Royal College of Psychiatrists in Northern Ireland

Response to the Consultation on Proposed New Capacity Legislation

The Royal College of Psychiatrists in Northern Ireland welcomes the opportunity to respond to the Consultation on the proposed new capacity legislation.

The Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.

The College has 370 members in Northern Ireland, including doctors in training. These doctors provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

This is submitted on behalf of the Royal College of Psychiatrists in Northern Ireland Executive Committee.

Introduction

The Royal College of Psychiatrists Northern Ireland welcomes the Draft Mental Capacity Bill (NI). The Bamford Review (2007), recommended that- “there should be a single comprehensive legislative framework for the reform of Mental Health Legislation and for the introduction of Capacity legislation in N. Ireland.” The Northern Ireland Departments of Health, Social Care and Justice have taken the courageous step, which to date, has not been replicated elsewhere in the world, of bringing Capacity and Mental Health Legislation together in this draft ‘fused’ capacity bill. This proposed Bill removes the interfaces between the Mental Health Order NI and the Common Law framework dealing with incapacity,
best interests and deprivation of liberty. The absence of established integrated capacity-based models in other jurisdictions does not mean that a capacity-based model is ‘unworkable,’ but rather is a reflection of their histories. Fused legislation is a novel approach and as such it is essential to identify and critically consider any potential advantages and disadvantages.

The College raised concerns about the short timeframe of the consultation which has been over the summer months, given the gravity of this legislation, but understand that the timetable is to accommodate the Assembly’s timetable.

As a Profession psychiatrists welcome legislation which treats patients with physical and mental health problems using the same principles. This should reduce the stigma associated with mental health, and protect the rights of people who lack decision making capacity.

The College believes that modern health and social care must have legislation promoting Capacity. In Northern Ireland this is currently dependent on the implications of the Bournewood judgement and case law. Elsewhere in the NHS capacity legislation exists; however in these jurisdictions case law continues to evolve, particularly in relation to the Bournewood gap and Deprivation of Liberty (DoL). In Northern Ireland we have been afforded the opportunity to review, not just our mental health legislation, but also introduce capacity legislation, and in so doing consider issues relating to deprivation of liberty at an early stage. We are fortunate in that we can learn from the experiences elsewhere.

The College believes that the introduction of fused legislation will improve the safety and quality of care provided to all those within Health and Social Care in Northern Ireland, by ensuring that every individual is always treated in their best interests. The Bill recognises the importance of respecting the autonomy of every individual, and promotes the presumption of capacity, unless it is concluded that the person has been unable to make a decision despite all practicable help and support having been given. This proposed capacity legislation is in harmony with the European Convention on Human Rights; of particular relevance are Articles 3, 5 and 14. By placing what is now dealt with under common law in statute, it will provide both the individual and the decision maker with increased protection under the legislation.

We are extremely concerned that the criminal provisions of the proposed Bill are not available. It is our experience that in practice, civil and criminal provisions are inextricably linked, and as the proposed criminal provisions are not described
in this draft there is an enormous gap. The College would recommend further consultation once these have been developed as it is imperative that there are ample opportunities for reflection and discussion with stakeholders. The College is very willing to work with the Departments to develop this part of the legislation.

The Code of Practice is a key document which will determine how and when the proposed Capacity is used and as such the College strongly recommends the early introduction of a clear, unambiguous Code of Practice to aid and support practitioners, patients and carers. The absence of The Code of Practice in The Draft Bill prevents interpretation of how widely the legislation might be applied. The College would wish to avoid a replication of the lack of clarity in parts of the current Mental Health Order, which in spite of being in use for over 30 years remain subject to interpretation, as evidenced by a recent case in which the judge defined the word ‘substantial’ in the context of substantial likelihood of harm to self or others. Many other key words in the proposed legislation have yet to be clearly defined, with some having been already the subject of Court judgements in different jurisdictions. For example, “Substantial likelihood”, “serious harm”, “treatment” (medical, psychological), “assessment (how long, does it include physical investigations such as scans or lumbar puncture), reasonable (efforts to do something) available treatment (locally, nationally, in England or Scotland, now or in the future, who will pay etc). “Emergency” can also be open to interpretation, especially out of hours, when a situation becomes urgent because services or staff are not available.

The college’s members have the necessary skills and knowledge to actively contribute to the development of the Code of Practice, and are well placed to liaise with our colleagues in the other medical specialities and disciplines in contributing to this.

We recognise that the introduction of this legislation will have to be supported by a comprehensive training programme, encompassing all Health and Social Care providers and that this training cannot be a ‘one off’ exercise but will require regular updating. This will be an important component of the continual professional development of social and health care staff of all grades both in the statutory and voluntary sectors.

The College recognises that the enactment of the proposed Bill will require a significant investment of time, expertise and money, and it is not until the full
Code of practice is developed that the extent of resources required can be known.

Consultative process
The College in Northern Ireland include the Faculties of Child and Adolescent Psychiatrists, Forensic Psychiatrists, Intellectual Disability, General Adult, Liaison, Psychotherapy, Addictions and Older people’s Psychiatrists. Each of the Faculties considered the Draft Mental Capacity (Northern Ireland) Bill, and as would be expected the headline concerns for each have identified different issues.

Principles
The College supports the Principles of Capacity and Best Interests as laid out in the Draft Bill. The assumption of capacity unless established otherwise respects the personal autonomy of every individual, having regard for the dignity of the person at all times. That a person cannot be regarded as lacking capacity unless all practicable help and support have been given without success must also be welcomed. This “principles” approach is a positive development in respect of removing the specified exclusions and stigmatisation around Personality Disorder, Alcohol dependence and Sexual deviance in MHO 1986 s.3(2) which is overdue and clearly necessary if the move is towards capacity-based legislation.

The “best interests” principle is also to be welcomed as a significant safeguard building upon the current Common Law through the provision of a checklist to be used in the determination of what would be in the best interests of each and every individual. The tensions inherent in satisfying the primacy of the capacituous patient and the requirement to act in his or her best interests are likely to become more explicitly recognised. The College recommends that the Principle of Reciprocity should be given more prominence, in that if the state acquires greater powers then it has a responsibility to also identify commensurate treatment resources.

Future Decision Making Arrangements
We welcome the formalization of future decision making powers, and that these are set in statute, whilst recognizing the importance of ensuring that they remain valid, through the process of regular review, and indeed that they are accessible to all applicable Health and Social Care staff at all times.
**Advance directives**

It is recognised that the directives must be drawn up when a person has capacity specific to that time and decision, but it can be difficult to apply in all circumstances. For example, if a person decided in advance that he never wanted Clozapine however ill he became in the future as he hated blood tests, and at a future time he became ill again, and was deemed to lack capacity, but a Clozapine type 2 had become available which only needed annual blood tests, could his directive be overridden? If all treatment is refused, does this include care and food? Clarification will be required as to how and when advance directives should be reviewed and how they can be accessed in the Code of practice.

**Lack of Capacity**

The draft Bill establishes that capacity is issue specific. Paragraph 2.19 of the Bill emphasises that:

> “The test is issue and time specific”.

This is indicative of the limitations of capacity based legislation. The meaning of “lacks capacity” in section 2(1) could apply to all mental disorders in current classification systems, or even in a person with normal psychological functioning and a temporary disturbance at a time of crisis. Mental disorder is, by nature, dynamic and can change in short order. The consideration of Capacity Assessment and Mental Disorder allows this to be recognised in the Draft Bill and it is essential in practice that the provisions of the Bill protect both the patient and ensure public safety.

In practice there is the concern that a mentally ill patient whose delusional thought content does not involve decision making around hospital admission may not be liable to detention despite the fact that the delusional thought content places themselves and others at risk. The College considers that delusional thinking can impair a person’s ability to appreciate, use and weigh information. A further example is the patient deemed to have capacity to decline admission to hospital who may well lack capacity hours later and, in consequence, place themselves and others at risk. These examples emphasise the importance of recognising both the nature and degree of mental illness within the Capacity Bill, and the need to consider time over a reasonable period.
The College notes that “Unable to make a decision” is defined in paragraph 2.21 of the consultation document. Paragraph 2.22 goes on to state that the inclusion of an “appreciation element” which may prevent a person whose insight is distorted by their illness or a person suffering from delusional thinking as a result of their illness from meeting the test. The impact of delusional thought process on capacity to make a decision is likely to vary from patient to patient depending on the patient’s mental state and its interplay with the decision requiring capacity -“appreciate the relevance of that information and use or weigh the information as part of the process of making the decision”.

Any mental illness or disorder can be long term and fluctuating in nature. There are concerns that Capacity Assessment as defined may not capture accurately the nature of the changes in cognition that can occur and often concentrate on short term rather than longer term developments. Although research has shown similar inpatient populations measured by Mental Health and Capacity criteria\(^1\), they are not exactly the same patient group, and close review of the Order in practice will be vital. The Code of Practice must be developed and implemented at the same time as the Bill. This will require education, training and modification with time.

**Practical Assessment of Capacity**

The Bill introduces new nomenclature to the legal process namely Nominated Person, Appropriate Medical Practitioner, Advocate. These people will require to be identified and their roles defined and supported. This will necessitate significant training, validating and reviewing tasks to be undertaken. It is important that what is eventually agreed in the Code of Practice is workable in all situations by staff trained to different levels.

Many Health and Social Care professionals will be drawn into the identification and assessment of those whose capacity is in doubt, particularly in acute general hospital wards, and those with Deprivation of Liberty in care homes, “the Bournewood group”. Theoretically these people will require repeated assessments for decisions about finances, placement, physical and mental health care as the appreciation of capacity becomes much more sophisticated and

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legally tested. As a result there will be a requirement for ongoing training and education among all health and social care staff.

**Protection from Liability**

The inclusion of a Nominated person when determining best interests is also to be welcomed. The term however reads as somewhat defensive. A mechanism for determining the aptitudes of people in these roles will have to be agreed. A menu of people to draw from may prove more supportive. It is not clear how exhaustive professionals will have to be in locating these individuals.

**General Safeguards**

The College welcomes the mechanisms proposed in regard to “All acts, whether routine or serious.” We welcome the conditions which apply to restraint, and that these have now been made explicit in the context of a legal framework. The College recognises that restraint must be subject to the additional condition that there must be a reasonable belief that there is a risk of harm and that restraint must be proportionate. This is consistent with established best practice. However, as with other points, the Code of Practice will need to provide definitions for “proportionate” and “reasonable.”

The Supreme Court recently clarified a deprivation of liberty for the purposes of Article 5 of the European Convention of Human Rights as “the person is under continuous supervision and control and is not free to leave”.\(^2\) It follows that any act of restraint, wherever it occurs, is a deprivation of liberty and should result in the application of additional safeguards for deprivations of liberty.

**Additional Safeguards for Serious Interventions**

The College welcomes the Additional Safeguards as outlined in the Draft Bill. The College understands that detention in hospital would be regarded as a serious intervention.

The Code of Practice will need to make explicit the details regarding the process of involving the Nominated Person, including the level of accountability of the HSC Trust to ensure engagement of this nominated person.

We welcome the provision in this section that appears to state that requiring residence or compulsory treatment in the community would be subject to the
same constraints as detention in hospital. In times of reduced hospital facilities this would appear to allow increased flexibility in managing those who are mentally ill in the community.

**Deprivation of Liberty Safeguards**
The House of Lords Select Committee on the Mental Capacity Act 2005 (MCA 2005) recently described Deprivation of Liberty Safeguards (DOLS) as not fit for purpose and ineffective in closing the Bournewood Gap. A recommendation was made to replace DOLS with new legislation. DOLS are strikingly similar to the safeguards contained in Mental Capacity Bill and so it would be reasonable to expect that some of the same problems could arise. In particular, DOLS were described as complex and bureaucratic resulting in under use of the safeguards and marked variation in regional practice. There was also an “inherent conflict” in local authorities being responsible for both the deprivation of liberty and authorisation of deprivation of liberty. This appears to be the case with HSC trusts in the Bill.

A new gap of deprivation of liberty of those living in supported accommodation was also identified as the Court of Protection failed to address these deprivations due to barriers in accessing the court. Given the Supreme Court description of deprivation of liberty which could be widely applied and the cost of accessing the High Court, it appears that this gap would also exist with the Bill. The Deprivation of Liberty situations involving such placements should be included in the provisions in relation to deprivation of liberty in hospital and care homes with only matters of dispute being referred to the High Court.

**Second Opinions**
The College welcomes the mechanisms outlined in regards to “Second Opinions.” This is well established as best practice already in our legislation for certain treatments with serious consequences.

**Authorization for certain Serious Interventions**
There is a requirement established in the Bill for a “HSC Trust panel” to authorise certain serious interventions. This would include a deprivation of liberty. Whilst we as a College are supportive of these principles, we foresee possible challenges in the time frame for the HSC panels to be convened, and have concerns that unless this is adequately resourced, that an individual’s care could potentially be compromised.
**Deprivation of Liberty**

The College recognise that deprivation of liberty would require evidence that failure to so act would present a risk of serious harm to the person or serious physical harm to others. However, the use of the term “serious” is not defined. Experience of the use of the term “serious” in the Criminal Justice Act 2003 and subsequently the Criminal Justice (Northern Ireland) Order 2008 would indicate that failing to meaningfully define what level of harm is “serious” would place great difficulty in interpreting the prevention of serious harm condition. In addition to this the failure to recognise serious psychological harm to others is anachronistic and not consistent with criminal justice legislation. We would submit that a Mental Capacity Bill which fails to recognise serious psychological harm is failing victims of such harm.

**Attendance Requirements**

The idea of imposition of an attendance requirement is welcomed. The provision that failure to impose the requirement would be more likely than not to result in the person not receiving the treatment is necessary and proportionate. How this would function in practice is less apparent.

**Compulsory Residence Requirement**

The idea that a requirement can be introduced for a patient to live at a particular place or to allow access to the place of residence is cautiously welcomed. We accept that the risk of harm criteria would need to be met. We do not see how this could be enforced in practice and are concerned about the potential DoL inherent in this, the need for this to be proportionate and for it to be rigorously reviewed rather than becoming prolonged unnecessarily. The Bill does not make it clear as to what the consequences would be if the individual was to refuse to agree to live in a particular place, or to allow access to that place. This was one of the deficiencies relating to Guardianship under the Mental Health Order(1986).

**Compulsory Treatment with Serious Consequences**

The provisions in this regard appear to be appropriate. However, we are concerned with the definition of “serious intervention”. This may not describe accurately the term “serious” and does not define such harm. Any lack of clarity will cause confusion in practice.

The language of “treatment with serious consequences” is of concern to the College. A more balanced term such as “treatment decision making” with a
risk/benefit analysis would be more appropriate. The inclusion of electroconvulsive therapy as a treatment with serious consequences is stigmatising given that it is generally a safe and effective treatment with severe adverse outcomes being rare, compared with for example Aortic Aneurysm repair. Neurosurgery as a treatment for mental illness is a very rare occurrence.

Again we recognise the importance of the prevention of serious harm and proportionality criteria.

**Authorisation Process**

The College notes that the authorisation process contains two schedules. In the practice of Psychiatry Schedule 2 is particularly relevant. This allows for the "short term" detention in hospital for "examination". "Short term" appears to us from the Bill to be up to twenty eight days, but this requires clarification.

The proposed process is described as “largely based on the current process for detention for assessment under Mental Health Order”. It is not yet clear within the Bill how this will blend with the fundamental principles of capacity based legislation, and tensions may arise. It is not yet clear if “examination” in the Bill is analogous to “assessment” in the current Order.

At present detention to hospital for “assessment” is carried out by an approved social worker and a general practitioner, both of whom have examined the patient. A fundamental principle of capacity to make a decision is that this assessment must be carried out by the practitioner who will be carrying out the intervention. In the case of detention to a mental health hospital it is the accepting psychiatrist who will be carrying out the detention and who will be “responsible” to borrow the terminology from current mental health legislation. This would be consistent with practice in other jurisdictions. Requiring a General Practitioner and an Approved Social Worker who may not be currently au fait with the nature and consequences of the proposed intervention to the same extent as the consultant psychiatrist may inadvertently contradict the principles of capacity assessment. This should be considered explicitly in the Code of Practice and appropriately resourced.

Schedule 2 2,4(a) states that as criteria for admission, P has an illness, or there is a reason to suspect that P has an illness, while in part 12 para 160 “illness” is further defined as including “any injury, disorder or disability” requiring treatment or nursing which requires treatment or nursing care” this is a very loose definition-which will require clarification in the Code of practice.
We are concerned that Schedule 2 allows “examination” but does not appear to consider treatment. The failure to apply the same principles for emergency treatment in this setting may not be consistent with capacity based legislation. “Examination” should be considered to include “treatment” and, in practice, trial of treatment forms an essential part of examination.

Schedule 1 sets out the process for authorisation for any other act requiring such authorisation. This would include detention in hospital other than short term detention for examination.

This schedule requires that a HSC Trust panel of three members consider the application. Again there is a stipulation that an approved social worker make the application. This may be inconsistent with the principles of capacity based legislation which would require the party carrying out the intervention to make the assessment and, logically, the application.

The requirement of a panel to consider all detentions to hospital other than short term for examination may become incredibly cumbersome. Any such panel would require the appointment of appropriate experts to consider the matter at hand and these experts would need to have expertise in the question at hand. How such a panel could be convened in any meaningful time frame is difficult to visualise. This process may become a severe drain on clinical resources to an administrative process which has historically not been required.

Where a HSC panel is convened to review authorisation, the nominated person can represent in addition to an independent advocate. Again, the nominated person may not necessarily be the primary carer. In this situation, where collating evidence is central, a primary carer who is providing / has provided significant support runs the potential of being excluded from this process. There should be a mechanism in this process for incorporating knowledge of primary carers who are positively supporting the recovery of their loved one.
Medical Reports
Senior Psychiatry Trainees (ST4+, and who have full Membership of the College) are suitably experienced and qualified to write section 53 medical reports for the purposes of Schedule 2 and should be included as practitioners who may be appointed by RQIA for prescribed purposes. Senior Psychiatry Trainees should be able to write medical reports for the purposes of Schedule 1 under the supervision of a Consultant Psychiatrist, the Responsible Medical Officer.

Independent Advocate
The College supports the role of an independent advocate where serious compulsory interventions are required. The College recognises that independent advocates will require ongoing training and support. It will be essential that an advocacy service infrastructure is in place across Northern Ireland to ensure that there are shared Standards which are quality assured, opportunities for shared practice as well as equity of access.

Rights of Review
The provisions proposed for a “Review Tribunal” are in keeping with established best practice.

The College retains some concern as to the composition of such a Review Tribunal. When considering the detention of a patient in a psychiatric hospital we consider it essential that the panel include a Consultant Psychiatrist. Failure to provide appropriate expertise to Review Tribunals will promote the imposition of indefensible decisions by unqualified panels which may short change the patient and put public safety at risk. Members of review tribunals will require training and ongoing support.

Emergency Interventions
The College recognises the importance of emergency interventions and acknowledge that failure to take practicable steps would remove the protection from liability provided by the Bill.

Other Decision Making Mechanisms

High Court
The College supports the proposal for the High Court to have declaratory and decision making powers.
Court Appointed Deputies
The College supports these provisions.

Office of Public Guardian
The College supports these provisions.

Expenditure and Payment for Necessary Goods and Services
The College supports these provisions.

Research
The inclusion of Research within the Bill is welcomed by the College. The College supports these provisions.

Offences
The College welcomes the offences proposed by the Draft Bill.

It would be useful to have clarification around the degree of “wilful neglect” which constitutes an offence perhaps with consideration to the harm that is caused to P. It should also be recognised that X delivers care in a complex healthcare system and that failures in care are often for systemic reasons. Consideration should therefore be given to prosecution of the organisations responsible for providing care in addition to the individuals at the front line. If the provider organisations are not held liable, there is a risk that individuals could be unfairly prosecuted for systemic failures.

Transfers between Jurisdictions
The Bill makes reference to provisions for the transfer of persons detained in hospital to a hospital in England, Wales or Scotland, but not the Republic of Ireland or other European Jurisdictions.

The practice of transferring persons to other jurisdictions is relatively common in psychiatry. Of particular note is the provision of High Secure Hospital care which is provided by the State Hospital in Scotland. It is our clinical experience that the majority of patients so transferred would not meet the criteria established within the Bill as these patients are detained in hospital as a result of the nature of their mental disorder rather than the degree. They will have the capacity to refuse hospital admission despite this being required in the interests of public safety. This means that patients who present a grave and immediate danger to public safety may longer be able to have their care needs met in an appropriate level of security.
There are patients at present who are not considered to be liable to detention under the present mental health legislation in Northern Ireland, largely those with a primary diagnosis of a personality disorder, who find themselves transferred to hospital care in other jurisdictions where the mental health legislation allows such detention. As now, this may cause concern particularly for the patient who is capacitous but who finds him/herself detained in England.

The omission of provisions for the transfer of persons detained in hospital to The Republic of Ireland is a particular area of concern given our proximity to this jurisdiction.

Excluded Decisions
There are concerns about the exclusion of sexual matters from the Bill. The College believes that some decisions relating to intimate relationships, particularly where sexual contact is involved, may have far reaching implications for patients lacking the capacity to consent to such relationships. People without capacity can be vulnerable and exploited, and though of course maximum choice and autonomy is important, leaving someone open to serious exploitation would be a failure of duty of care.

Direct Payments
The College welcomes the provisions included within this section of the Draft Bill.

Children and Young People
The College is concerned that children (persons under the age of 16) are excluded from this bill whilst fully recognising the need, at this juncture, for a separate project to consider the complex legal framework that currently exists in respect of children. The College would urge that this separate project be taken forward as a priority and that the process will consider fully the possibility of extending capacity-based legislation to include children. There is an imperative to put in place a robust rights-based legal framework for decision-making in relation to the health and welfare of children which can be implemented alongside existing human rights legislation.

Whilst it is true that it would not “make sense to presume...that a two year old has capacity“, this is a marked oversimplification of the issue. Capacity is situation- and decision-specific and many fifteen years olds clearly have the capacity to make many decisions about their health and welfare e.g. to accept or refuse certain medications. Current case law allows “competent” children to
accept, but not to refuse, treatments and this creates potential conflicts in clinical practice between respecting the autonomy of capacitous individuals and the existing legal provisions.

The College will seek to advocate for a legal framework which recognises emerging capacity in children. Cognitive and emotional skills are acquired differentially throughout adolescent development and there are both neurobiological and psychosocial explanations for this. We need to adopt a definition / understanding of capacity which is developmentally congruent and to build a legal framework around this. Whilst decision-making is primarily dependant on information retention and processing, emotional maturity is needed to make balanced, unwavering decisions and to cope with the consequences of those decisions.

The College accepts there is an inherent responsibility and expectation on parents and society to protect the right to life, survival and development of their children. The degree of risk of psychological / physical harm attached to the consequences bears some relevance as to whether or not the child should be allowed to make that decision for themselves. A determination should be reached as to whether decisions taken by a capacitous child can ever be over-ridden to protect them from certain harms. Consideration also needs to be given to the impact of life experience and to what extent that allows children to understand and weigh up their options when making any decision, and therefore to what extent it is core to the concept of capacity. Children need the opportunity to learn about the consequences of choices in a safe and nurturing environment. Parents and the state have the responsibility for co-creating the conditions which promote the welfare and development of the child.

The College therefore advises that the separate project will bring together relevant experts to consider (a) how emerging capacity should be defined in children i.e. whether there is a higher test that concerns not just cognitive processing but also takes into account emotional maturity and life experience and (b) to consider the following options:

1. To consider the position initially proposed in the Bamford Review of a rebuttable presumption of capacity in relation to the health / treatment decisions for mature minors with or without the application of a lower-age limit (i.e. twelve years old).

2. To consider a “both / and” position that allows the decisions of capacitous children to be over-ridden to protect them from the worst harms. The “zone of parental responsibility” decreasing as the child’s maturity
increases could be a useful concept to retain here, although we are of the view that parental assent alone is not sufficient in relation to decisions about deprivation of liberty i.e. compulsory hospitalisation for treatment of a mental illness.

The views of College members are currently fairly evenly divided between these positions. We would recommend convening an expert group with wide representation to consider these options fully. This should bring together experts from the fields of child health especially mental health, social work especially child protection, youth justice and law. Young people and parents / carers should also be involved in this process. We would encourage the Department to consider taking this project forward initially using a consensus rather than a consultation model, given the complexity of the issues which need to be dealt with and the far-reaching implications of introducing capacity-based legislation.

The College would caution against the 3rd option (which may be prevailing in the minds of the DHSSPSNI) i.e. maintaining existing legislation albeit with certain modifications / enhancements such as codification of Gillick principles or strengthening the Mental Health Order. Continuing to apply out-of-date, piece-meal legislation to increasingly complex clinical scenarios will not prove resilient to legal challenges on human rights grounds.

In the interim however, the College agree with the retention of the Mental Health Order and strengthening the safeguards it contains. This is the only legal mechanism by which a robust set of deprivation of liberty safeguards can be implemented within the existing legal framework. The recent judgement in British Supreme Court regarding the “Cheshire West” case offers some insight into how robust and over-arching these safeguards need to be. There should always be a legal oversight mechanism when a young person is deprived of their liberty and, as above, parental assent alone is not a sufficient safeguard in relation to decisions about deprivation of liberty i.e. compulsory hospitalisation for treatment of a mental illness. Consideration should be given to automatic recourse to a Mental Health Review Tribunal within a much shorter time frame.

Consideration should also be given to the immediate introduction of robust regional policies and guidelines in relation to the use of restrictive practice in hospital and the community, where the criteria for detention under the Mental Health Order is not met but where there are significant restrictions on the child’s liberty to ensure their safety. Future legislation should also deal with this issue.
Patients in General Hospitals

We welcome legislation that treats patients with physical & mental health problems using the same principles. Psychiatric patients in general hospital often face stigma and sometimes receive a lesser quality of care because of misunderstanding of their difficulties. A unified Bill will reduce the stigma of having a separate legislative framework for psychiatric patients, from others who require treatment without consent.

Patients in general hospitals are not well served by the current legislative frameworks. A more coherent law is required for

1. patients who lack capacity and refuse physical treatment – currently resolved by seeking a Declaratory Judgement in the High Court.
2. Patients who lack capacity but acquiesce to treatment (see below)

A positive effect of the proposed new law will be removal of the interface between the MHO and the common law framework dealing with incapacity and best interests. In the general hospital situation it is not always clear which framework applies, and staff who are not experts in psychiatry or law have to grapple with a Mental Health legislative framework and Capacity case law, which can be confusing.

Large numbers of patients (approximately 30% according to one study) of general hospital patients lack capacity – much of this is due to delirium, dementia and long term effects of alcohol misuse. This will rise as the proportion of elderly people in hospital increases. Our experience as liaison psychiatrists is that patients come to attention when they refuse treatment and capacity is in question. But there are also large numbers who acquiesce to treatment with doubtful capacity who do not come to attention. There is no statute which currently protects the rights of this group (in England and Wales they fall under the remit of the MCA, and the equivalent legislation in Scotland).

Recent evidence from England and Wales (House of Lords Report, 2014) shows that the implementation of the Mental Capacity Act has been hampered by lack of understanding and unnecessary complexity. An Act that aimed to boost autonomy and empowerment is failing in its purpose. We would have concerns that the NI Capacity legislation could run into similar problems in the general hospital, if its introduction is not accompanied by a coherent programme of education and awareness raising.
We have concerns about the level of training which will be required given that the new law is potentially applicable to any patient in general hospital. Experience tells us that the level of knowledge and skill with respect to capacity assessment is, at the very best, patchy, and there is limited awareness among general hospital staff that a change in the law is imminent. General hospital staff often regard legal issues (the MHO and Capacity issues) as the remit of psychiatrists. Liaison psychiatrists are often asked to undertake basic capacity assessments. A fundamental principle of capacity to make a decision is that this assessment must be carried out by the practitioner who will be carrying out the intervention. In line with GMC guidance, Liaison Psychiatrists are available to offer assistance in assessment of capacity where there is a degree of ambiguity or doubt following the initial assessment as carried out by the responsible medical team. In our view we are well placed to advice in complex capacity issues, but uncomplicated cases should not be beyond the competence of any doctor (or other trained professional). For example, a Liaison Psychiatrist may have particular expertise in assisting in the assessment of capacity of an individual to consent to or refuse a procedure when they have a delusional belief that the doctors/nurses are wanting to harm them and that the proposed procedure will, in their mind, lead to such harm. However, it is not the psychiatrist but rather the person carrying out the procedure who is best placed to explain the intricacies of said procedure.

We anticipate that the frequency of capacity assessments in the general hospital will rise under the new legislation, and if training is not adequate then the expectation for carrying these out will fall to psychiatric liaison teams which are not resourced to do them, resulting in delays then in providing for vulnerable patients.

Clarity is also needed with regard to how the new legislation will work in emergency situations. The pressures on ED departments are well recognized. Legislation and the Code of Practice requires to be easily workable in practice and allow for rapid fluctuations in levels of capacity due to intoxication for example particularly in a demanding environment such as the ED. It is often difficult for staff and patients to make decisions in emergency or crisis situations where anxiety is high, and decision making abilities then impaired, sufficient and relevant information is lacking and those who know the patient well may not be available.
There is also an issue around assessing capacity when somebody is intoxicated. It is important to highlight that it is common for people with severe and enduring mental health conditions to use intoxicating substances, meaning that it is important not to assume that a lack of capacity is solely due to use of such substances and that in fact the substance use can increase the risk of harm to self or others. Adequate assessment is required to differentiate the role of substance use and mental health in someone’s presentation if there is a lack of capacity.

It is important to consider the consequences of addiction (e.g. Alcohol Related Brain Damage), where optimal treatment may be a requirement for someone without capacity to reside in supportive environment to sustain abstinence. There is reference to a Community residence requirement which need to be authorized by Trust panel which may well cover this area, but if not the Bill should address it.
Criminal Justice Policy

Introduction
The College supports the introduction of capacity based legislation in criminal justice policy incorporating mental health legislation.

Overview of Policy
Capacity based legislation by its very nature is both issue and time specific. On its own, it fails to recognise the dynamic nature of mental disorder. In the Bill and the Code of Practice there requires to be a clearer description of the presentation of mentally disordered offenders detained in hospital most of whom have the capacity to make decisions with regards to the specific issue of hospital admission but who present a significant risk of serious harm to public safety.

The Three Key Criminal Justice Stages

Police and the Place of Safety
The College supports the retention of a power exercisable by police to remove a person from a public place to places of safety. We do not understand how a police officer is expected to reach a decision that “the person is unable to make a decision because of an impairment or disturbance in the mind or brain as to whether he needs to go to a place of safety”. We consider this to be unrealistically demanding. We further note that there is a proposed requirement of a serious harm criterion. Not only is serious harm not defined we consider that any harm should be sufficient for the relatively unobtrusive process of removal to a place of safety.

It should be noted that people requiring removal to a place of safety come to the attention of the police as a result of a behavioural issue that is, by definition, placing themselves or others at risk. Indeed, as the provisions are presently written this must be “serious harm”. Too often such a person is removed to hospital as a place of safety under these circumstances. Custody suites are designed to manage aggressive behaviours and would allow a meaningful assessment of such a person’s needs and the appropriate level of security to provide this.

Remand
The consultation document recognises that there are two remand powers to hospital in present legislation. In practice these are very seldom used.
If the Bill persists with these powers the receiving Responsible Medical Officer has the power to veto any such decision. The present situation where Courts attempt to remand defendants to hospital without necessary regard to mental health services should not continue. This needs to be more specific than the present arrangements where any medical practitioner can provide evidence and the Department of Health, Social Services and Public Safety is given an opportunity to make representations. At this time there is no expectation for the receiving hospital staff to be consulted. This poses numerous challenges in communication, safe transfer and adequate, appropriate and safe provision for the proposed patient and other patients already in the receiving unit. Given the seriousness of such decisions these should be subject to review.

We note that the criteria for these remands would include that the person either consent to the examination or treatment or that they lack the capacity to so consent. It is our clinical experience that the overwhelming majority of such patients would consent but that we could not safely manage such a patient without the restrictions imposed by the present mental health legislation.

**Sentencing**
The College note that the Bill proposes the introduction of an Inpatient Treatment Order. This is essentially analogous to the present hospital order. The criteria for this order again include the capacity question. This may be problematic as the basic principles of capacity are time specific. If an Inpatient Treatment Order is awarded at a time when a person lacks capacity, will this order continue once capacity has been regained? This needs to be clarified in the legislation.

A second issue will be that a person who has capacity (the overwhelming majority by the time the cases come to sentencing) can refuse an Inpatient treatment Order. This will mean that people with capacity will remain in prison even if they have a serious mental illness.

The College recognise the proposal for an interim form of the inpatient treatment order.

Restriction Orders are the very cornerstone of forensic psychiatry in the management of the most dangerous mentally disordered offenders. The Bill makes reference to such a Restriction Order being available to the Court but it is not immediately clear how this Order is in keeping with the principles of capacity
which are issue and time specific. Mental disorder has a nature and degree and recognition of this is important in treating the patient and protecting the public.

The College recognises the proposed Inpatient Direction Order. We have no particular objection to this but would note that where available in other jurisdictions analogous legislation is rarely used.

The College notes that there is a proposal for a Community Residence Order. We note that the consultation document makes no reference to the criteria for such an order. We would presume that these criteria would be capacity based and would, as such, present the same limitations of fluctuating capacity as the other proposals.

**Unfitness to Plead**
The College recognises that unfitness to plead is, at present, determined by consideration of the Pritchard Criteria. These have served forensic psychiatry and the Courts well over many years.

We acknowledge the work of the Northern Ireland Law Commission in reviewing these arrangements and have considered the proposed revisions. We do not consider that these revisions are in any way beneficial to the accused, the Courts or medical practitioners. The criteria as they are recognised throughout the English speaking world have been demonstrated to be effective. We see no grounds for change.

The criteria in paragraph 4.52 make references to “certain decisions that he or she is required to make in relation to the trial” without specifying what these are. This lack of clarity would appear to increase the risk of inconsistent decision making with regard to expert opinions on fitness to plead.

We would encourage the extension of unfitness to plead to the Magistrates Court although we would note that unfitness hearings are resource and time consuming.

We note that the proposed sentencing options for a person found unfit to plead or to be not guilty on the grounds of insanity will include the Inpatient Order. This would, of course, involve an assessment of the capacity of a patient to agree to such an Order. The consultation document recognises that situations will arise where a person found unfit to plead who retains capacity to make decisions about treatment will refuse such treatment. There is a proposal for a Protection Order in these cases. The College considers this to be an admission
that capacity based legislation simply will not always work with mentally disordered offenders. The proposal that the patient with capacity who is refusing treatment should be “detained in a care-based environment until the level of dangerousness had reduced” “In which care or treatment is available” appears to be based on the flawed assumption that dangerousness would reduce without treatment.

It has been interpreted very broadly by the courts in England. The treatment doesn’t have to be accepted, it may not even have to be offered, it certainly doesn’t have to be effective for that person. The detention of Personality Disordered patients in High Secure settings is predicated on the following reasoning:

- Treatment is available in this hospital for the condition this patient has
- It is effective in about 50% of cases
- It may not be effective in his case, but we can detain for it.

This has led to patients being detained for prolonged periods of time and in some cases, impossible to discharge from hospital care. The test in law is not that the patient responds, but that treatment exists in the setting. Therefore a cohort of patients are effectively stuck in hospital settings. This has been an unintended consequence of the wording of the law in England.

This proposal has significant resource implications for secure hospital care. Worrying this will raise significant Deprivation of Liberty concerns. Additionally, there are concerns about reciprocity. In the spirit of the 1986 Order it was recognised that if a patient was deprived of liberty that it was incumbent to provide treatment that would improve them.

The consultation document describes this as a “rare” event. This will not be the case. It is our clinical experience that most of the people who are found either unfit to plead or to have been insane at the time of the index offence will have capacity to make a decision about hospital admission by the time of their sentencing. We would point out that this is often several years after the index offence. We do not believe that any legal counsel would advise their client to accept what is essentially a time unlimited sentencing option. Protection Orders will become the norm thus defeating the intent of introducing capacity based legislation. The duration of six months for such an Order will be very demanding. Most hospital orders at present are in place for many years.
Community based disposals in unfitness cases
We note that the consultation document proposes retaining the Supervision and Treatment Order. No mention is made of the criteria for such an Order. If this requires either consent or a lack of capacity then we believe that these Orders will suffer from the same shortcomings as the Inpatient Order. Effectively no person will “volunteer” for this given that the only alternative available to the Court is an absolute discharge. Most people considered for a Supervision and Treatment Order would have the capacity to agree to such an Order.

Transfer of Prisoners
The College note that there is a provision for the transfer of prisoners to hospital.
As with the other provisions discusses there is a criterion that the prisoner either consents to such a transfer or lacks capacity to so do.
It is our clinical experience that the overwhelming majority of transferred prisoners would have capacity in this regard. The consultation document indicates that authority for detention will pass from the prison to hospital in these cases. We do not understand how this can be if the hospital is then expected to effectively detain a patient who has capacity to decide to leave. This appears contrary to the principles of capacity legislation which are time and issue specific. We believe that this process will be open to legal challenge and that hospitals will find themselves managing patients who have capacity but refuse to remain.
This potential for confusion in the application of the principles of capacity indicates the importance of retaining mental health legislation within the Bill which recognises the nature and degree of mental disorder.

The Review Process

The Tribunal
The College recognise the importance of the Review Tribunal subject to our earlier remarks.

Review and Discharge
The College recognises the importance of the powers of the Review Tribunal to grant either absolute or conditional discharge. We must, however, note that this may not be consistent with a capacity based approach which is issue and time specific.
Recall

The College note that the consultation document contains the following:

“The Department proposes to retain its powers to recall a patient who has been conditionally discharged but is not complying with discharge conditions”.

The College believe this statement to be misleading. It is our understanding that, at present, the Department can recall a patient who has a mental illness or severe mental impairment who presents a substantial risk of serious physical harm to others. The mere lack of compliance with discharge conditions is not sufficient for recall. We believe that this may reflect a lack of consideration of the nature and degree of mental disorder as this is the key element, along with the risk profile, in determining liability to recall.

We presume that liability to recall would come into play if a conditionally discharged patient lacked the capacity to make such a decision as regards hospital treatment. We do not consider that this would be sufficient to ensure public safety.

In summary The College support the introduction of capacity legislation which harmonises with Mental Health Legislation and that this should have a role to play in the criminal justice arena.

However, a review of the criminal provisions of the Bill indicates that the principles of capacity run the risk of being inconsistently applied to the provisions.

Equality and Human Rights

The College welcomes a proposed legislation that is at harmony with the European Convention on Human Rights. By placing what is now dealt with under Common Law in Statute, this will provide both the individual and the decision maker with increased protection under the legislation.

Other Areas of Concern to the College

The duty of Trusts to preserve life

The MCA England is far from perfect. For example there has been considerable debate about the death of Kerrie Wooltorton ² where a decision was made not to treat for a patient with a history of repeated overdose despite the fact that an

² BMJ 2009;339:b4112 Live and let die McLean S; Mentally disordered or lacking capacity? Lessons for management of serious deliberate self harm David A  http://www.bmj.com/content/341/bmj.c4489
advance statement was eventually found not legally binding. It is of note that in a recent case with a similar fact base the English Court of Protection found that treatment should be provided.

In the legal academic literature in particular the Wooltorton decision provoked widespread discussion around the concept of "Moral Conscience" and the awareness that people with Personality Disorder because of their own psychological makeup potentially have an impaired capability to respond as others might.

There is therefore a potential conflict between the exercise of autonomy and the requirement of public authorities to protect life. This issue must be clarified within the legislation. This requirement is particularly stringent where the public authority has taken away an individual's liberty right.

Interfaces
The spectrum of the proposed Bill is wide, but the interfaces between the constituent parts or stages of the Bill are not yet clearly defined. As written, it is not immediately clear when the primacy of capacity is overridden by risks to the self and others by the mentally ill, or those with fluctuating capacity or by criminal law. This will require to be more succinctly described. The interface between capacity and vulnerable adult procedures requires further attention.

Summary
The College recognizes and supports the need to introduce capacity legislation which protects individuals, their carers and professionals. While we have

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This version available at: http://eprints.lse.ac.uk/39443/
5 Reeves v Commissioner of Police of the Metropolis [1999] 3 All ER 897;
Savage v South Essex Savage v South Essex Partnership NHS Foundation Trust[2008] UKHL 74
6 Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2. The positive operational duty to save life, which would most likely have been triggered on the facts, would require the professionals involved and the Court to do all that could reasonably be expected to minimise the real and immediate risk
http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_judgment.pdf
commented on the current draft order we note that there is an urgency in developing the criminal justice provisions as the interface between what has been proposed and these will be pivotal.

While the College support the principles within the Bill it has concerns about the current wording of the document which is open to different interpretations and in its present format would not be in keeping with The Bamford Review recommendation that legislative solutions “be clear and efficient for professional staff to operate”. The Code of Practice is of paramount importance to the successful introduction of this fused legislation, and must be clear and accessible to all. It is essential that this is launched in a timely fashion.

We emphasise that the introduction of the legislation will have to be supported by an intensive, all inclusive training strategy designed to meet the individual needs of different groups of patients, carers and staff. This training programme must be structured in such a way as to ensure that all Health and Social Care staff, irrespective of their discipline, can ensure that their knowledge and skills remain up to date.

We believe that as a College we have much to contribute in the development of the Code of Practice and training strategy, and welcome the opportunity to be associated with what could potentially prove to be an International example of good practice.

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2 September 2014