



Knowledge Exchange Seminar Series (KESS)

...is a forum that encourages debate on a wide range of research findings, with the overall aim of promoting evidence-based policy and law-making within Northern Ireland



How will the Mental Capacity Bill work in practice?

Dr Gavin Davidson

Senior Lecturer in Social Work
School of Sociology, Social
Policy and Social Work
Queen's University Belfast
g.davidson@qub.ac.uk

The need for a new legal framework

- The current mental health law was drafted at a time when care was more hospital focused and is based on mental disorder and risk
- Concerns about the specific exclusion of personality disorder
- No current statute law to enable health and welfare decisions to be made for people who lack the capacity to do so – reliance on common law principles of necessity, reasonable belief and best interests
- Over past 15 years new mental health and mental capacity laws developed in Scotland, England/Wales and the Republic of Ireland
- ECHR/Human Rights Act Judgements – Bournewood
- Dawson and Szmukler (2006) Fusion approach
- Recommendation arising from the Bamford Review
- UNCRPD (2006) supported decision making

The process of developing the new law

- Bamford Review of Mental Health and Learning Disability (2002-2007)
- A Comprehensive Legislative Framework (2007)
- “The Review considers that having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust”
- “.....the Review considers that Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory.”

The process of developing the new law

- August 2007 Bamford Review Legal Issues Committee Report
- January 2009 DHSSPS Public Consultation
- September 2009 Decision to develop one capacity based law
- Project Board (includes DHSSPS, DoJ and Court Service, Bamford rep)
- Project/Bill Team (includes subject groups and costings)
- Reference Group (professionals, users, carers, voluntary organisations)
- July 2010 Equality Impact Public Consultation
- June 2011 First set of instructions to Office of Legislative Counsel
- July 2012 DoJ Public Consultation
- March 2014 DHSSPS and DoJ Public Consultation
- It is hoped that the Bill will be enacted within the current Assembly mandate



Mental Capacity Bill - key points

- Principles based: autonomy, presumption of capacity, support, unwise decisions, decision specific, best interests
- Scope: everyone, across settings, aged 16 and over
- Assessment of capacity: person must be unable to make a decision because of an impairment of, or disturbance in, the functioning of the mind or brain
- Decision making ability: understand, retain, appreciate, use and weigh and communicate
- The capacity based approach will apply to the criminal justice system
- For those in the CJS whose decision making ability is impaired there will be police, court and transfer powers to ensure they receive care and treatment in the most appropriate setting

Mental Capacity Bill - key points

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



How will it work in practice? Process

- The need for a decision arises
 - Concern identified about the person's ability to make the decision
 - Assessment of the person's ability to make the decision
 - Support provided to try to enable the person to make the decision
 - If the person hasn't put in place alternative decision making arrangements (such as LPA) but a decision needs to be made, appropriate safeguards provided
 - Authorisation and appeal processes
- Examples devised to give a sense of the how the new framework should work in practice. The cause of why the person might lack capacity is relatively unimportant and these are perhaps some of the more commonly considered scenarios. There is also a need to consider the more unusual.

How will it work in practice? Enabling intervention

- Mrs A is a 75 year old woman with dementia who lives with her husband
- Mrs A's ability to make certain decisions is impaired by her dementia
- For routine decisions Mr A and other carers, assuming that Mrs A doesn't resist or object, can proceed on the basis of a reasonable belief that Mrs A is unable to make that decision (lacks capacity), for example to dress, eat and wash, and that it is in her best interests to do so
- For serious decisions, for example if Mrs A required life sustaining/threatening surgery, a formal assessment of capacity by an appropriately trained professional and consultation with Mrs A's nominated person or default primary carer/nearest relative would be required
- If Mr A objected or, in certain circumstances, Mrs A resisted to the proposed serious intervention and/or if it involved deprivation of liberty then independent advocate, and authorisation required
- Appeal to Tribunal and/or eventually automatic referral to Tribunal

How will it work in practice? Protecting autonomy

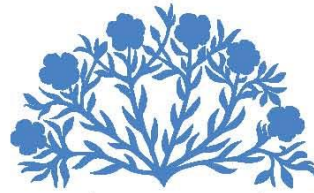
- Mr B is a 25 year old man with learning disabilities who lives with his parents
- Mr B's ability to make certain very complex decisions (for example involving long term consequences, specialist knowledge, probability) may be impaired by his learning disability
- Mr B is able, with appropriate supports,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

How will it work in practice? Managing risk

- Mr C is a 45 year old man with a diagnosis of schizophrenia who lives alone
- He has some delusional paranoid beliefs that impair his ability to make certain decisions such as whether to harm himself or other people
- The new framework would continue to allow emergency intervention, if it was necessary and proportionate, based on the reasonable assumption that Mr C's lacked capacity and intervention was in his best interests. So, for example to prevent him harming himself and/or others
- If, even with support, Mr C's mental health problems also impair his ability to make some specific decisions, such as whether to attend for treatment and reside in supported housing then, with the appropriate safeguards in place, the new framework would allow those interventions to be required
- If physical force was necessary, however, then that should continue to be in an appropriately staffed and safe setting
- If Mr C's relevant decision making ability was not impaired then any identified risk would have to be managed through alternative approaches – assertive community treatment, forensic services, probation, PPANI and MARAC

Mental Capacity Bill – ongoing issues

- New framework will not fully resolve all the current complexities involved in assessment, engagement, professional judgements, managing risk and fluctuating circumstances
- Title and wording of the Bill needs to be as clear and accessible as possible - decision making, supported and substituted, care, intervention, safeguards
- Need for comprehensive legislative framework for under 16s
- Application in the criminal justice system – potential to harmonise fitness to plead, insanity, diminished responsibility
- Need for education and training across levels – public education, health and social care staff, key staff, capacity assessors, specialist roles – ASW, medics, Trust panels, advocates, Tribunal
- Need for research – prevalence, supported decision making, comparison with current framework , qualitative experiences, issues in practice



Northern Ireland
Assembly



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