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Mental health: Legislative update

1 Introduction

This paper has been prepared in relation to a research query submitted by the Committee for Regional Development. The query relates to the Mental Health (Northern Ireland) Order (1986) and a provision outlined within the Transport Bill. In response, this paper provides: 1) an overview of the current mental health legislation in Northern Ireland, 2) details of its imminent reform, and 3) an overview of how the NI Order (1986) differs from that in other nearby jurisdictions.

2 Mental Health Law

The fundamental aim of mental health legislation is to “protect, promote and improve the lives and mental well-being of its people”.¹ However the nature of mental health law is complex and contentious. Most notable is the tension that exists between preserving the **patient’s autonomy** and **protecting the patient and others** from harm or significant risk. Coupled with ‘autonomy’, is the notion of ‘capacity’ – where the decision making capabilities of the individual need to be considered. In such cases, the person may not be able to make decisions themselves due to the nature of their condition.

¹ WHO Resource Book on mental health, human rights, and legislation (2005). Available online at: http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf page 19. Website accessed 26.11.10.

2.1 Northern Ireland

As part of the Committee Stage of the Transport Bill, the Regional Development Committee is considering provisions in the Transport Bill whereby a permit to provide public passenger transport services would be considered terminated if-

- a) the individual dies, or
- b) the individual becomes a patient within the meaning of Article 2(2) of the Mental Health (Northern Ireland) Order (1986).**

[Clause 7 (6)(b)]

The next section of this paper considers Article 2(2) in more detail and provides further background to the use of the MHO.

At present, the Mental Health (Northern Ireland) Order (MHO), 1986 provides the legal framework regarding **the compulsory admission and treatment of patients** suffering from a *mental disorder*, as defined within the Order. This is a very powerful piece of legislation because it has the power to take away an individual's rights.

2.2 Definition of a Mental Disorder

Under Article 2(2) of MHO (1986) a 'patient' is defined as a "person suffering or appearing to be suffering from *mental disorder*" (except Part VIII).² In Article 3 of the 1986 Order, a 'mental disorder' is defined as "*mental illness, mental handicap and any other disorder or disability of mind*". This is further defined in the legislation as:

- "***mental illness***" means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons;
- "***mental handicap***" means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning;
- "***severe mental handicap***" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning;
- "***severe mental impairment***" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

The MHO contains a number of duties which concern the care of the patient in relation to: **compulsory admission into hospital, guardianship, consent to treatment, and management of a patient's property and affairs.**³ The legislation is accompanied by a **Guide** and **Code of Practice**. Both documents contain guidance information for professionals. The Code focuses on information on everyday practical issues which

² Mental Health (NI) Order (1986), available online at: <http://www.legislation.gov.uk/nisi/1986/595> Website accessed 26.11.10.

³ <http://www.nidirect.gov.uk/index/information-and-services/people-with-disabilities/health-and-support/your-rights-in-health/the-mental-health-act.htm>. Website accessed 28.11.10.

are not dealt with in the primary or secondary legislation.⁴ It also states that people suffering from a mental disorder should be cared for with dignity, have their needs and preferences taken into account, and have the least degree of control and segregation necessary as is consistent with their safety and the safety of others.⁵

2.3 Mental Health Order: Patient Assessment

If a person is suffering from **severe mental health problems**, they may become a patient under the Order, subject to a Mental Health Order assessment.⁶ According to the World Health Organisation Primary Care Guide,⁷ GPs can be involved in the MHO assessment in two ways:

Community: *The patient may be causing serious concern to family or neighbours. An application can be made for compulsory hospital admission for seven days, renewable to 14 days for assessment (Article 4). In extreme circumstances, if access is denied, a warrant authorising a police officer to secure access may need to be used (Article 129). This warrant is obtained by an approved social worker (ASW), other officer of the Health and Social Services Trust or a police officer from a Justice of the Peace. If the officer has to enter the premises, by force or otherwise, they must be accompanied by a medical practitioner (usually a GP) who will administer medical treatment if required.*

Hospital: *The patient may have been admitted informally and now wants to leave or is refusing treatment. An application for assessment involves the patient's own GP (or another practitioner who has previous knowledge of the patient) in attending hospital to give the medical recommendation. A doctor on the staff of the hospital in which it is intended that the assessment should be carried out cannot give the recommendation, except in a case of urgent necessity.*

2.4 Use of the Mental Health Order

In order for the MHO to be invoked, an application for compulsory admission must be made by: either 1) the 'nearest relative'⁸ or 2) an Approved Social Worker (ASW), **and** supported by a medical recommendation (usually the patient's GP or a doctor who knows the patient personally). Compulsory admission for assessment of a patient can only occur when:

⁴ Department of Health and Social Services (1992) Mental Health (Northern Ireland) Order 1986 Code of Practice, Belfast, HMSO.

⁵ Ibid, page 3.

⁶ NIdirect Government Services: The Mental Health NI Order (1986) available online at:

<http://www.nidirect.gov.uk/index/information-and-services/people-with-disabilities/health-and-support/your-rights-in-health/the-mental-health-act.htm>. Website accessed 29.11.10.

⁷ WHO Guide to Mental and Neurological Health in Primary Care. Information available from:

www.mentalneurologicalprimarycare.org/page_view.asp?c=16&fc=006003&did=2230. Website accessed 30.11.10

⁸ The Order gives certain rights to the nearest relative which can be used to protect the patient's interests. Usually, the nearest relative is the older of the two people in the following list: husband, wife or civil partner; partner who has lived with the patient for at least six months; daughter or son; father or mother; brother or sister grandfather or grandmother, aunt or uncle, nephew or niece.

- The individual is suffering from a mental disorder of a nature or degree that **warrants detention in hospital for assessment** (or for assessment followed by medical treatment); and
- failure to detain the patient would create a substantial likelihood of **serious physical harm** to themselves or to other persons.

The latest figures⁹ show that in 2009, **1,400** people in Northern Ireland were recommended for compulsory admission to psychiatric hospitals for assessment. Of these, **743** were detained.

2.5 Issues with the Mental Health Order

Given that the MHO was developed over two decades ago, it is now considered outdated in light of current policies, best practice and the different models of care delivery. The MHO (1986) has also been criticised for using stigmatising terminology and for lacking in a human rights approach.¹⁰

3 Mental Health Reform: Northern Ireland

Unlike its neighbours, Northern Ireland has yet to update its mental health legislation. In light of the significant gaps in local policy and legislation, an independent and extensive *Review of Mental Health and Learning Disability in Northern Ireland* was established by Department of Health, Social Services and Public Safety (DHSSPS, 2002). This became known as the Bamford Review.¹¹ Taking account of a wide range of stakeholder views, the Review's final report, ***A Comprehensive Legislative Framework (2007)*** stipulated:

*the need to respect the **rights** of all citizens, to provide rights for those whose freedoms may need to be interfered with on healthcare grounds, where appropriate, to protect public safety and the need to encourage best practice generally.*¹²

The main crux of the Bamford Review proposed a rights-based approach as the guiding principle for the reform of mental health legislation. This approach respects the decisions of all who are assumed to have capacity to make their own decisions. It further states that there should be a “***single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland...A framework is proposed for interventions in all aspects of the***

⁹ Figures obtained from Patrick Convery of the Regulation, Quality and Improvement Authority on 30.11.10

¹⁰ See: DHSSPS (2007) *The Bamford Review of Mental Health and Learning Disability: A Comprehensive Legislative Framework, Consultation Report*. Belfast: DHSSPS, p.11.

¹¹ *The Bamford Review of Mental Health and Learning Disability*. Available online at www.rmhdni.gov.uk Website accessed 26.11.10.

¹² DHSSPS (2007) *The Bamford Review of Mental Health and Learning Disability: A Comprehensive Legislative Framework, Consultation Report*. Belfast: DHSSPS, p.1.

*needs of persons who require **substitute decision-making**, including mental health, physical health, welfare or financial needs.*"¹³

The proposed legislative framework is underpinned by four guiding principles aimed at supporting the person's dignity. These include:¹⁴

- 1) **Autonomy** – respecting the individual's capacity to decide and act on his own and his right not to be subject to restraint by others
- 2) **Justice** - applying the law fairly and equally—persons with a learning disability or mental health disorder should retain the same rights and entitlements as other members of society.
- 3) **Benefit** - acting in the individual's best interests
- 4) **Least Harm** – treatment and care must be provided in the “*least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care*”

These principles are in keeping with other person-centred human rights statutes such as the UNs *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991), the *Human Rights Act* (1998), and the *European Convention on Human Rights* which has been incorporated into domestic law.

3.1 Delivering on the Bamford Vision: Current Status

In 2008, a consultation response on improving services for people with a mental health or learning disability was published by the NI Executive entitled ***Delivering the Bamford Vision***.¹⁵ The government broadly accepted the thrust of the Bamford Review and the principles-based approach, and suggested that a number of changes be made in order for the vision to become a reality.

In 2009, an accompanying *Action Plan* (2009-2011) on Delivering the Bamford Vision was published which provided details about how changes should be progressed.¹⁶ Following on from the consultation on the Department's proposal, *A Legislative Framework for Mental Capacity and Mental Health Legislation* (2009), the DHSSPS Minister announced a ground-breaking decision to prepare a **single bill** encompassing **both mental health and mental capacity** entitled the **Mental Capacity (Health, Welfare and Finance) Bill**. More recently, an Equality Impact Assessment consultation has been conducted to measure the impact that the single Bill may have on section 75 groups (Northern Ireland Act 1998).¹⁷ A summary of the provisional timetable for the Mental Capacity Bill is presented in Table 1 overleaf.

¹³ Ibid page 4.

¹⁴ Ibid page 5.

¹⁵ Delivering the Bamford Vision: The response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability. Available online at www.dhsspsni.gov.uk/bamford_consultation_document.pdf Website accessed 28.11.10.

¹⁶ Delivering the Bamford Vision www.dhsspsni.gov.uk/bamford_action_plan_2009-2011.pdf Website accessed 26.11.10.

¹⁷ DHSSPS Consultation on an Equality Impact Assessment for New Mental Capacity Legislation. Available online at: www.dhsspsni.gov.uk/showconsultations?txtid=43469

Stages	Timeframe
EQIA consultation	July-October 2010
Policy cleared by Minister and Executive	November/December 2010
Bill Drafted	March 2011
Bill consultation	July/August 2011
Bill introduced to Assembly	Autumn 2011
Bill enacted	Spring 2013

Table 1 Provisional timeframe for the Mental Capacity Bill¹⁸

4 Other Jurisdictions

New but **separate** mental capacity and mental health legislation has been introduced in nearby jurisdictions in recent years. Table 2 below provides an overview of the current legislation and an overview of some of the new features.

Jurisdiction	Current legislation	Summary of key features
Northern Ireland	<ul style="list-style-type: none"> The Mental Health Order 1986 	<ul style="list-style-type: none"> No statute dealing with capacity at present. Legislative reform proposes a single Bill, principles-based approach covering mental health & mental capacity law
Scotland	<ul style="list-style-type: none"> Mental Health (Care and Treatment) (Scotland) Act, 2003 Adults with Incapacity (Scotland) Act, 2000 	<ul style="list-style-type: none"> Capacity-based mental health legislation based on 10 key principles. Informal treatment is regarded as “the norm” Specifies compulsory treatment orders (CTOs) tailored to the personal needs of patients New Tribunal process Strengthens the rights of users of services and introduces advocacy support Gives courts new options on how they deal with people who enter the criminal justice system Includes provisions for welfare Guardianship which originally fell under “Mental Health” legislation in order to safeguard the welfare and finances of people who lack capacity. Court can appoint a Welfare Guardian to make decisions
England and Wales Amended the Mental Health Act (1983)	<ul style="list-style-type: none"> The Mental Health Act, 2007 	<ul style="list-style-type: none"> New criteria for detention - introduces an “appropriate medical treatment test” Broadens role of professionals involved in the process Gives the patient rights to make an application to displace their nearest relative

¹⁸ Information requested from DHSSPS about the verified timeline was not obtained in time for the writing of this paper.

	<ul style="list-style-type: none"> • The Mental Capacity Act, 2005 	<ul style="list-style-type: none"> • Introduces new rights for victims of mentally disordered offenders who are not subject to restrictions • Introduces supervised community treatment (STC) for patients following detention in hospital • Introduces a Review Tribunal • Framework for decision-making for those who lack capacity including decisions about treatment, property and personal care • Set out 5 principles which govern decisions taken • Can nominate substitute decision makers under Lasting Power of Attorney • Development of a new Court of Protection with extended powers • Checklist for consideration of best interests • Enables people to plan ahead for when they lose capacity
<p>R.O.I.</p>	<ul style="list-style-type: none"> • Mental Health Act (2001) • Capacity legislation underway 	<ul style="list-style-type: none"> • Strengthens the rights of users of service by introducing a Mental Health Commission • Gives early automatic reviews of detention for every patient by a Mental Health Tribunal

Table 2 Mental health and capacity law: UK and R.O.I. legislatures

Recent experiences have highlighted gaps and inconsistencies in the application of the separate Acts in the other jurisdictions.¹⁹ Coupled with the continuing stigmatising effect of enacting separate mental health legislation, and the need to provide protection to the most vulnerable individuals, the decision to proceed with a capacity based single Bill approach signals a unique opportunity for Northern Ireland to create legislation which more effectively meets the needs of its patients, members of the public and professionals.

¹⁹ See for example, Thompson, J. (2008) Reform of mental health legislation in the UK. Northern Ireland Assembly Research paper 41/09