Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Mental Capacity (Health, Welfare and Finance) Bill: Children's Law Centre

9 May 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Mr Eamonn McNally	Children's Law Centre
Ms Natalie Whelehan	Children's Law Centre

The Chairperson: Natalie and Eamonn, you are more than welcome to the Committee. Thank you for your briefing paper. We have a number of people in after you, including the commissioner and officials from the Department, so we should try to keep this as tight as possible. I hand over to you to make your presentation, after which we will open it up for questions.

Ms Natalie Whelehan (Children's Law Centre): Thank you for the opportunity to present to you today on behalf of the Children's Law Centre. One of the centre's long-standing priorities is child and adolescent mental health. We have been heavily involved in the Bamford review and in the development of the legislative proposals to date, and we have taken the lead in the children's sector on that work for several years. We are members of the Department of Health, Social Services and Public Safety (DHSSPS) legislation reference group and the Department of Justice's reference group. Eamonn is employed as a full-time mental health solicitor. We deliver legal advocacy, advice and representation, as well as training, policy and legislative commentary on child and adolescent mental health services. We estimate that Eamonn has represented at 70% of mental health tribunals involving children that have been heard over the past year in Northern Ireland.

We are extremely concerned about the Department's proposals to exclude under-16s from the scope of the Mental Capacity (Health, Welfare and Finance) Bill. Although it is proposed that under-16s who are formally detained for assessment or treatment of a mental health condition in a hospital setting will come within the scope of the legislation, in practice that will mean that only under-16s who are formally

detained will be able to access the protections and safeguards of the Bill. Less than 1% of children in mental health hospitals are formally detained, and 99·5% of in-patients under 16 are voluntary in-patients. That means that they will not be able to access any of the protections or safeguards in the legislation.

The Bill, in many respects, is incapacity as opposed to capacity legislation. It does not give capacity to anyone, but it gives protections to a very vulnerable group of people: those who lack capacity as a result of a mental illness or learning disability. The Department's proposal to exclude all under-16s who are not formally detained from the scope of the legislation will result in a small number of mature minors under the age of 16 who lack capacity due to a mental illness or learning disability not being able to access the safeguards and protections of the Bill. It is vital for the protection of the rights of those young people that they be included within the scope of the legislation. Some of the safeguards proposed in the Bill that under-16s will not be able to access if they are excluded from the legislation include enhanced advocacy services for those who lack capacity and who have no one to speak on their behalf. That will mean that those who lack capacity and are aged 16 and over will have enhanced advocacy services available to them; yet only under-16s who are formally detained will have a statutory right to advocacy services. It is fundamental, to ensure the rights of children with mental health difficulties and learning disabilities, that advocacy services be available to all children and young people, regardless of age.

The Department also intends to create a new offence of ill treatment or neglect of those who lack capacity. As it is proposed that the Bill will not apply to under-16s unless they are formally detained, it appears that protection from that offence will not apply to under-16s. The Bill will also take account of the European Court of Human Rights judgement known as the Bournewood case, which provides for safeguards to be put in place regarding the deprivation of liberty of an individual who lacks capacity either in a hospital or care home when it is in their best interests to be deprived of their liberty. Those safeguards are designed to protect the rights of an individual from an unjustified deprivation of their liberty, as protected by article 5 of the European Convention on Human Rights. Under the Department's proposals, if a state authority intended to deprive someone over 16 of their liberty, it must justify that deprivation, and it will be open to scrutiny. As under-16s will fall outside the scope of the Bill, that provision will not apply. There will be no safeguards, including the scrutiny and monitoring of, and the need to justify, the deprivation of liberty of a person under 16. The Bournewood case made no distinction between the rights of under- and over-16s to have safeguards put in place to guard against an unjustified deprivation of liberty as protected by the European Convention on Human Rights. As the convention applies to everybody, regardless of age, there is considerable scope for legal challenge of the exclusion of under-16s from the provision due to potential breaches of the child's right to liberty.

The Bill also provides statutory recognition to ensure that the views of carers are taken into account when decisions are being made about a person who lacks capacity. As under-16s who are not formally detained fall outside the scope of the Bill, there will be no statutory recognition of the views of carers of under-16s. The Bill will provide legal protection to a person who provides care or treatment for someone who lacks capacity. As under-16s who are not formally detained will not be included within the scope of the legislation, that protection will not be available to those who provide care or treatment to someone under the age of 16 unless they are formally detained. The Bill will also make it clear that restraint will only be permitted if the person using restraint reasonably believes that it is necessary to prevent harm and is proportionate to the likelihood and seriousness of the harm. Again, that protection will not apply to those under 16 years of age unless they are formally detained.

Mr Eamonn McNally (Children's Law Centre): The Department has made it clear that the Mental Capacity (Health, Welfare and Finance) Bill will repeal the Mental Health (NI) Order 1986; therefore provision must be made to allow for the compulsory detention of under-16s for assessment and treatment of a mental health condition. However, of significant importance for the rights of under-16s is that, under the Department's current proposals, it will be disproportionately easier for a child under the age of 16 to be formally detained for assessment or treatment of a mental health condition.

Under current proposals, in order to detain a person aged 16 or over formally, it is first necessary to assess their capacity. Only once elective capacity has been established is it possible to apply the test for formal detention to that person. In the case of a young person under the age of 16, there is no

requirement to establish first that there is a lack of capacity before applying the test for formal detention. Therefore, persons over the age of 16 will have the added protection of not being subject to the test for detention if they are first found to have capacity.

The Children's Law Centre is gravely concerned that there is a requirement to be formally detained in order to access the protections of the Bill and that this may lead to situations where it would be preferable for some children to be formally detained in order to have access to the safeguards of the legislation. We have many such examples from our casework; I will relate one by way of illustration.

One client was a 15-year-old whose father was deceased; he was estranged from his mother, who had refused him re-entry to the family home. He was classified as homeless and was living in accommodation provided by the Northern Ireland Housing Executive for six months prior to attending an accident and emergency department with threats of self-harm. He was admitted to hospital, where it was decided that he would be best placed in the regional Child and Adolescent Mental Health Services (CAMHS) unit. The young person was Gillick competent and consented to that course of action. After one week's assessment, the unit discharged him.

Upon discharge, he reported to the Housing Executive to request a return to his accommodation. However, he did not understand that he would lose his accommodation while in hospital; he also did not know how to obtain further accommodation on release. As a voluntary patient, he would have had no statutory right to advocacy services while in hospital under the Mental Capacity (Health, Welfare and Finance) Bill. He did not have assistance from his parents and was not a looked-after child, so there was no corporate parent. If that child had refused to enter the regional unit by consent, he could have been detained for assessment and would therefore have access to all the protections under the Bill.

There are also worrying implications for children and young people because of the obligation on them to declare a detention for treatment of a mental health illness when they become an adult. It may be necessary to declare it to people such as an employer, to the Driver and Vehicle Licensing Northern Ireland (DVLNI) if they wish to hold a driving license, to an insurance company, and when applying for a US visa. That could create obvious difficulties with travel and work.

Several arguments have been put forward by the Department why it believes that the Bill should not apply to those under the age of 16. I will very briefly address these in turn. First is the importance of the age of 16. One of the arguments put forward for the non-application of the Bill to those under 16 has been because of the importance of the age of 16 in the lives of children and young people. We do not believe that the age of 16 is any more or less important an age in the lives of children than any other age, such as, for example, 10, which is the age of criminal responsibility in Northern Ireland; 13, which is the age at which a young person can get a part-time job; or 18, the age at which a person can vote. There are numerous ages prescribed in law when a young person can do certain things. The fact that 16 is the age for some of these is not sufficient justification for the Bill not to apply to those under the age of 16 in line with the recommendations of the Bamford review.

Second is the application of the capacity test. The Department has argued that a test of capacity cannot be applied to children in the same way as adults because of their developmental stage. The Children's Law Centre and others who work with young people believe that it cannot be concluded that capacity cannot be measured in children. Professionals such as doctors, lawyers and social workers determine capacity in those aged under 16 daily in the course of their work. The fact that capacity cannot be measured in precisely the same way as it is measured in adults does not mean that it is impossible and should not be done. We believe that the Department has assumed too readily that, because there are difficulties in assessing capacity, there should be no attempt to address it in legislation.

Thirdly, one of the Department's reasons for excluding those under the age of 16 from the Bill is due to its perceived interface with the Children (Northern Ireland) Order 1995. In the Children Order, the age of 16 is used as a threshold concept in many Children Order proceedings. However, the issue with Children Order proceedings is frequently about the location and quality of care that a child receives and the identity of those with parental responsibility. We do not believe that the Children Order provides any protection for mature minors under the age of 16 who lack capacity as a result of mental illness or a learning disability.

Finally, on the continuing application of Gillick competency, the Department proposes that the issue of capacity for those aged under 16 will continue to be determined by common law principles laid down in the case of Gillick versus West Norfolk and Wisbech Area Health Authority, more commonly known as the Gillick case. In that case, it was held that anyone below the age of 16 is deemed not to be competent to consent to medical treatment unless they fit the criteria laid down by the court. For a child to be Gillick competent under the criteria, it is necessary for him to be able to make his own decisions when he reaches sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.

If the Bill proceeds as proposed by the Department, the situation for persons aged under 16 in Northern Ireland will be that, although they may consent to surgical, medical or dental procedures, they never may refuse such treatment. We do not believe that the continuing application of the Gillick competence test to young people under 16 is adequate for a number of reasons. It is old: it is 1985 law; it is case law that can be easily overturned; it predates the Human Rights Act, the Children Order and the United Nations Convention on the Rights of the Child; and it applies only to a child's decision to consent to treatment. Evidence given to CLC by medical practitioners states that clinical practice has now moved to a position where Gillick, in its strictest sense, is no longer used by them.

The Chairperson: Thank you very much. Again, thank you for your briefing paper. Your paper states that you have been engaging with the Department on its proposals for a new framework for some years. At this stage, there is probably stalemate — my words — over what you believe should be in the Bill and what the Department believes should be in it. The Department says that it does not want to undermine the Children Order by including under-16s. Is the Department right? In the presentation you imply that it is not. Explain to us why the Department thinks that that would undermine the Children Order. What age do you think it should be?

Ms Whelehan: We do not feel that the inclusion of under-16s in the legislation would undermine the Children Order, as the order's purpose is very specific. As Eamonn said, Children Order proceedings relate to the quality and location of care that a child receives; it relates to disputes about, for example, where a child lives, about contact and residency, about a child in the care of the state and about looked-after children. In our view, the Children Order does not in any way — we have looked at this in some detail — deal with issues that relate to mental health, mental capacity or a learning disability. We are very clear about that. We can see no connection between the Children Order and the mental capacity legislation. In fact, Scotland has capacity legislation that applies regardless of age; it applies below the age of 16 without age limits. The Children (Scotland) Act 1995 is incredibly similar to our Children Order. The two co-exist without any conflict, and there is no undermining of that. Therefore we do not believe that the inclusion of under-16s in the legislation would impact in any way on the Children Order.

The Chairperson: Have you suggested an age? You talked earlier about the age of criminal consent and about the age at which a child can get a part-time job. There are various age ranges.

Ms Whelehan: We have stayed away from choosing an age. We have spoken to clinicians who have told us that this is all very decision-specific; it depends on the individual child. Based on a test that a clinician applies, a 13-year-old might be found to have capacity and a 15-year-old might not. I do not know whether you can apply an arbitrary age limit in that way. Therefore, we have stayed away from that and tend to leave it to the clinicians who make daily decisions about whether a child has the understanding to make such decisions.

The Chairperson: When we get presentations, I am very keen that the Department be here to listen to what you are saying.

Ms Whelehan: We have raised those issues with the Department; the Department knows our arguments and we know theirs. As you say, it has been difficult to get agreement, although we appreciate the ongoing engagement with the Department.

The Chairperson: Has the Department made suggestions for the future to deal with your concerns?

Ms Whelehan: One of the proposals that we are aware of is that the Department will look at a capacity project. We welcome that as a separate proposal because the evolving capacities of under-16s need to be looked at as a separate issue. However, as we say, this is incapacity legislation; it is not capacity legislation. In our view, a capacity project will not address the issues around young people who lack capacity. Although evolving capacity needs to be clarified, I see them as two very separate issues. I do not think that a capacity project will address any of our concerns about the non-inclusion of under-16s in the legislation. Our focus in the legislation is about ensuring that children who lack capacity due to a mental illness or a learning disability have access to safeguards and protections. Those concerns reflect Bamford's concerns, which were that children should be afforded the same protections as everybody else in moving the reform of mental health law forward in Northern Ireland.

In our view, the only way that very vulnerable young people who lack capacity due to mental illness or a learning disability can access protections and safeguards within the Mental Capacity (Health, Welfare and Finance) Bill is to have them included in the legislation.

Mr Wells: I was hoping that you would give us a figure. Ten years of age might have been reasonable, given that it is the age of criminal responsibility. As you are aware, this will be a massive piece of legislation. We have already agreed that those who are in custody — those who are subject to the criminal law — will be included, and that will cause huge problems. Later, the Committee will discuss the Justice and Health Committees merging to deal with it. If we throw in this additional element, is there not a danger that the legislation will become completely unwieldy and take years to process? Is this not another major departure?

Mr McNally: You are right; it is only talking about a very small section of the population. We are talking about the mature minor who loses capacity and requires protection and assistance; we are not taking about everybody under the age of 16 gaining something from this legislation. The legislation does not do that. It provides protection and safeguard for a person who loses capacity, which is a small percentage of the population.

Mr Wells: Is there not a resource problem, in the sense that those young people will, as of right, be entitled to a series of protections and services? Presumably, the knock-on impact is that that will have to be paid for.

Mr McNally: Scotland is a prime example of where safeguarding is provided to under-16s. Advocacy, for example, is available in Scotland to persons under the age of 16. Studies have shown that putting advocacy services in at a young age saves a great deal of money down the line because it assists the person when he or she needs it. Instead of waiting until people are old enough to access the service, it saves money in the long run.

Mr Wells: You have had a series of discussions with the Department on the issue, and they are not, presumably, unreasonable people. That being the case, has there been a meeting of minds on this or are you still poles apart on the issue?

Ms Whelehan: We have had good interaction with the Department. I feel that the engagement was genuine in that we tried to reach common ground. However, the difficulty is that it is our view that the only way to provide the protections and safeguards for under-16s is to include them in the legislation; we think that it would better reflect clinical good practice as well as upholding the rights of children, particularly very vulnerable young children. As Eamonn said, the number of young people concerned is small, but you either include them or you do not. The difficulty is that we have received formal correspondence from the Department stating that it has taken the decision to exclude under-16s. Our position has not changed; we think that they still need to be included, which is why we are here today to raise our concerns with the Committee and, we hope, see where we can go from here.

Mr McDevitt: As it stands, under-16s who are detained are in; under-16s who are not detained are out.

Mr McNally: That is correct.

Mr McDevitt: Does that create an incentive for young people in need to get themselves detained?

Mr McNally: We have many very vulnerable clients who stand alone and face situations in which they really need the protections of the legislation to assist them. I hate to think that I would have to say to any young person, "The only way to get a safeguard under legislation is to be deprived of your liberty through a formal detention in a mental health hospital, which you will have to declare for the rest of your life." The best example that I can think of is the ward in our Beechcroft unit for 14- to 18-year-olds. Let us say that there are two people in the same ward — one aged 16 and one aged 15 years and 11 months. The 16-year-old will be able to access all of the protections of the Bill, but the only way in which the individual aged 15 years and 11 months, who has exactly the same diagnosis as the 16-year-old, can do so is to be formally detained. They are on the same ward, being treated by the same doctor and have the same mental health condition. One cannot access the protections unless detained; the other gets them automatically because he is a month older. That is not balanced.

Mr McDevitt: The 16-year-old is not detained.

Mr McNally: The 16-year-old does not have to be detained but has to lack capacity in some form.

Mr McDevitt: So he can lack capacity but not be detained. In other words, if the 16-year-old's situation improves, the consequences for him are not those of someone who has been detained. He will not have to declare his detention under mental health legislation at some future point in his life.

Mr McNally: Article 10 of the Mental Health (Northern Ireland) Order 1986 places an obligation on people to declare detention for treatment. It seems that the new Bill will also include that obligation. Voluntary patients, however, do not have to make the same declaration.

Mr McDevitt: Your argument is that we are proposing to introduce a law that will make it better for young people in certain circumstances to get themselves detained.

Ms Whelehan: It will be easier to detain under-16s if the proposals go ahead as planned, because there will be no need to apply the first stage of the capacity test to them. As under-16s fall outside of the scope of the legislation, that part of the test will not be applied. If an under-16 needed access to any of the protections or safeguards, it would not be easy to get himself or herself formally detained, but it might be preferable, which is a huge concern for us.

Mr McDevitt: You made the point that, in your opinion, the continued application of the Gillick competence is a cop-out — those are my words, not yours — in other words, relying on case law when proper statutory provisions could be provided. I did not mishear you, did I?

Mr McNally: No. That is right. In England and Wales, they maintain Gillick. Scotland chose the different option of statute law. The best example that I can give is that there has been only one challenge to the legislation in Scotland, as far as I am aware, and, in England and Wales, there were persistent challenges to the concept of Gillick through the late 1980s and early 1990s, because it was evolving and was laid down in case law as opposed to statute law.

Ms Whelehan: We have concerns about another issue concerning Gillick. Strictly speaking, Gillick allows the mature minor only to consent to treatment, not to refuse it. From speaking to clinicians, I have heard that clinical good practice has moved on somewhat, and so we feel that it would undermine clinical best practice to fail to legislate in a manner that reflects that good practice. Medical professionals have told us that when dealing with young people, they very often have to work with them. It is about developing relationships and trust to try to ensure that a child receives the best possible treatment. Very often, that will involve respecting a child's right to refuse treatment, which, strictly speaking, Gillick does not provide for. Therefore, failing to legislate in a way that reflects good practice and its development over past years would make doctors and health professionals vulnerable and undermine existing good practice. That is another major concern about leaving Gillick in place.

Mr McCarthy: Thanks for your presentation. I am concerned about under-16s with learning disabilities. You explained how you view their position. In your briefing paper, under the heading, "Application of the Capacity Test", you state that exclusion of under-16s is:

"in conflict with the Bamford recommendations and in breach of the UNCRC."

The Bamford review was hailed as the be-all and end-all, because everyone affected by what we are talking about today participated. This throws that on its head. Will you explain that?

Mr McNally: Bamford examined Child and Adolescent Mental Health Services and produced several reports, one of which was a comprehensive legislative framework. In that was the recommendation to give great consideration to a rebuttable presumption of capacity in those under the age of 16. Somewhere in the process that seems to have been forgotten about, for want of a better way of putting it. However, Bamford recommended that we consider such a presumption.

Mr McCarthy: Yes, so what we are talking about is in conflict with Bamford.

Ms Whelehan: Our concern is that, if the legislation does not apply to under-16s, Bamford will have delivered nothing for that age group.

Mr McCarthy: That is very worrying.

The Chairperson: Jim mentioned criminal justice, but where do young people being cared for by the state sit? Is there a special provision for them?

Mr McNally: There is not a special provision for them. Under the Gillick rules, the corporate parent —

The Chairperson: That would be the state.

Mr McNally: — would be the state, and the consent would rest with social services. Our experience is that there can be disagreement between the young person and social services, but we have a situation in which Gillick states that the young person may consent but not refuse. A young person's refusal can be overridden by the parent, and, in that case, the state would be the corporate parent. It does not sit well to leave that situation in place. In fact, doing so could lead to a legal challenge.

Ms Whelehan: Some years ago, for example, a child in state care came across a leaflet from our advice line, which we call Chalky. At the time of writing to us, she was in the care of the state at Muckamore, but detained. She wrote to us, through Chalky, wanting her placement to be reviewed. As she did not have anybody to advocate for her, that was how she got in touch with us. She was in that strange position of being in the care of the state but also in a state facility. She was in the very vulnerable group of young people to whom it is essential that the legislation is applicable. Otherwise, they could be in the difficult position of not having somebody acting on their behalf. That is where an advocate would be vital.

Mr Brady: Thank you for your presentation. Is the Gillick case legally binding in the North or is its outcome used as guidance?

Mr McNally: It is a House of Lords judgement, so it is a read-across to, and legally binding in, Northern Ireland.

Mr Brady: Is it legally binding here?

Mr McNally: That is the danger with case law: another case may be pending in the House of Lords that could override Gillick tomorrow. We could proceed down this line and depend on prevailing case law that could disappear in six months' time.

Mr Brady: That could put in place a completely different scenario.

You mentioned other ages such as 13, 18 and 10. Is the Department picking 16 in an almost arbitrary fashion? You gave the example of someone aged 15 years and 11 and a half months not having the same rights as a 16-year-old. It is almost as though date of birth will determine whether the legislation applies, and, in those circumstances, that seems fairly arbitrary and inequitable.

Ms Whelehan: We think that the age of 16 has been chosen for the Bill because that is the age that applies in England.

Mr Brady: Yes, but we have a different age of consent here, which is 17, so what logic or rationale is being applied?

Ms Whelehan: That would be our argument. Sixteen is an arbitrary age that reflects the position in England. One of the things that we have done very well with this legislation is that we have charted our own course, if you like. It is a single Bill, and it should be the best that it can be for everyone in Northern Ireland and for all our children and young people.

Mr Brady: Particularly in light of the Bamford review, which is often talked about but never, as far as I am aware, entertained.

The Chairperson: You also mentioned the practical safeguards that over-16s can access. Will you give us some more information about that?

Mr McNally: The first safeguard would be advocacy services. The statutory right to advocacy services applies only to those aged 16 and over. The second is that there will be a new criminal offence of maltreatment of someone who lacks capacity, which appears to be available only to those aged over 16 who are not formally detained. There is a statutory recognition of the views of carers, which, in most cases, will be the parent. Those views will not have statutory recognition in the case of under-16s.

The deprivation of liberty safeguards are put in place when someone is deprived of their liberty, not through formal detention but because the person is being compliant. It would, for example, be very common in learning disability cases. There is a protection available to a person who provides care and treatment, either a parent or a medical professional, which it appears will not be available to those who provide care and treatment for under-16s. Those are the main protections in the Bill.

Mr McCallister: I want to follow up on the Chairperson's point about advocacy services. Eamonn, would a parent or carer be able to access those services, presumably for over-16s, on their behalf?

Mr McNally: As far as I am aware, the parent would also have to lack capacity to be able to access the advocacy services. Very often, we find ourselves in a situation where, for most of the children for whom we act, it is the first time that the parents have encountered the mental health system and do not really understand it. It is essential that their children are able to access those services. The parents are trying to guide their child through a system with which they are unfamiliar, do not understand and have not had any dealings with. There are examples of cases in which the automatic referral has come from mental health detention after one year, but the parents have not even realised that they had the right to challenge it before the year was up, because they did not know about it. If the child had access to advocacy, that could be explained.

Mr McCallister: Do you see any advantages in not including under-16s? Why are we not doing so? You are saying that they are not entitled to any advocacy and would not be anywhere close to having the same safeguards as those aged 16 and over. That just seems wrong.

Ms Whelehan: We see no advantages in excluding under-16s from the legislation. Rather, we think it vital that they are included. We are not saying that it will be easy to include under-16s, but it is possible, and it has been done in Scotland, where the capacity legislation applies regardless of age. As we said, health professionals make decisions about capacity daily when dealing with young people. It would not be the most straightforward process, but it can be done. We believe that it absolutely

should be done and that it is totally justified, given what those young people who are included can access under the protections and safeguards in the legislation.

Mr McCallister: Do you think that that is the main reason why they are not included — because it is just too difficult? I will ask the Department that. *[Laughter.]*

Ms Whelehan: That would be better.

Mr McCallister: It is a key issue, because we have been working on the assumption for a good while now that under-16s would be included. I think it important to highlight that this is not a good way to proceed with huge and important legislation. If there is some great reason why under-16s are not being included, I would like to hear it from the Department.

The Chairperson: Your briefing paper and presentation have been very useful, so, on behalf of the Committee, thank you.

Ms Whelehan: Thank you very much. We will make a copy of our presentation available by sending it to the Committee Clerk. Thank you for the opportunity.