability, social class, culture or religion.
- Reciprocity – the loss of a person's rights by detention or by compulsion to treatment and care should be matched by an obligation to provide adequate treatment and care for that person.
- Partnership – services should develop effective partnerships to ensure continuity of care across age and service boundaries,
- Fairness and transparency – there should be fairness and transparency in decision-making, and the right to representation for challenge of due process. Proceedings should be timely.
- The specific rights of children, including the right to education, should be protected.

Benefit: promoting the health, welfare and safety of the person, while having regard to the safety of others

- Where interference is necessary and permissible, the best interests of the person should be protected and promoted, including protection from abuse and exploitation.
- Interventions should only be undertaken using the legislation to achieve benefits which cannot be achieved otherwise. Benefit to the person should include, but not be limited to, reduction of risk of harm to self or others

Least Harm: acting in a way that minimises the likelihood of harm to the person

- The person should be provided with the necessary care, treatment and support in the least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care. The perception of the restriction by the person him or herself should be taken into account
- There should be clear guidance on the use of restrictive practices such as restraint, seclusion and time out for both adults and children, and these should be monitored and subject to evaluation research.
- There should be clear guidance on how and when research may be carried out with persons who have impaired decision-making capacity and this should be monitored.⁵

The Bamford Review did not highlight any one of the four principles as being ‘core’ and, addressing the balance and relationship between principles, the Review Group’s final report underlined that:

Having a recognition and acceptance of principles does not provide a means of choosing between them. There remains fundamental tensions [sic] between autonomy and benefit for example where emphasis on benefit can lead to paternalism. However the need to have regard to all the principles provides a balance in the process.⁶

4 Post-Bamford Policy Development

Post Bamford both the DHSSPS and DoJ undertook significant consultation and policy development, albeit that DoJ activity initially lagged a number of years behind that of their colleagues in the DHSSPS.

In June 2008, the DHSSPS published the consultation document ‘Delivering the Bamford Vision – The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability’.⁷ Whilst this document did not contain direct reference to the four specific principles, it did underline support for a principles based approach stating that:

The Bamford Review has put forward a strong case that both the proposed amended mental health and new mental capacity provisions should be governed by an overarching statutory statement of human rights principles. Failure to do this could result in the human rights of mentally ill patients and people with a learning disability not being adequately protected and vulnerable patients being dealt with under the wrong legislation, or falling between two Acts.

⁵ As above para 5.1

⁶ As above para 1.11

⁷ DHSSPS (2008) Delivering The Bamford Vision - The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability p25
www.dhsspsni.gov.uk/bamford_consultation_document.pdf

An essential first step, the consultation document went on to say, would be the preparation of a legislative framework document which would provide a statement of the human rights principles to govern the drafting and enactment of both mental health and mental capacity legislation. This reflected the intention at this stage to proceed with two separate pieces of legislation, albeit that these would be underpinned by a single set of principles.

In January 2009, the DHSSPS consulted on its legislative proposals⁸ and stated that it accepted that the broad principles developed by the Bamford Review should be embedded in legislation to cover both mental capacity and mental health legislation. The consultation document went on to identify autonomy, defined as the right of the individual to decide and act on his or her own decisions, as the primary principle. The document explained that a statutory presumption of mental capacity together with a requirement that individuals be supported to exercise their capacity would be derived from this principle.

Following consideration of the responses to *A Legislative Framework for Mental Capacity and Mental Health Legislation*, the then Minister, Mr. Michael McGimpsey, announced in September 2009 that he had decided not to proceed with two separate bills but rather to develop a single Mental Capacity Bill encompassing both mental capacity and mental health provisions.⁹

In 2010, further consultations around an EQIA¹⁰ indicated support for the Minister's proposal to use the principles developed by the Bamford Review as the basis for the principles to be contained within the single Bill. These principles it was also argued should be included on the face of the bill. In October 2011, officials from the DHSSPS briefed the Assembly's Health Committee on development of the Bill. During this briefing officials noted that:

The Bill will be based on the principles set out in the original Bamford report, and the leading principle will be Bamford's principle of autonomy, which will empower individuals to exercise their own mental capacity to make decisions where they can and to encourage participation as far as possible. The starting point, therefore, will be that a person is presumed to have the mental capacity to make their own decisions unless the contrary is proved. That will be stated in the Bill and will give effect to Bamford's autonomy principle.¹¹

Whilst the official noted that autonomy would be the 'leading principle', reference was also made to acting in a person's best interests. Officials stated, for example, that the

⁸ DHSSPSNI (2009) Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland - A Policy Consultation Document <http://www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf>

⁹ DHSSPS website: Consultation on an Equality Impact Assessment for New Mental Capacity Legislation. <http://www.dhsspsni.gov.uk/showconsultations?txtid=43469>

¹⁰ DHSSPS (2010) Equality Impact Assessment (EQIA) of its proposals for a new Mental Capacity Bill <http://www.dhsspsni.gov.uk/equality-impact-assessment-for-new-mental-capacity-legislation.pdf>

¹¹ Committee for Health, Social Services and Public Safety (Official Report – 5 October 2011) <http://www.niassembly.gov.uk/assembly-business/official-report/committee-minutes-of-evidence/session-2011-2012/october-2011/mental-capacity-health-welfare-and-finance-bill/>

Bill would ‘...work by giving effect to the common law defence of necessity, which provides those intervening in the life of someone who lacks capacity with protection from liability, providing they establish that the person lacks capacity and that they apply the safeguards, particularly the best interests one’.¹²

Picking up on departmental officials’ references to autonomy and best interests, the Mental Health and Learning Disability Alliance, giving evidence at a subsequent meeting of the Health Committee, stated that:

We spoke about the importance of the principle of autonomy, but we also see the principle of benefit as critical. We have suggested benefit as opposed to best interest, because the Bill is about driving attitudinal change and changing mindsets, and language is important. Members of the alliance have expressed the view that the term “benefit” conveys a sense of objectivity, whereas “best interest” conveys a sense of paternalism. It comes from England and Wales’s Mental Capacity Act 2005. Bamford did not pluck the word “benefit” out of thin air. We feel that language matters in driving attitudinal change. We want the principle of benefit to be articulated clearly in the Bill.¹³

Interface with Criminal Justice System

The Bamford Review concluded that the proposed legislative framework, which would integrate capacity and mental health legislation, should be applicable to all people in society, including those who are subject to the criminal justice system. Commenting on the principles-based approach the Bamford Review in its final report stated that:

People who have decision-making capacity should be free to make their own decisions. If those decisions are unwise or imprudent, or if they result in a crime, then those individuals must take responsibility for the decisions they have made. The principles-based approach cannot excuse people who have decision making capacity from the consequences of their decisions. Similarly, the approach cannot impose compulsion or restriction on people who have decision making capacity, even where they are considered to pose a risk of serious harm to the public. Instead, the necessary provisions and protections must be made under Criminal Justice Legislation. There are, therefore, important interfaces with the criminal justice system which requires further consideration.¹⁴

In July 2012, Justice Minister David Ford published for consultation proposals on how new mental capacity legislation would extend to people subject to the criminal justice system. The consultation in particular sought comments on:

- whether particular arrangements will be required for people subject to the criminal justice system;

¹² As above

¹³ Committee for Health, Social Services and Public Safety (Official Report – 16 November 2011)

http://www.niassembly.gov.uk/Documents/Official-Reports/Health/2011-2012/111116_MentalCapacityBill.pdf

¹⁴ The Bamford Review of Mental Health and Learning Disability (Northern Ireland) A Comprehensive Legal Framework (DHSSPS) August 2007 (accessed May 2015) para 5.53

- how existing court powers in relation to compulsory mental health assessment and treatment and transfer to and from prison and hospital should operate in the context of a mental capacity-based approach; and
- the principles, assessments and safeguards to be set out in the legislation.¹⁵

In its report on the consultation, the DoJ noted that a total of thirty four responses had been received and that the responses had come from a wide spectrum including professional bodies, voluntary organisations, and the statutory health and justice sectors. The DoJ stated in its report that ‘all respondents agreed in broad terms to the application of mental capacity proposals to the criminal justice system’.¹⁶ In terms of the operation of the criminal justice system, the DoJ stated that ‘the principles, safeguards and protections being developed within the Mental Capacity (Health Welfare and Finance) Bill by the DHSSPS would be applied’. This would include the application of the substitute decision-making framework where it was compatible with existing duties and powers. In addition, the DOJ indicated that a Code of Practice would be developed for criminal justice system practitioners to provide guidance as to the applying the new system in the context of existing statutory powers and common law duties.

Briefing the Committee for Justice on the Mental Capacity Bill in February 2014, departmental officials highlighted that:

The key phases of the criminal justice system in which statutory powers are currently exercised under the 1986 order will be brought into line with the capacity approach. There are three categories: first, police powers to remove persons from a public place to a place of safety; secondly, court powers to impose healthcare disposals at remand and sentencing or following a finding of unfitness to plead; and, thirdly, the powers by which the Department can transfer prisoners for inpatient treatment in a hospital. When an offender has the capacity to refuse an intervention in relation to his or her care, treatment or personal welfare, that decision will be respected. When that person lacks capacity, decisions will be made in accordance with the Bill's procedures, principles and safeguards.

The departmental official went on to stress, however, that the model being developing would ‘see the courts, the police and the Prison Service retain their overarching statutory powers around detention as distinct from treatment’. In summary, the official noted that, whilst detention for an offence might be imposed regardless of capacity, treatment would be based on the capacity principles.¹⁷

¹⁵ Consultation on proposals to extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and implications for Mental Health powers. (July 2012)
<http://www.dojni.gov.uk/index/public-consultations/archive-consultations/consultation-paper-on-proposals-to-extend-mental-capacity-july-2012.pdf>

¹⁶ Consultation on proposals to extend mental capacity legislation to the criminal justice system in Northern Ireland Report on Responses and Way Forward (January 2013) para 1.1
<http://www.dojni.gov.uk/index/public-consultations/archive-consultations/report-on-responses-and-way-forward-extending-mental-capacity-to-the-criminal-justice-system-in-northern-ireland-january-2013.pdf>

¹⁷ Committee for Justice (20 February 2014) Mental Capacity Bill: DOJ Briefing - Official Report (Hansard)

5 Consultation on draft Mental Capacity Bill

On 27 May 2014, the then Health Minister, Edwin Poots, and Justice Minister David Ford launched a consultation document which included the draft provisions of the Bill relating to civil society, and set out the proposed approach for those subject to the Criminal Justice system. The draft Mental Capacity Bill it was stated would ‘...introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a physical or mental illness) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision for themselves’. The overview of the draft Bill set out in the consultation document stated that:

The draft Bill is principles-based. The principles are set out at the start and underpin the entire draft Bill. They include, and build upon, the existing common law presumption of capacity in persons aged 16 and over and the common law principle of best interests. Significantly, they place greater emphasis on the need to support people to exercise their capacity to make decisions where they can. If, on the other hand, it is established that a person lacks capacity to make a specific decision at a particular time, the Bill provides alternative decision making mechanisms.

The consultation document explained that Part 1 of the draft Bill, which has been included as Appendix 1 to this paper, sets out:

the underpinning statutory principles (Clause 1), such as respect for personal autonomy, which anyone acting under the Bill will have to comply with where a determination is being made about whether a person lacks capacity in relation to a particular matter:

- A person is assumed to have capacity unless it is established otherwise. This enshrines in statute, what is referred to as the common law presumption of capacity;
- It cannot be concluded that a person is unable to make a decision unless all practicable help and support have been given without success. Clause 4 then expressly sets out the practicable steps, in particular, that must be taken to ensure compliance with this principle (to be elaborated on in the Code of Practice which will be published alongside the Bill when enacted);
- It cannot be concluded that a person is unable to make a particular decision because he/she makes an unwise decision; and

- It cannot be concluded that a person lacks capacity merely on the basis of his/her age, appearance, condition or behaviour.¹⁸

The consultation document also highlighted that Clause 1 placed the 'best interests' principle, which it described as a fundamental principle of the existing common law, on a statutory footing. This provision it went on to explain required that any act done or decision made on behalf of a person who lacks capacity, must be in his/her best interests.

In the context of the provision regarding the best interests principle, the consultation document also noted that:

Notwithstanding its robust nature, it is also worth mentioning that, given the scope of decisions to which it might apply, this provision in the draft Bill has been drafted in such a way as to allow it to operate in a wide range of situations, including for example an emergency or what might generally be a routine intervention, such as washing or dressing someone. This has been achieved by conditioning some of the requirements set out above around what is reasonable, practicable or appropriate.

The document also noted that 'reference to preventing harm to others, resulting in harm to the person who lacks capacity in the best interests clause, is one of a number of places in the draft Bill where the protection of others is a relevant factor in decision making in respect of persons who lack capacity'.¹⁹

Consultation Responses

The Departments received one hundred and twenty one responses to the consultation and these individual responses, together with the Departments' summary of them, were published online. The summary document states that approximately forty five percent of total responses received commented on the principles in clause 1 of the draft Bill.

The information provided in this paper below is designed to provide an illustrative rather than a representative summary of the range of views expressed in the consultation responses. These views ranged widely from unqualified support for the principles and approach adopted in the draft Bill to the view that the model upon which the Bill was based was conceptually ill founded, particularly within the framework of the UK's post-Bamford ratification of the United Nations Convention on the Rights of People with a Disability.

Selected extracts from the consultation responses have been provided below in order to provide some, albeit limited, explanation of ideas underpinning these different opinions.

¹⁸ Draft Mental Capacity Bill (NI) Consultation Document May 2014 (para 2.6)
http://www.dhsspsni.gov.uk/mental_capacity_bill_consultation_paper.pdf

¹⁹ As above paragraphs 2.8-2.9

The British Psychological Society's response provides an example of an unconditional broad welcome to the draft Bill.

The Society believes that Draft Mental Capacity Bill (the Bill) provides a progressive, positive and comprehensive framework with regard to capacity and best interest providing explicit principles and clear guidance for putting these into practice. It has clarified the legal position and the role of the law within capacity issues. It has illustrated the need to balance care and protection against empowerment and the individual's right. The Society welcomes the emphasis within the Bill to ensure that a person must be given all practicable help and support to enable him or her to make a decision. We would recommend that the Code of Practice should develop robust mechanisms whereby persistent inquiries to establish preferred supports for the individual be enacted. This will ensure that all avenues are explored to 'enable' supported decision making and to maximise chances for informed expression of will and preferences. The Bill addresses the discrimination implicit in separate Mental Health Legislation by bringing together all decision making into the same legislative framework – this is welcomed by the Society.²⁰

Other consultation responses highlighted within this paper are considered under the following headings: presumed capacity; practicable help and support; Bamford Principles; the United Nations Convention on the Rights of Persons with Disabilities; harm to other; appreciation; and fusion concerns.

Presumed Capacity

The principle of presumed capacity, which is fundamental to the operation of the draft Bill, was highlighted in many responses as being welcome and of fundamental importance to achieving positive change for those suffering from mental illness. The Northern Ireland Association for Mental Health (Niamh), for example, stated in its response that it was '*...supportive of the Principle of assumed capacity unless it is established otherwise*' adding that it '*...believed that this principle has the ability to fundamentally create a culture shift in our society including our clinical and legal settings by empowering individuals and reducing stigma*'.²¹ The Older Person's Commissioner also expressed support for the principle stating that '*This statutory presumption provides a clear guideline for practitioners making a determination on capacity as well as older people and their families*'. The Commissioner's response,

²⁰ British Psychological Society response to the Department of Health Social Services and Public Safety in Northern Ireland

(DHSSPSNI) <http://www.dhsspsni.gov.uk/british-psychological-society-mcb.pdf>

²¹ Niamh Consultation Response to the Department of Health, Social Services and Public Safety
<http://www.dhsspsni.gov.uk/ni-association-mental-health-mcb.pdf>

addressing some of the specific provisions relating to the principle of presumed capacity, added that:

The prohibition on practitioners making a decision on a person's capacity merely by referencing their age under Clause 1(5)(a) of the Bill is an essential statutory requirement. It is important that older people are treated fairly in the decision making process. The autonomy of older people should be strongly valued, respected and protected in any process to determine their capacity.

The Commissioner further welcomes the legislative guarantee under Clause 1(5)(b) of the Bill that an older person's capacity will not be determined by reference to a particular condition they may be living with. This clause is particularly relevant to many older people living with dementia. It is imperative that this particular group of older people are protected from arbitrary detention.²²

Carers NI also welcomed the presumption of capacity contained within the draft Bill, highlighting the importance of respecting 'unwise' but capacitous decisions.

We are pleased to note that the Bill takes a positive approach to mental capacity. It sets out a number of important principles, most importantly the assumption of capacity to make decisions. It is easy to think that a person cannot make a decision when they want to do something that we think is wrong or harmful or, as the Bill puts it, 'unwise'. The Bill does not explain 'unwise' and could do with some clarification. An example could be where someone wants to live on their own, but they might be at risk because they are forgetful. We naturally would want to protect them and keep them safe. But the Bill does make it clear that, provided the person understands the risks they are taking and chooses to take those risks, they are capable of making the decision and have the right to make decisions even if we think they are unwise.²³

Practicable Help and Support

There was a broad welcome too in the consultation responses for the principle that it cannot be concluded that a person is unable to make a decision unless all practicable help and support have been given to them without success. Other

²² Draft Mental Capacity Bill - Written Response submitted by the Commissioner for Older People for Northern Ireland
<http://www.dhsspsni.gov.uk/commissioner-for-older-people-ni-mcb.pdf>

²³ carersNI Consultation Response - Draft Mental Capacity Bill (NI)
<http://www.dhsspsni.gov.uk/carers-ni-mcb.pdf>

responses whilst broadly welcoming the principle, added further observations such as those shown below.

*Action Mental Health welcome the Bill's effort to include support provisions for P to enable their decision making. We would ask for clarification on what will constitute, 'practicable help'. Those we consulted with were concerned that a resource stretched environment where delivery of provision is not currently equitable across Trust areas; the phrasing, 'practicable help' might in a worst case scenario mean no help at all. How do the Departments' plan to ensure; equitable, regional delivery of a suite of 'practicable help' that P can be provided with, irrespective of P's location or, the time or day of need?*²⁴

*Age NI recommended that access to information is included within the principles section to ensure that this is seen as a fundamental component of the presumption of capacity.*²⁵

Bamford Principles

A number of responses compared the Bamford principles and the principles contained in the draft Bill. Mencap, for example, in its response noted that the draft Bill had not included all the principles identified in the Bamford Review and expressed the view that 'the principles of autonomy, justice, benefit and least harm should all be enacted on the face of the legislation and applied in all decision-making under the new law'. The Federation of Experts by Experience (FEBE) responded that they were of the general opinion that the:

*Department is heading in the right direction with principle based capacity legislation. However, we have major concerns with regard to the inherent conflict between the two prominent principles cited in the Bill – i.e. Personal Autonomy and 'Best Interests' (not one of the four original Bamford principles) upholding this bill. We feel that the principles are particularly important, in light of Advance Decisions not been given legal status. We wonder whatever happened to the other three (Bamford) principles of– Justice and Benefit and Least Harm.*²⁶

The Northern Ireland Association for Mental Health (Niamh) also made reference to the Bamford principles stating:

²⁴ Action Mental Health 'Draft Mental Health Capacity Bill'
<http://www.dhsspsni.gov.uk/action-mental-health-mcb.pdf>

²⁵ cause – Draft Mental Capacity Bill NI
<http://www.dhsspsni.gov.uk/cause-mcb.pdf>

²⁶ The Federation of Experts by Experience (FEBE) Response to the Department of Health, Social Services and Public Safety NI
<http://www.dhsspsni.gov.uk/federation-of-experts-by-experience-mcb.pdf>

We note that the principles referred to in the CD and Bill are not those envisaged by the Bamford Review. The Autonomy principle remains in place. However the Justice principle (applying the law fairly and equally) has been removed. The key Bamford principles of Least Harm and Benefit have been replaced with a Best Interests principle. We recognize the Bamford Review's fundamental contribution to enhancing the lives of people with mental health problems and learning disability. However, the Bamford Review has been unevenly and partially implemented. Therefore, there are significant deficits in mental health service provision, which need to be addressed if the legislation is to be successfully implemented.²⁷

In response to such comments, the DHSSPS noted that, whilst the Bamford principles had not been directly transposed into the draft Bill, they had 'acted as a reference point throughout the drafting process'. The DHSSPS also stated that in its view 'respect for personal autonomy is a recurring theme in the draft Bill' and that the best interests principle achieves what the Department understands to have been the thinking behind the Bamford principle of benefit. The DHSSPS added that 'Justice is a universal characteristic that applies to all Northern Ireland legislation'.

In line with the view taken by the DHSSPS's, the Law Center in its response addressed, amongst other things, the relationship between the 'benefit' and 'best interest' principles.

It has been suggested that 'benefit' should replace 'best interests'. It is worth noting that the Bamford Review did not suggest that the principle of 'benefit' be transposed directly into the legislation and that it made use of the concept of 'best interests' in articulating the meaning of the principle of 'benefit' (at 5.1, p. 38). There is great value in retaining the current concept of best interests as it differs from benefit. There are many situations where multiple options would all be of benefit to P, but only one option can be in P's best interests. 'Benefit' would not serve as a criterion to choose between options where all of those options provide benefit to P.²⁸

The United Nations Convention on the Rights of Persons with Disabilities²⁹

Of significant note were the consultation responses which expressed concern, in the context of *the United Nations Convention on the Rights of Persons with Disabilities*

²⁷ Niamh Consultation Response to the Department of Health, Social Services and Public Safety
<http://www.dhsspsni.gov.uk/ni-association-mental-health-mcb.pdf>

²⁸ The Law Centre NI Response to the Department of Health, Social Services and Public Safety NI
<http://www.dhsspsni.gov.uk/law-centre-ni-mcb.pdf>

²⁹ Convention on the Rights of Persons with Disabilities:
<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx>.

(UNCRPD), about the use of the best interests principle and substituted decision making for those deemed to lack capacity. The UNCRPD, which sets out a set of international standards for the protection of the rights of people with disabilities, was adopted by the United Nations in December 2006 and came into force in May 2008. As the UK signed the Convention in 2007 and ratified it in 2009³⁰, some organisations argued that the draft bill did not take sufficient cognisance of this post-Bamford development. For example, the Centre for Disability Law and Policy (CDLP) at the National University of Ireland Galway stated that it was:

...concerned that crucial developments in contemporary international human rights law do not appear to have informed the Mental Capacity Bill. Since the Bamford Review, the adoption of the CRPD by the United Nations in 2006, and its coming into force in 2008, have generated new ideas and standards in law, policy and practice governing the provision of disability support and safeguards.

Based on these developments the CDLP is concerned that the Mental Capacity Bill rests on a foundational conceptual confusion, which risks undermining efforts of drafters to overcome disability-based discrimination. The Mental Capacity Bill should move away from its current focus on substituted decision-making, 'best interests' and mental capacity. The functional assessment of mental capacity in the Mental Capacity Bill, even as it appears prima facie to be non-discriminatory, continues to impose substantive discrimination against people with disabilities — particularly persons with intellectual, cognitive and psychosocial (mental health) disabilities.

Instead, the Mental Capacity Bill should move toward a framework based on supporting individuals to exercise legal capacity on an equal basis with others. This 'legal capacity support model' would remove disability-based discrimination and build on existing protection against discrimination in Northern Ireland and complement existing UK and ECHR case law.³¹

The Northern Ireland Human Rights Commission also made reference to the UNCRPD, when highlighting the emerging legal framework within which the draft Bill would now needed to be considered.

³⁰ Convention and Optional Protocol Signatures and Ratifications, UN Enable website, accessed 14 May 2015: <http://www.un.org/disabilities/countries.asp?id=166>.

³¹ Centre for Disability Law and Policy (CDLP) Response to the Department of Health, Social Services and Public Safety NI <http://www.dhsspsni.gov.uk/centre-for-disability-law-and-policy-mcb.pdf>

The Commission notes that the proposed Bill does not differentiate in law between persons with disabilities and persons without. However in its application it will impact on persons with disabilities more than those without, due to the greater propensity for persons with disabilities to have impaired decision making skills. As acknowledged in the consultation document the proposed Bill, whilst making extensive provision for supported decision making, continues to make provision for substitute decision making.

Whilst noting that the Bill contains aspects which are broadly in compliance with the UNCRPD by continuing to make provision for substitute decision making, on the basis of the Committee's interpretation, the proposals are in breach of Article 12. Alongside the other UK Commissions the Commission raised concerns with the UNCRPD Committee regarding the lack of clarity provided by the then draft General Comment 1.⁶

In particular noting that the draft General Comment did not fully consider regional human rights standards, in particular the ECHR, the Commissions advised the Committee to "consider and clearly articulate how Article 12 of the CRPD is to be read alongside regional international law and standards". The finalised General Comment unfortunately did not address this matter. The Department's proposals for recognition of capacity represent a substantial progress in developing greater adult capacity. The Commission acknowledges that supported decision making is an emerging area of law and practice, which makes the task of the Departments in ensuring compliance complex.³²

⁶ Joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission UN Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12 28 February 2014

The Law Centre in its submission, however, expressed the view that the Bill was progressive in human-rights terms and compliant with the European Convention of Human Rights and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Its response stated that:

Appropriate safeguards are proposed to be put in place that extend the protection of the rights of those who do not have the capacity to consent to their deprivation of liberty which bring Northern Ireland in line with its obligations under Article 5(1) of the European Convention. The gateway to compulsory interventions is disability and illness neutral, with a statutory duty added to maximise an individual's decision-making capacity.

Substitute decisions are made as a last resort, in line with the UNCRPD. The Bill removes the stigmatising concept of a need for a piece of legislation designed for treatment of the "mentally disordered", replacing

³² Northern Ireland Human Rights Commission Response to the Department of Health, Social Services and Public Safety <http://www.dhsspsni.gov.uk/ni-human-rights-commission-mcb.pdf>

this with a focus on whether or not the individual has the capacity to make the relevant decision for him/herself.³³

Harm to others

In addition to the concern about CRPD, a number of responses drew attention to how the best interests principle had been extended to include the interests not only of the incapacitated person but also of third parties. The BMA, addressing this issue, noted that:

One of the most significant departures from the sponsoring legislation has to do with the definition of best interests. Under the checklist of factors that must be taken into account when determining what would be in someone's best interests, Clause 6 states: 'The person intervening must also have regard to whether failure to do the act proposed is likely to result in harm to other persons with resulting harm to the person lacking capacity.' BMA(NI) agrees that this statement is broad and requires clarification. No definition of 'harm' is given here, nor is there any explicit reference to the direct risk of harm to others. It would certainly be plausible, on the face of it, to extend this to include psychological or even 'moral' harms to an adult who lacks capacity and harms others while under the influence of a mental disorder. Although the extent to which a 'best interests' judgment in relation to an individual can or should incorporate the interests of others has been addressed by the courts, they have largely focussed on individuals with whom the incapacitated adult has a significant personal relationship such that their interests interpenetrate or overlap. To incorporate the interests of third parties who have no relationship with the incapacitated adult in order to protect that third party from a risk presented by the incapacitated adult looks like a significant departure for which, to our knowledge, there is no statutory or common law precedent. Arguably, an attempt to incorporate the security and safety interests of third parties into an assessment of the index individual's 'best interests' risks incoherence.³⁴

The General Medical Council in its response, addressing the argument that the 'best interests' test as set out in the draft Bill reflected the approach taken in recent court judgements in about the Mental Capacity Act best interests test, stated:

³³ The Law Centre NI Response to the Department of Health, Social Services and Public Safety NI
<http://www.dhsspsni.gov.uk/law-centre-ni-mcb.pdf>

³⁴ British Medical Association Response to the Department of Health, Social Services and Public Service NI
<http://www.dhsspsni.gov.uk/british-medical-association-ni-mcb.pdf>

We are aware of a number of cases where the courts considered the extent to which a 'best interests' judgment can or should incorporate the interests of third parties. But these cases were about incapacitated adults who had a significant personal relationship with the third party e.g. a family member where their interests clearly intersect. It seems a significant departure from precedent, to incorporate the interests of third parties where they do not intersect directly with the incapacitated adult, in order to justify actions to protect that third party from a risk of harm presented by the incapacitated adult.

The Belfast Health and Social Care Trust also addressed the inclusion of harm to others within the best interests test, stating:

The assessment of the likelihood of harm to other persons with resulting harm to the person lacking capacity is likely to be at best an imprecise science at the best of times, much less in fraught situations such as a busy Emergency Department. This criterion carries a risk that this judgment may only be made properly in hindsight. This is also a departure from the English MCA best interests' statute and again will have no precedents to aid interpretation.³⁵

Appreciation

Another feature of the draft Bill which was clearly an extension of the relevant MCA provisions, namely the inclusion within the functional capacity test of the need for a person to 'appreciate' information, was addressed by, amongst others, The Federation of Experts by Experience (FEBE). In its response it stated that:

Surely P will satisfy the 'appreciation' dimension if they appreciate that they are so emotionally and/or mentally exhausted that they are in need of care and not necessarily medication only- a safe therapeutic environment; a listening ear; personal space etc □ FEBEs have concerns that 'appreciation' will equate with the woolly medical term 'lack of insight'. Thus 'lacks appreciation/insight' will become the status quo for the medical assessor and will be too readily accepted by Authorisation Panel and Review Tribunal. We would suggest the term 'lack of appreciation/insight' needs to be further defined as to its specific nature and limitations i.e. what actually is it that the person lacks appreciation/insight of.³⁶

³⁵ General Medical Council Response to the Department of Health, Social Services and Public Service NI
<http://www.dhsspsni.gov.uk/general-medical-council-mcb.pdf>

³⁶ The Federation of Experts by Experience (FEBE) Response to the Department of Health, Social Services and Public Safety NI
<http://www.dhsspsni.gov.uk/federation-of-experts-by-experience-mcb.pdf>

Fusion Concerns

In spite of the lengthy policy development and consultation exercises, a number of organisations, albeit for different reasons, continued to express concerns, as shown below, regarding the fusion in the draft Bill of mental capacity and mental health legislation.

*'Behind the proposed changes lies a principled desire to ensure that mentally disordered individuals have equality of rights – equal respect for their personal autonomy – as those suffering from physical disorders. As a result, it is anticipated that the new Bill will also help tackle the stigma associated with mental illness which is whole-heartedly welcomed across the profession. Certainly in principle the justification for this approach is strong and is clearly set out in the consultation document. The Association question whether Northern Ireland is prepared to accept the possible implications of allowing mentally ill people to refuse treatment with the possible consequences to them and society.'*³⁷

BMA

*'The widening of the proposed legislation to include the treatment of physical illnesses is quite significant with professionals having the ability of detaining and treating someone for their diabetes or asthma. One wonders how the public will react to that extension of enforced treatment to physical illnesses. Although, it will put mental and physical health conditions on the same footing legislatively'.*³⁸

Mental Health Social Workers of the South Eastern Health Social Care Trust

*We should note that the criminal provisions of the proposed Bill have not been made available. It is our experience that in practice the civil and criminal provisions are inextricably linked and the failure to provide the criminal provisions is a serious shortcoming. The group supports the idea of the implementation of the Mental Capacity Legislation and its role in the Criminal Justice Arena. However while we support the implementation of the Mental Capacity Bill we do not support the removal of the Mental Health Legislation.'*³⁹

Regional Forensic Group (Mental Health & Disability)

³⁷ British Medical Association Response to the Department of Health, Social Services and Public Service NI <http://www.dhsspsni.gov.uk/british-medical-association-ni-mcb.pdf>

³⁸ Mental Health Social Workers of the South Eastern Health Social Care Trust Response to the Department of Health, Social Services and Public Safety NI <http://www.dhsspsni.gov.uk/south-eastern-health-and-social-care-trust-mcb.pdf>

³⁹ Regional Forensic Group (Mental Health and Disability) Response to the Department of Health, Social Services and Public Safety NI <http://www.dhsspsni.gov.uk/regional-forensic-group-mcb.pdf>

6 Conclusion

It is now over a decade since the Bamford Review was launched and over seven years since it published its final report on legislative reform. The time taken to bring forward the draft Mental Capacity Bill for consultation reflects the inclusive, structured approach taken by the DHSSPS (and more recently the DoJ too) to policy development and the complexities involved in drafting a bill which, for the first time in any jurisdiction, seeks to fuse together mental capacity and mental health law.

It has been observed in the past that ‘The UK’s tortuous ten year attempt to update the Mental Health Act 1983...can be interpreted in two ways. One, as a failure of resolve to properly grasp the principles of the primacy of autonomy, using capacity as the threshold for compulsion...as originally proposed by Richardson’s expert committee. The other is that the proposals were rejected as judged not to adequately address common, and serious clinical challenges, and to run the risk of unacceptable and unforeseen consequences’.⁴⁰

Whilst many responses to consultation on the draft Bill indicated broad support for the principles and approach adopted by the DHSSPS and the DoJ, the responses also revealed concern regarding the potential for unforeseen consequences, particularly regarding the functional test of capacity and the definition of best interests.

From a different perspective, of note when considering the consultation responses were the references to the UNCPRD. The UNCPRD is a post-Bamford development and it provided the basis upon which a number of consultation responses challenged the substitute decision model proposed by the Bamford Review and adopted in the draft Bill. It was, however, also recognised in responses that, given the emerging law and practice relating to supported decision making, ensuring compliance with the UNCPRD was complex and challenging.

⁴⁰ Tom Burns (2010) Mental illness is different and ignoring its differences profits nobody. Special Ed. J. Mental Health L. 34 (p36)

Appendix 1

DRAFT MENTAL CAPACITY BILL

PART 1		
PRINCIPLES		
Principles		
Principles		
1	(1)	For the purposes of this Act, a person is to be assumed to have capacity in relation to a matter unless it is established that the person lacks capacity in relation to the matter (within the meaning given by section 2).
	(2)	The principles in subsections (3) to (5) must be complied with where, for any purpose of this Act, a determination falls to be made of whether a person lacks capacity in relation to a matter.
	(3)	The person is not to be treated as unable to make a decision for himself or herself in relation to the matter unless all practicable help and support to enable the person to make a decision in relation to the matter have been given without success (see section 4).
	(4)	The person is not to be treated as unable to make a decision for himself or herself in relation to the matter merely because the person makes an unwise decision.
	(5)	A lack of capacity cannot be established merely by reference to -
	(a)	the person's age or appearance; or
	(b)	a condition of the person, or an aspect of the person's behaviour, which might lead others to make unjustified assumptions about the person's capacity.
	(6)	The principle in subsection (7) applies where any act is done, or any decision is made, under this Act for or on behalf of a person who lacks capacity.
	(7)	The act or decision must be done, or made, in the best interests of the person who lacks capacity (see section 6).
<i>Establishing whether a person has capacity</i>		
Meaning of "lacks capacity"		
2	(1)	For the purposes of this Act, a person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
	(2)	It does not matter
	(a)	whether the impairment or disturbance is permanent or temporary;
	(b)	what the cause of the impairment or disturbance is.
	(3)	In particular, it does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability.
	(4)	In this section "unable to make a decision" has the meaning given by section 3.
<i>Meaning of "unable to make a decision"</i>		
3	(1)	For the purposes of sections 1 and 2, a person is unable to make a decision for himself or herself in relation to a matter if the person
	(a)	is not able to understand the information relevant to the decision; or
	(b)	is not able to retain that information for the time required to make the decision; or
	(c)	is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or
	(d)	is not able to communicate his or her decision (whether by talking, using sign language or any other means).

	(2)	In subsection (1) “the information relevant to the decision” includes information about the reasonably foreseeable consequences of
	(a)	deciding one way or another; or
	(b)	failing to make the decision.
	(3)	For the purposes of subsection (1)(a), the person is not to be regarded as “not able to understand the information relevant to the decision” if the person is able to understand an appropriate explanation of the information.
	(4)	An appropriate explanation means an explanation of the information given to the person in a way appropriate to the person’s circumstances (using simple language, visual aids or any other means).
<i>Supporting person to make decision</i>		
4	(1)	A person is not to be regarded for the purposes of section 1(3) as having been given all practicable help and support to enable him or her to make a decision unless, in particular, the steps required by this section have been taken so far as practicable.
	(2)	Those steps are
	(a)	the provision to the person, in a way appropriate to his or her circumstances, of all the information relevant to the decision (or, where it is more likely to help the person to make a decision, of an explanation of that information);
	(b)	ensuring that the matter in question is raised with the person
		(i) at a time or times likely to help the person to make a decision; and
		(ii) in an environment likely to help the person to make a decision;
	(c)	ensuring that persons whose involvement is likely to help the person to make a decision are involved in helping and supporting the person.
	(3)	The information referred to in subsection (2)(a) includes information about the reasonably foreseeable consequences of
	(a)	deciding one way or another; or
	(b)	failing to make the decision.
	(4)	Nothing in this section is to be taken as in any way limiting the effect of section 1(3).
<i>Compliance with section 1(1)</i>		
5	(1)	In proceedings under this Act or any other statutory provision, any question whether a person lacks capacity within the meaning of this Act is to be decided on the balance of probabilities.
	(2)	Subsection (3) applies where, other than in such proceedings, it falls to a person to determine for any purpose of this Act whether another person (“P”) lacks capacity in relation to a matter.
	(3)	If
	(a)	the person making the determination has taken reasonable steps to establish whether P lacks capacity in relation to the matter,
	(b)	the person reasonably believes that P lacks capacity in relation to the matter, and
	(c)	the principles in section 1(3) to (5) and section 4 have been complied with, for the purposes of section 1(1) the person is to be taken to have sufficiently “established” that P lacks capacity in relation to the matter.

<i>Establishing what is in a person's best interests</i>		
Best Interests		
6	(1)	This section applies where for any purpose of this Act it falls to a person to determine what would be in the best interests of another person ("P").
	(2)	In determining what would be in P's best interests, the person making the determination must not make it merely on the basis of
	(a)	P's age or appearance; or
	(b)	a condition of P's, or an aspect of P's behaviour, which might lead others to make unjustified assumptions about what might be in P's best interests.
	(3)	The person making the determination
	(a)	must consider all the relevant circumstances (that is, all the circumstances of which that person is aware which it is reasonable to regard as relevant); and
	(b)	must in particular take the following steps.
	(4)	That person must consider
	(a)	whether it is likely that P will at some time have capacity in relation to the matter in question; and
	(b)	if it appears likely that P will, when that is likely to be.
	(5)	That person must, so far as practicable, encourage and help P to participate as fully as possible in the determination of what would be in P's best interests.
	(6)	That person must take into account, so far as they are reasonably ascertainable
	(a)	P's past and present wishes and feelings (and, in particular, any relevant written statement made by P when P had capacity);
	(b)	the beliefs and values that would be likely to influence P's decision if P had capacity; and
	(c)	the other factors that P would be likely to consider if able to do so.
	(7)	That person must
	(a)	if it is practicable and appropriate to do so, consult the relevant people about what would be in P's best interests and, in particular, about the matters mentioned in subsection (6); and
	(b)	take into account the views of those people (so far as ascertained from that consultation or otherwise) about what would be in P's best interests and, in particular, about those matters.
	(8)	In subsection (7) "the relevant people" means
	(a)	if at the time of the determination there is someone who is P's nominated person (within the meaning given by section 70), that person;
	(b)	if at the time of the determination there is an independent advocate who is instructed under section 88 to represent and provide support to P, the independent advocate;
	(c)	any other person named by P as someone to be consulted on the matter in question or on matters of that kind;
	(d)	anyone engaged in caring for P or interested in P's welfare;
	(e)	any attorney under a lasting power of attorney granted by P; and
	(f)	any deputy appointed for P by the court.
	(9)	The person making the determination must, in relation to any act or decision that is being considered, have regard to whether the same purpose can be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.
	(10)	That person must, in relation to any act that is being considered, have regard to whether failure to do the act is likely to result in harm to other persons with resulting harm to P.
	(11)	If the determination relates to life-sustaining treatment for P, the person making the determination must not, in considering whether the treatment is in the best interests of P, be motivated by a desire to bring about P's death.

<i>Compliance with section 1(7)</i>		
7	Where a person other than the court does an act or makes a decision for or on behalf of another person who lacks capacity (“P”), the person doing the act or making the decision is to be taken to have sufficiently complied with the principle in section 1(7) if that person	
	(a)	reasonably believes that the act or decision is in P’s best interests; and
	(b)	in determining whether the act or decision is in P’s best interests, has complied with section 6