Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Mental Capacity (Health, Welfare and Finance) Bill: Departmental Briefing

9 May 2012

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Ms Christine Jendoubi	Department of Health, Social Services and Public Safety
Ms Alison McCaffrey	Department of Health, Social Services and Public Safety
Mr Patrick McConville	Department of Health, Social Services and Public Safety
Ms Patricia Nicholl	Department of Health, Social Services and Public Safety

The Chairperson: I welcome the witnesses from the Department. I am delighted that you sat through the presentations from the Children's Law Centre and the commissioner, so you are aware of the issues. Christine, I take it that you will lead. If you introduce your team and make the presentation, we will open it up for questions and comments. Thank you very much for the information that you sent to the Committee on this important topic.

Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): Thank you very much, Chairperson. From your left to right are Alison McCaffrey and Pat McConville from our legislation unit — they are involved in the drafting of the legislation — and Patricia Nicholl from the office of social services, who is happy to talk to you about Children Order issues and the access that children already have to advocacy services in the system and under the legislation. I apologise for the length that the presentation is likely to be. This is a hugely complicated issue, so we felt that we needed to do it justice.

Thank you for the opportunity to discuss the Mental Capacity (Health, Welfare and Finance) Bill and, in particular, the question of its application to those under 16. I understand that members would like to know more about the relationship between the proposed statutory right to an independent advocate in the Bill and the Department's policy guide for commissioners on developing advocacy services, which we will publish next Monday. I will say a few words about that towards the end.

The Chairperson: We will allow you time to deal with that separately. If you deal just with the Bill, we will come back to that issue.

Ms Jendoubi: I will give an overview of the Bill's key provisions to put into context the main issue of children under the age of 16. It is important to make it clear that the main aim of the Bill is to put in place a system of substitute decision making for people who lack capacity to consent to an intervention in their lives such as a health treatment. The Bill, as drafted, is not about recognising emerging capacity in children. The Bill will be complex and substantial, but it will employ two key devices to achieve its aim.

First, the Bill will provide for a presumption of capacity similar to that in the Mental Capacity Act 2005, which is, broadly speaking, based on the current, somewhat complex, law on consent. That will require, among other things, that people are assisted to exercise their own mental capacity to make decisions where they can. That means that a person to whom the Bill applies will be presumed to have capacity unless it is established otherwise. It is only where it has been established that a person does not have capacity that the Bill and its safeguards will apply. Therefore, if a person has capacity, the Bill's only application to them is that it will protect their right to take decisions, even decisions that others, including their clinicians, would regard as bad or unwise.

It is important to emphasise that, because it is that fundamental provision of a presumption of capacity that the Department believes cannot be applied to those under 16 until we have had a full debate about the issue of emerging capacities in children and the associated issues around parental responsibility. That is a complex issue in its own right. I will say more in a minute or two about why we think that this is the case and why we think that it needs to be considered separately from the Bill.

As I said, when it is established that a person lacks capacity to consent to an intervention — that could be due to a stroke, mental illness or learning disability, for example — and no alternative decision-making arrangements, such as a power of attorney, have already been put in place, the main provisions of the Bill apply and, specifically, the second key device comes into play.

That device is the provision that will put the common-law defence of necessity into statute. It will provide that, where an intervention is to be made on a person's life around their health, welfare or finances that would otherwise require the consent of that person, the person intervening would be protected from civil or criminal liability to the extent that they would have been protected had the person had capacity and consented. This protection from liability can, however, be relied on only provided that it has been established that the person lacks the mental capacity to consent and provided that the safeguards included in the Bill had been met. It will not protect a person who intervenes from any liability arising out of a negligent act.

The approach to safeguards is one of reciprocation, which is another key concept in the Bill. The safeguards — which go further than the safeguards currently available under common law — reflect the nature and seriousness of the intervention. The more intrusive the intervention in the life of the person lacking capacity, the greater the safeguards that will need to be met. The fundamental safeguard that will apply to all interventions is that it must always be in the person's best interests. Other safeguards that will apply to the more serious interventions include the appointment of and consultation with nominated persons and independent advocates.

I turn now to the main focus of today: children under the age of 16. It is important to state that, as the Children's Law Centre said, the Department has spent substantial time over the past few years considering the issues raised by the Children's Commissioner and the CLC. Indeed, it has been considering those issues with the CLC over recent months. As Bamford recommended, this included consideration of a rebuttable presumption of capacity in children aged between 12 and 15. However, the outcome of that work, as reflected in the Minister's recent letter to the Committee, is that, without first doing further work on the recognition of emerging capacities in children under the age of 16, it would not seem prudent to put into the Bill something that would have a significant impact on existing substitute decision-making arrangements for children, and on existing law relating to children and parental responsibility, without an in-depth consideration of its wider effects.

This is a complex issue that, in our view, needs separate consideration at this stage. It is complex because it is based in a complex area of law involving common law, statute, emerging case law and the courts' inherent jurisdiction. I will attempt to outline some of the complexities.

Fundamentally, the Bill is about the ability of a person to consent to someone else doing something to them that requires their consent; it therefore has to take account of who can give that consent in law. Starting with those aged 18 and over, the only person who can give consent to an act is that person; any intervention without that consent could attract civil or criminal liability. To avail of the defence of necessity in the Bill, the person intervening must first believe that the person lacks the capacity to consent, they must undertake the intervention in the best interests of the person, and must appropriately apply the other safeguards in the Bill.

Various areas of law already recognise the right of 16- and 17-year-olds to make important decisions for themselves; for example, to leave school or to leave home, as the Children's Law Centre said. It is therefore appropriate that the presumption of capacity and the other safeguard provisions in the Bill will apply to them. However, the absolute nature of consent applicable to those aged 18 and over is diluted to an extent for those aged 16 and 17 because other statute law makes provision in respect of this group. For example, a 16-year-old may not drive, and a 16- or 17-year-old cannot enter into a binding contract. The Children Order provides that parental responsibility for 16- and 17-year-olds remains to some extent and is applicable in certain circumstances. The presumption of capacity for this group is therefore limited to a degree by the provisions of other legislation.

For a person under 16, the situation is radically different. Here, the Children Order says that the person who can give consent on behalf of the under-16 is the person exercising parental responsibility. The order goes on to provide that all decisions that are made by the parent must be in the child's best interests and that the voice of the child must be taken into account; however, it does not give to the child the right to make the decision, nor, indeed, does article 12 of the UNCRC. There are some exceptions, the principal one being the Gillick case, which recognises the right of a Gillick-competent child to agree to medical treatment. As both previous presentations mentioned, that is diluted by the fact that the Gillick decision did not permit the competent child to refuse medical treatment.

To extend the statutory presumption of capacity below 16, even as far as 12, and, therefore, the right to consent, would create fundamental issues that require to be considered more fully and openly as they would change the central tenet of society that parents make decisions for their children. It is for this reason that the Minister proposed a separate project to consider the recognition of the emerging capacity of those under 16. A most significant question that will have to be addressed bt this project has to be what effect a lowering of the age of capacity would have on parental responsibility. Also requiring consideration will be the impact that lowering the age limit would have on other areas of law, such as the Age of Majority Act (Northern Ireland) 1969, other age-related legislation, and case law such as Gillick. As I have already said, these are complex issues, some of which fall outside the immediate scope of the Bill and my Department, and we are starting by making arrangements to get all relevant officials from other Departments with responsibility for the law in these areas around the table soon to consider how best this can be taken forward.

The outcome of the project might well be that consideration should be given to extending downward the presumption of capacity in, perhaps, a defined range of circumstances; that could result in a subsequent change to the Bill — or the Act if the Bill has been enacted by then. It is the Department's view that, until the implications of this are considered, it would not be right at this stage to propose a change to the lower age limit or to have no age limit, which would have a substantial impact in other areas, especially the area of parental responsibility.

For completeness, I should also address some of the other points in the Bill relating to children under 16. As has already been said and as we mention in the briefing paper, we have to make provision in the Bill for a small number of under-16s. Those are the young people who require compulsory treatment for mental illness and who are currently dealt with under the Mental Health (Northern Ireland) Order 1986, which the Bill will revoke. In making treatment compulsory for mental illness, the Bill says that one of the criteria that will have to be met is a determination that the person lacks capacity. For the reasons that I have already explained, that criterion cannot be applied when the need to detain a child under 16 arises. Therefore, the Bill will provide for different criteria concerning the risk that the child presents to himself or herself and/or to others and around necessity: when there is no way of dealing with the child other than by detention. Any child detained for the treatment of mental illness under the Bill will have access to all the safeguards that the Bill will provide for a person aged 16 or above being dealt with in the same way.

Furthermore, the child under 16 will also have additional safeguards around the need to be treated in an age-appropriate environment and to have access to the same educational opportunities as children in the general population. Therefore, although it is true to say that, under the Bill, the basis upon which a child under 16 may be detained is different from that of a person who is aged 16 or above, it is not right to say that it is easier to detain the child. The criteria are different because the lack-of-capacity criterion cannot be applied. Nor is it right to say that it might be better for a child to be detained for the treatment of mental illness rather than to be dealt with as a voluntary patient. For clarification, a voluntary patient in these circumstances is one who either has Gillick competence to agree to the treatment or who does not have that competence but whose parents have agreed to the treatment. The Bill will not create a situation in which it would be preferable for a child under the age of 16 to be detained. It will not be for the patient to choose, or for a parent to choose on a patient's behalf, to be detained. Rather, it will be a doctor's decision that the criteria of risk and necessity have been met. The serious consequences of compulsory treatment mean that the option would be considered only as a last resort. We question whether the scenario painted by the Children's Law Centre would ever arise, given the wider implications of being detained, which it, in fact, demonstrated.

It has also been suggested that the Department's proposal to apply the Bill to those aged 16 and over is not compliant with the requirements of the UNCRC. Although the convention is not part of domestic law, it has been ratified by the United Kingdom and is an important persuasive influence on the development of government policy as it relates to children and in the deliberation of courts when considering human rights issues. That persuasive influence led the Department to seek legal advice to ensure that its proposal to apply the Bill to those aged 16 and over was compliant. That advice confirmed that the Bill is compliant with the convention. That is also confirmed in the other legislative jurisdictions, which have already applied the same age limit.

I will stop there. We are happy to take questions.

The Chairperson: Thank you, Christine, for your presentation. I have just a couple of points. You ended with the Department's receiving legal advice that the Bill is compliant with the UNCRC, but we have heard from others who believe that it is not. There we have an issue: some organisations believe that the Bill is not compliant, whereas the Department believes that it is. We need to tease that out a bit.

In an earlier presentation, we heard about Bamford. You mentioned the study of capacity in children. The Bamford review was published a long time ago, so why have you waited until now to carry out that study?

Your final comments on compliance with the UNCRC were based on what happens in different jurisdictions. However, we were advised earlier that capacity legislation in Scotland deals with the under-16s. Why can we not consider that option?

Ms Jendoubi: I will take those questions in order, Chair.

It is important to remember that article 12 of the UNCRC does not give children the right to make decisions about matters that affect their lives; it gives them the right to have their voice heard. That being the case, nothing in the proposed legislation is inconsistent with that. Decision-making and procedural mechanisms are already in place for children, including those in care, under the Children Order, and they ensure that children have their voices heard at all relevant stages of the process. The Bill will cover those under compulsory detained treatment. For those reasons, we do not feel that the Bill is inconsistent with article 12 of the convention.

Sorry, Chair, will you remind me what the second issue was?

The Chairperson: You mentioned the study of the capacity of children. It is years since the Bamford review was published, so why was the study not carried out then, and what impact will it have on what Bamford was supposed to achieve?

Ms Jendoubi: To be honest, that issue has never gone away. It has been discussed backwards and forwards for years since we started working on the Bill, and it simply has not reached resolution because it is such a complex and finely balanced issue. It is not that we think that the issue of emerging capacities in young people is not important. In fact, the Minister did not state in his letter to the Committee that the Bill would not apply to children. Rather, he said that it could not be applied to children in the same way as it could be applied to adults, and he proposed the setting up of this separate project.

As the area is so complex, we need to tease out the issues fully and understand what they mean. What would it mean to introduce a presumption of capacity in everybody below the age of 16 in matters concerning their health and welfare? What would that mean for the small minority of capacitous minors in situations with which the Children's Law Centre deals? It would be a presumption of capacity for all children, so you have to tease out what that would mean for everyone's parental responsibility and what the provisions would be for children in care. As I said earlier, Patricia will be happy to talk to you about access to advocacy services and how the current system should work for children under 16 in that kind of situation.

The Chairperson: Has Scotland not already done that?

Mr Patrick McConville (Department of Health, Social Services and Public Safety): I can answer the question about Scotland. There has been a slight misconception. The Adults with Incapacity (Scotland) Act 2000, which is the equivalent of our Bill, has a 16-year-old limit, which is the same as what we propose. The issue to which the Children's Law Centre referred was the age of legal capacity legislation in Scotland, which was amended and codified Gillick in statute law. That effectively allows for a child under 16 years of age to agree to medical treatment. That is already in the law here as part of common law. The difference is that it is in common law here and it is in statute law in Scotland. However, the mental capacity legislation in Scotland has the same age limit as the one that we propose.

Mr Brady: Thanks for the presentation. I have a few questions.

You said that the Department came to the view that the rebuttable presumption of capacity in children under the age of 16 was not a workable option. You made a fairly sweeping statement that the vast majority of children under the age of 16 are unlikely to have capacity in relation to important decisions that need to be made in respect of them, not because they have an impairment or disturbance in the functioning of their mind or brain, which is the test in the Bill, but because they simply lack the maturity to do so. As was asked earlier, what is the difference between someone who is 15 years and 364 days old and a 16-year-old? That is a presumption. What you are saying is that Bamford simply made a recommendation. Bamford made many recommendations. Unfortunately, none of them, to my knowledge, have been put into operation. You are saying that it is not appropriate to put that into a legal framework.

From listening to the previous two presentations from experts in their fields, my personal observation is that the Department seems to be saying that it knows better. The Children's Commissioner said that she could not make any decisions on legal action to rebut. Surely there has to be a consensus to avoid that kind of situation, because the interests of children are paramount. It seems to be a total waste of time, effort and money if you cannot come to some consensus. We are dealing with people who know what they are talking about, yet the Department is saying, "We accept what you say up to a point, but we will not put that into the legislation."

The Children's Commissioner also mentioned the lack of deprivation of liberty safeguards for under-16s. That seems to be a breach of the rights of under-16s under the convention and means that it will be possible to deprive under-16s of their liberty without justification. What safeguards does the Department intend to put in place to rectify that situation? Has that been thought about?

Ms Jendoubi: In the Bill, the definition of lacking capacity will be an "impairment of, or disturbance to, the functioning of the mind or brain." It will not be that a child is not mature enough to take a decision. Once the definition of capacity is changed, we get into the whole business of asking in which fields capacity can be exercised and how that affects a parent's right to take decisions for his or her child.

As for whether the age should be 16, 15 and a half, or 15, when setting a threshold for when people are allowed to do things, that can be debated. You can get a driver's licence at 17 years and a week, but you cannot get one at 16 years and 364 days — that is just where the line is drawn. The age of 16 seems to be — the Children's Law Centre did not particularly like this argument — the age by which, by common consent in society, we assume that children have the capacity to take a good few decisions about how their lives are run. We can argue whether that age should be 15, 16 or 12. However, in every case, whether to fix a limit at all and where any limit should be fixed requires a consideration of how it affects parental responsibility.

I understand that the Children's Law Centre concern is primarily about a very small group of mature minors who, in the main, are caught up in the mental health system in some form and do not have anyone else to speak for them. For a start, that is not the way in which the Children Order is supposed to operate. The system is not supposed to allow children to find themselves in that position. Patricia can talk more about that. As an observation, I think that, if a statutory system is already in place, we need to look first at why it is not working in the way that it is supposed to and fix it if it is broken, rather than overlaying it with fresh legislation, the implications of which we are just starting to fathom. If it is broke, fix it. That is the first avenue that we should seek to go down.

Mr Brady: You mentioned that, in society, 16 is the benchmark. Yet, in our society, the benchmark for consent is 17, so there is a difference.

Ms Jendoubi: According to the Children's Law Centre, the benchmark is 16.

Mr Brady: There was some discussion about that here before, and the age of consent was understood to be 17. It certainly was 17 previously.

Mr McConville: The age of consent to what?

Mr Brady: Sex.

Ms Jendoubi: It is 16.

Mr Brady: Sorry, it must have changed.

My other question is about capacity. If there is rebuttable presumption, is that done in terms of a medical assessment?

Ms Jendoubi: It would depend on what the decision was.

Mr Brady: I presume that it is the mental capacity to make a decision.

Ms Jendoubi: It would depend on what the decision was. If it concerned social care, I do not expect that children would be referred to a clinical psychologist, for example, to determine whether they were capable of making that decision, because professional social workers would provide the intervention.

Mr McConville: It is wrong to say that the Department's approach is one of saying that it knows best. The way in which we have gone about this and our level of engagement with the likes of the Children's Law Centre and a wide range of other interests is unprecedented. It would not be fair comment that the Department is just sweeping this aside, because it has spent a lot of time looking for consensus on this and in other areas.

When we talk about deprivation of liberty cases, we talk, in the main, about people who have advanced dementia, are very difficult to handle and must be restricted and restrained to such an extent that they become deprived of their liberty, under the terms laid down in the European Convention. We have been told by the European Court that we need to do something about that, as we cannot allow that situation to go unauthorised. So there has to be an application process, an authorisation process, and a person or a person's nominated representative has to have some right of review at a court. Deprivation of liberty is aimed mainly at tackling dementia in older people. The Bill will place a responsibility on the manager of a facility to identify such cases and to do something about getting them authorised. That will apply all the way down to those aged 16 and over. Generally, however, that type of provision will be aimed at much older people with dementia.

As for why the Department is creating a gap by not covering under-16s, it should be remembered that this power is held not in a domestic situation but in an institutional setting. Generally, when we talk about children who will be affected, we are talking about those who are looked after by the state in a children's home or secure accommodation. The Children (Northern Ireland) Order 1995, to a large extent, provides the required safeguards and meets the standard set by the European Court's judgement on the Bournewood case, by providing for constant, ongoing judicial oversight of the management and care of children being held in circumstances that may equate to a deprivation of their liberty.

Mr McDevitt: At this stage in this process, the question to ask is this: why are you afraid of having the debate about under-16s now? What are the issues? Christine, you keep referring to all these "issues" and "questions". Outline to me five issues that you are scared of debating in the relatively short time available to us to work through the legislation.

Ms Jendoubi: We are not afraid of the debate. We are afraid of bringing in legislation that would allow your 14-year-old child to say to you, "I do not want to go to this school, I want to go to that school", and be able to hire a solicitor and take you to court to force through his or her will. Children under 16 might decide that they no longer want to live with their parents; they want to live with their grandparents.

Mr McDevitt: OK, let us take just those two examples: how, specifically, would a mental capacity Bill confer those rights on a child? How would the legislation be so permissive that, by codifying Gillick and other guidance, you would end up granting to children of 14 the rights that you described?

Ms Jendoubi: The Bill cannot extend safeguards to people who lack the capacity to make a decision without according them, or presuming that they have, the capacity to make that decision in the first place.

Mr McDevitt: "That decision" does not mean every decision. The age of consent, for example, is 16, and instils in children the right to make a decision about their body, but it does not extend a franchise to them.

Ms Jendoubi: Exactly.

Mr McDevitt: Therefore, it is quite easy to form legislation that is highly specific in affording rights to some people. It is quite easy to do. You do it all the time. I would understand if the legislation in question was constitutional, huge and pervasive, but it is not; it specifically concerns mental capacity.

Mr McConville: It is about the mental capacity to make decisions about health treatment, welfare and finances.

Mr McDevitt: Yes, but Christine gave two examples, neither of which as to do with —

Ms Jendoubi: They were to do with welfare, and they would be covered by a presumption of capacity in the Bill.

Mr McDevitt: And you could not restrict it, for example, to mental health issues, rather than to welfare?

Ms Jendoubi: We can certainly look at that. That is Gillick done better, because we would want to look at the capacity to refuse treatment as well.

Ms Alison McCaffrey (Department of Health, Social Services and Public Safety): That is one of the issues that we want to examine as part of our wider separate project.

Mr McDevitt: I appreciate that, Alison. My second question is this: why not codify Gillick?

Ms Jendoubi: That is an option.

Mr McDevitt: So why do you propose not to?

Mr McConville: We put the codification of Gillick to the Children's Law Centre in talks over the past few months, but its representatives did not think that it went far enough. What they wanted was not a limited ability for under-16s to make decisions on health treatment but a much wider concept that allowed them to make decisions on matters that extended well beyond health.

The Chairperson: You do not cut off your nose to spite your face. It was a step in the right direction.

Mr McDevitt: Yes. It sounds to me as though you are adopting the position that you cannot do everything and, therefore, will do nothing.

Mr McConville: No. We said that there is a major issue with the emergence of capacity in those under 16 years of age, and we need to consider it in much more detail.

Mr McDevitt: Let us explore the codification of Gillick. None of us is expressing an opinion on whether it is a good idea or a bad idea, but could it be done?

Mr McConville: Yes.

Mr McDevitt: How easy would it be?

Mr McConville: We could amend the age of majority legislation that limits the ability of a child below 16 years of age to agree to medical treatment. The reference to 16 or 17 years of age could simply be removed, which would allow any child to make the decision, as long as he or she had the competence to do so.

Mr McDevitt: Give us a good departmental policy reason why you would not do that in this Bill.

Mr McConville: It does not meet the concerns of the Children's Law Centre —

Mr McDevitt: No. Give me a departmental reason, a good policy reason. Forget about the lobbying.

Mr McConville: Contrary to some views, we are looking for consensus, so we want to bring the Children's Law Centre along with us. We thought that the way to do that was to widen the scope to a project that looks at the wider emerging capacity of children under 16, rather than narrowing it down to —

Ms McCaffrey: A piecemeal approach.

Mr McConville: Yes, a piecemeal approach.

Mr McDevitt: I suppose that what I am hearing is that there is no good policy reason why you would not do it.

Mr McConville: You are not hearing that from our side. That is not what I said.

Mr McDevitt: I am trying to establish your position.

Ms Jendoubi: No one has specifically asked us to codify Gillick and include that in the Bill.

Mr McDevitt: That is not my question. Is there a good reason why you would not want to codify Gillick and put it into legislation?

Ms Jendoubi: It would alter the nature of this Bill. That little add-on would differ from the purpose of the Bill, which is to provide substitute decision-making for people who lack capacity, not to extend the capacity for people to take decisions. It would be an issue of emerging capacity. That is not to say that it could not be done, just that it is inconsistent with the thrust of the Bill as it is being drafted.

Mr McDevitt: I understand that. That is an administrative answer, and I appreciate that.

I genuinely do not know the answer to my next question. What of the cohort of under-16s who are detained? They will fall under the Bill as it stands today. If, for argument's sake, I had a 14-year-old and he or she was detained, what role, as a parent, do I still have? What responsibilities do I still have over that young person?

Mr McConville: At present?

Mr McDevitt: Yes.

Mr McConville: At present, the decision to detain your child is not yours. One reason for detaining a child is either that he or she is Gillick-competent and refuses to agree to treatment that a doctor deems necessary, or a child is not Gillick-competent and the parent refuses the treatment. In that case, the Mental Health (Northern Ireland) Order 1986 allows a doctor to step in, as long as there is a substantial risk to the child or to other persons and there is no way of dealing with the child other than by necessity. The state could override the right of the parent to say no in that situation. A clear statutory provision allows a doctor to do that.

Mr McDevitt: There are plenty of occasions on which the state overrides parental responsibility for children below the age of 16. There are situations in which that happens. It is not an absolute —

Mr McConville: Clearly, there will be situations that require the state to step in if it is of the view that the parent is not responsibly exercising his or her parental responsibility.

Mr McDevitt: That is well codified, and there are lots of tests in place. The state does not have a pervasive right; it is not allowed to dictate other aspects of my child's life. The tests are specific, and there is plenty of statute, not case, law, which lays that out crystal clear.

Ms McCaffrey: It has to be necessary and risk based.

Mr McDevitt: It goes back to the basic argument. There is plenty on which to build. The question that I still do not quite understand and to which I am not getting an answer is this: "Why are we having this debate now?" How many years is it since the Bamford review was carried out? This is a major Bill that impacts not only on your Department but on the Department of Justice and other Departments. Why are you not being ambitious for this legislation? Why are you not allowing us, as your legislature, properly to test the arguments concerning children below the age of 16? Why are you taking such a cautious approach?

Ms Jendoubi: We have not fully worked through the implications of what it would mean to introduce a presumption of capacity in people under the age of 16.

Mr McDevitt: You could codify Gillick, though. That is straightforward and has been done in loads of other jurisdictions. You said that there would be no problem doing that.

Ms Jendoubi: Yes, we could codify Gillick, but it would change the nature of the Bill ever so slightly. Also, it would not satisfy the people who want to see what this debate is about, which is the safeguards that the Bill introduces for under-16s. Our belief is that the current system, as it stands, has safeguards in place for people under 16, and if those safeguards are not working properly, we need to do something to fix the way in which the system currently works. The project studying emerging capacities in young people will consider the Gillick competence and how that is recognised. My personal view is that, if we go as far as wanting to put something equivalent to Gillick into legislation in Northern Ireland, it should include the right to refuse as well as consent to treatment. However, we would want to have a debate about whether that recognition of capacity in young people should be extended to other areas of their lives. If it were found that it should be, one should consider the arguments for it and the arguments against. Such issues as how it would affect parents' relationships with their children and the state's position of having parental responsibility need to be properly worked through and, subsequently, put out for public consultation.

Mr McDevitt: The Chair is insisting that I ask one last question.

The Chairperson: I am not.

Mr McDevitt: You consistently answer as though legislation was invariably permissive and the law of unintended consequences invariably kicked in. All of you are senior civil servants and experienced policymakers. More often than not, legislation does not trigger the law of unintended consequences. The Scottish codified Gillick, and that has not led to all sorts of encroachments on other aspects of children's rights. Is that correct?

Ms Jendoubi: Yes, so I understand.

Mr McCarthy: Once again, I am very disappointed. The Bamford review has been about for eight, nine or maybe 10 years, and we are starting to see it unravel. I am very disappointed, as will be many of those who contributed to that review. However, we will see as we go along. Christine, you mentioned safeguards. What about someone under the age of 16 who has a learning disability and is in hospital? There is a distinction between those who are voluntary patients and those who are perceived to be compliant with the arrangements. What about the concern that a young person who ceases to be compliant may be automatically detained?

Ms Jendoubi: You say "automatically detained" as if that were a simple thing.

Mr McCarthy: It is a possibility.

Ms Jendoubi: Yes, it is a possibility, but it would not be simple. Whether or not that child had learning disabilities, the child's clinician would need to be convinced that the treatment being resisted was in his or her best interests, there was no alternative and that it was absolutely necessary. The two key criteria used for under-16s are risk and necessity. I mentioned necessity, and the risk criterion means that there must be a risk of harm to the child, or, although less likely, harm to other people, if he or she does not have treatment. Those criteria must be met before a clinician will consider detaining a child.

Mr McCarthy: What about the Department pulling out of the Bamford recommendations that we all were so excited about at the time?

Ms Jendoubi: Are you talking specifically about Bamford's legislative recommendations?

Mr McCarthy: Yes. Absolutely. We all thought that Bamford was the way forward. Are you now retracting?

Mr McConville: The Bamford recommendation was that the Department "consider" applying capacity legislation to those aged from 12 to 16. It did not tell us to do that. The Department has given the matter detailed consideration and arrived at the conclusion that, at present, it prefers to consider the implications for other areas of law and life before making a final judgement.

Ms McCaffrey: The Bamford review recognised that it was a particularly complex area of law and a particularly complex area to deal with in the context of mental capacity legislation. In doing so, it also recognised the strengths and benefits of the alternative substitute decision-making arrangements that are currently in place in law for children through the Children Order. It further recognised that the safeguards available in the Children Order are very similar to the types of safeguards — best interest, reciprocity and the voice of the child being heard — that we propose to include in our Bill.

The Chairperson: We can go around the houses again, and we can all play with words, but the Department has a statutory and moral duty to deal with these issues. I am in no way saying what way the Committee will go on this, but we need to be careful about saying that Bamford "suggested" things. Bamford suggested much that we, as political representatives, believed would make a difference in our constituencies. The purpose of today's session is to try to tease out some of the other issues so that we have all the information to enable us to come to a mature decision. Whatever the Children's Law Centre and Children's Commissioner say, we have a responsibility to make that decision on the basis that we have to justify it to our constituents and ensure that they get the best possible support. The emerging capacity project was mentioned a few times. Does that mean that, when that information comes out, there will be a possibility of amending the legislation further down the road?

Ms Jendoubi: Yes.

The Chairperson: That is useful. So you may decide to stick with what you are saying, but if information comes forward that goes against what you are saying, the legislation can be amended?

Ms Jendoubi: Yes.

Mr McCallister: There is a huge debate on all these issues. I take on board Conall's point, and it seems worth looking at whether to incorporate Gillick in the Bill. That seems to be quite a sensible approach. You considered an extension to under-16s but decided that it would be terribly difficult and open up a range of problems. You used examples of children wanting to live with granny, get rid of their parents in some way or live elsewhere. You have a separate project to consider emerging capacity. On what basis do you envisage that happening? What status will that project have? Do you envisage that getting to the stage at which you incorporate it in the legislation, or will it lead to guidelines?

Ms Jendoubi: Our intention is to get round the table every Department with responsibility for legislation on the age at which children can decide to do things for themselves. We intend to discuss with them whether emerging capacity has been an issue for them in their sphere of responsibility, examine the implications of competence for various legislation currently in place and draw up proposals that would be legislatively workable and acceptable to the Minister, because he will decide how the Bill is introduced. If he is agreeable, we will put the proposals out for public consultation. We will consider the responses to that and produce proposals for what might be included in the legislation.

Mr McCallister: In the one Bill? Do you not envisage separate legislation? It should be borne in mind that the Department has been working on the Bill for several years.

Ms Jendoubi: Yes.

Mr McCallister: We still do not have a date for its introduction. That is still a long way off.

Ms Jendoubi: Yes, and, from that perspective, that is probably a good thing. The Bill was to have gone forward in December of this year, but the exercise for the under-16s will probably extend beyond that date, so an amendment to an Act might have been required. However, now that we have the composite Bill with the Department of Justice, it will be introduced a year later, which should give us plenty of time to complete the exercise and arrive at an opinion on what, if anything, for under-16s should go into the Bill. The people of Northern Ireland may turn out to be quite conservative in what they want to be included in legislation on children's capacity to take decisions for themselves.

The Chairperson: Your Department is further on than the Department of Justice.

Ms Jendoubi: Yes.

The Chairperson: Do you have a timeline for the completion of the project on capacity? If the results were to become available during Committee Stage, we might decide to propose an amendment based on that information.

Mr McCallister: That could be as a Committee or as individuals. The Minister will not have complete control over the final product.

The Chairperson: When do you hope to have that information?

Ms Jendoubi: If the composite Bill is to be introduced by December 2013, we should have incorporated the fruits of that exercise by then.

The Chairperson: Are you talking about the emerging capacity project?

Ms Jendoubi: Yes. It should not take more than 18 months.

Mr McCallister: The current target for reaching agreement on how to balance members' comments and concerns is 18 or 19 months. I take Conall's point that we have not expressed a view either way; we are just asking questions to increase our knowledge. Do you envisage coming to some sort of compromise on how to support young people under the age of 16 without opening up other problems?

Ms Jendoubi: That is certainly possible.

Mr McCallister: Will that be seriously considered for inclusion in the Bill?

Ms Jendoubi: Yes.

Mr McCallister: You have 18 months to do that, provided that you can find something that you think will be legislatively workable.

Ms McCaffrey: It is also about the impact that the ultimate outcome of the project might have on the Bill as it stands. The more radical the approach, the more changes might be needed to the current draft. That would also affect the time that it would take to draft the legislation to give effect to the changes that you wanted. In addition, consideration would have to be given to the implications on the criminal justice side, which is the other big element of the project and also has an impact on timescales.

The Chairperson: We have received a lot of information from you and from the other two presentations. So I will ask the Committee Clerk to ask research staff to produce a paper on the key issues and who is saying what. We can then mark that against what is there and ask for any further information that we need. That is just to guide us; that is not to imply that the Committee has decided, because it has not made a decision on anything.

It is also important, Christine, although I do not want to put you on the spot today, that we receive a written timetable of that work. If the work on emerging capacity were to finish by a specific date, you might find, depending on the outcome, that many of the issues raised no longer existed, so it is important that we get that time frame as quickly as possible.

Ms Jendoubi: Yes. I am slightly hesitant, because that will depend very much on the resources that the Department applies to it.

The Chairperson: This is a big issue. I will leave it with you to come back to us, but you cannot tell us that you are looking at the issue but that it might take 10 years. Those of us around this table also have a responsibility.

Members, I will allow the Department to make a presentation on advocacy services. Please try and keep it as tight as possible, Christine.

Ms Jendoubi: Thank you very much, Chair.

In October last year, we told the Committee that a 16-week public consultation on the draft policy guide was nearing an end and that its purpose was to explain to commissioners what advocacy is and to help them to develop advocacy services by providing some practical guidance on how they can be commissioned, supported, monitored and evaluated. The public consultation has been of great benefit to us. We have made a number of modifications to the guide, which are summarised in the briefing paper provided to the Committee.

We wanted to highlight the fact that, having taken account of the outcomes of the consultation, we will publish the policy guide on Monday 14 May so that the HSCB can begin to take forward the associated action plan as soon as possible. The focus in the policy guide is not on the proposed new statutory right to an independent advocate in the Bill, but it should help to prepare the way for it. One of the key ways in which it should achieve that is by explaining that there are many different models of advocacy from which people can benefit at different times in their lives and that this should be recognised in the commissioning process. Together, the different models form what is described in the guide as a continuum of advocacy services. When introduced, the proposed new statutory right will be part of that continuum and the subject of further guidance for the commissioners once the detail of the provisions of the Bill have been developed and drafted.

It will also help to pave the way by putting in place core principles and standards to which commissioners will have to adhere in future when commissioning any model of advocacy. Advocacy providers will also have to adhere to them, and they are the sorts of principles and standards that are commonplace in other jurisdictions. They have another major benefit in that they should also help existing effective advocacy providers to gear themselves up to deliver the new statutory-based advocacy when it is introduced. The policy guide also recognises that building the capacity of existing effective advocacy provision so that, when introduced, the new right ideally complements rather than replaces what is currently being provided, is something that commissioners need to think about now as a matter of good practice. It suggests that this should be a key role for the new regional advocacy commissioning group proposed in the policy guide.

There are, of course, challenges involved for commissioners and providers alike, particularly given the financial constraints on us all. However, limited resources should not stop us seeking to improve how we do things, which is what the policy guide seeks to do for advocacy services. It also has the benefit of helping to prepare the way for the new statutory right in a timely way. As the action plan will illustrate, there is much to be done, and we are pleased to be in a position to publish the policy guide next Monday and, in so doing, move the project forward into its implementation phase.

The Chairperson: Thanks for that, Christine. I know that some of that comes under the Bill, and you said that a scoping study was carried out in May 2010 to gather more information. Could any of that information be useful to your study on the capacity of under-16s?

Ms McCaffrey: The scoping study was largely to find out what advocacy services exist and what services are being commissioned by the trusts and board for those who may need them.

The Chairperson: Could the same people not give you the information needed for that other work?

Ms McCaffrey: I think that the trusts will be involved in that other work, but I am not quite sure.

Ms Jendoubi: That will not, however, focus on advocacy. It will be based on what children's rights are and what the effects would be should there be a change to the age at which those rights come into play for competence issues.

The Chairperson: Yes, but if the trusts are seeking to build their capacity to deal with policy issues coming from the Department, there is a high possibility that they are aware of the issues. So the study that you mentioned should not take as long as two years because the lines of communication are already open.

Ms Jendoubi: The issue for the commissioners will be one of volume and the capacity of the existing system, including the third sector, to cope with an increase in demand for advocacy services. There is also the issue of the quality and standards of services commissioned for people who need advocacy services. Publishing the guide now will make those standards, values and principles clear so that people can gear themselves up. Unless more advocacy services are commissioned, however, that will not increase the capacity of the system to cope with an increased demand. You are right that the scoping exercise enabled the HSCB and trusts to get a handle on the existing volume of services and on the capacity of the system to cope.

The Chairperson: So the doors are open.

Ms Jendoubi: Yes.

Mr McCarthy: Would young people with a learning disability, who happened, unfortunately, to be in hospital, have equal access to the same quality and range of advocacy services as those detained?

Ms Jendoubi: There are advocacy organisations that specialise in providing advocacy for people with learning disabilities. Their standards are, in my very limited experience, extremely high.

Mr McCarthy: That is good to hear.

Ms McCaffrey: One objective of the guide is to try to achieve consistency in the standard of delivery across all advocacy services to bring all up to the same high level as that to which, as Christine said, many currently work.

Mr McCarthy: That is positive.

The Chairperson: Over the past two hours and 20 minutes, we have probably exhausted the subject. It was useful to hear a broad range of views. The Committee will do a wee bit of work on this, too. It is important that we get a timeline, Christine, so that we know what we need to do and what the Department is doing.

Ms Jendoubi: Yes.

The Chairperson: Further down the road, we may come to a sensible arrangement on some of the key issues raised with us. Again, thank you very much for your paper and presentation.