Law Centre (NI)

policy briefing

July 2014

The Mental Capacity Bill explained

The Mental Capacity Bill was issued for public consultation on 27 May 2014. The Bill fuses mental health and mental capacity law into a single piece of legislation.

The Law Centre believes it is important that all stakeholders engage with the consultation but we are aware that it is a complex piece of legislation. To this effect, we have put together an information briefing to clarify the core civil provisions of the Bill.

The aim of this briefing is to foster a greater level of understanding of the complexities of the draft legislation amongst the wide number of stakeholders with a keen and practical interest in the Bill.

The consultation ends on 2 September 2014. Consultation documents can be found at:

www.dhsspsni.gov.uk/pr-mentalcap270514

Law Centre (NI)

Introduction

The Mental Capacity Bill was issued for public consultation on 27 May 2014. The Bill fuses mental health and mental capacity law into a single piece of legislation. It will replace the Mental Health (1986) Order for those over the age of 16 and is the first time that a 'fused approach' has been attempted globally.

The Bill provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Law Centre believes it is important that all stakeholders engage with the consultation but we are aware that it is a complex piece of legislation. We have put together this information briefing to clarify the main civil provisions of the Bill. This paper is descriptive but we are in the process of developing an analytical and detailed response to the Bill which we will circulate at a later date.

Our aim is to foster a greater level of understanding of the complexities of the draft legislation among stakeholders with a keen and practical interest in the Bill. The briefing paper may be particularly useful for:

- those working in a health and social care context;
- voluntary and community sector organisations with a keen interest in issues affecting older people, people with mental health problems, people with learning difficulties, people with brain injuries and carers;
- people with lived experience of mental health services or having their mental capacity questioned;
- legal professionals; and
- MLAs and their staff.

The paper does not expand upon the policy proposals relating to under-16s or for those in the criminal justice system. The approach of the two Departments regarding those proposals is covered in the consultation documents which can be accessed at the link below.

The consultation ends on 2 September 2014. Consultation documents can be found at: http://www.dhsspsni.gov.uk/pr-mentalcap270514

Colin Harper, Assistant Director (Mental Health & Community Care)

colin.harper@lawcentreni.org

Michael Bower, Policy Officer (Mental Health & Community Care)

michael.bower@lawcentreni.org

Contents

Section 1 – Principles 4

1.1 Establishing whether a person lacks capacity 4

1.2 The requirement that support be provided for decision-making 5

1.3 Lack of capacity 5

1.4 Best interests principle 6

Section 2 – Interventions and safeguards 8

2.1 All interventions 8

2.2 Emergency interventions 8

2.3 Acts of restraint 9

2.4 Additional safeguards for serious interventions 9

2.4.1 Formal assessment of capacity 10

2.4.2 Ensuring a nominated person is in place and consulted with 10

2.5 Interventions requiring a second opinion 12

2.6 Interventions requiring a formal authorisation process 12

2.6.1 Schedule 1 Authorisation by HSC Trust panel 13

2.6.1.1 Treatment with serious consequences 13

2.6.1.2 Deprivation of liberty 14

2.6.1.3 Requirement to attend for certain treatment 15

2.6.1.4 Community residence requirements 15

2.6.2 Schedule 2 Authorisation of short-term detention in hospital 16

2.6.2.1 Disregard of short-term detention 16

2.6.3 Instruction of independent advocate 17

2.6.4 Rights of review for Schedule 1 and Schedule 2 authorised interventions 18

Section 3 - Future planning 19

3.1 Advance decisions to refuse treatment 19

3.2 Lasting Powers of Attorney 19

Section 4 – High Court Powers 21

Section 5 – The Public Guardian 22

5.1 Court visitors 22

Section 6 – Research 24

Section 7 – Transfer between jurisdictions 24

Section 8 – Offences 26

Section 9 – Miscellaneous provisions 27

Section 10 – Supplementary provisions 29

Section 11 – Schedules 30

NOTE: Throughout this Policy Briefing and in the draft Bill, reference is made to 'P' and 'D'. 'P' refers to an individual who is aged 16 or over and has been found to lack capacity. 'D' refers to an individual who is carrying out an act in P's best interests after determining that P lacks the capacity to make the decision, even with appropriate support provided.

FUTURE REGULATIONS

Some detail in the draft Bill is not specified as part of the primary legislation but instead will be left to future regulations as part of secondary legislation emanating from the Bill.

We have drawn attention in the briefing paper to where this applies to key pieces of detail.

1. Principles

The principles outlined at the start of the draft Bill provide a framework for how any assessment of an individual's decision-making capacity should be carried out. They also govern the process through which any subsequent substitute decision should be made.

The Bill contains the presumption that everyone has the capacity to make a decision for him/herself [**Clause 1 (1)**]. It confirms the legal situation that a person does not have to prove he or she has the capacity to make a decision; rather, it falls to the person questioning another person's capacity to establish lack of capacity.

In establishing whether someone lacks capacity the following principles in clauses 1(3) to 1(5) must be followed:

- nobody should be deemed to lack capacity unless all practicable help and support has been given to help an individual to make a decision for him/herself without success;
- making an unwise decision does not mean a person lacks capacity; and
- no-one can be deemed to lack capacity on the basis of age or appearance, his or her condition, or unjustified assumptions about behaviour (in other words, eccentricity cannot be considered to mean a lack of capacity).

If, after the above principles have been followed, a person is deemed to lack capacity, any substitute decision must meet the best interests principle.

1.1 Establishing whether a person lacks capacity

In legal proceedings, the standard of proof for a lack of capacity is the balance of probabilities.

In all other circumstances under the Bill which involve an individual having to determine whether another individual lacks capacity on a matter, the following requirements must be complied with:

5 (3) If:

(a) the person making the determination has taken reasonable steps to establish whether P lacks capacity in relation to the matter,

(b) the person reasonably believes that P lacks capacity in relation to the matter, and

(c) the principles in section 1(3) to (5) and section 4 have been complied with, for the purposes of section 1(1) the person is to be taken to have sufficiently 'established' that P lacks capacity in relation to the matter.

[Clause 5(3)]

This process of establishing a lack of capacity has two components:

- has all practical help and support been given to help the person make the decision; and
- does the person lack the capacity to make a particular decision at the material time?

1.2 The requirement that support be provided for decision-making

Any (non-emergency) intervention or substitute decision on behalf of an individual will not be lawful unless ***"all practicable help and support to enable the person to make a decision in relation to the matter have been given without success"*** [Clause 4(1)]. Any potential substitute decision maker will have to follow the steps outlined in the Bill to support an individual to make a decision for him or herself, namely:

(a) the provision to the person, in a way appropriate to his or her circumstances, of all the information relevant to the decision (or, where it is more likely to help the person to make a decision, of an explanation of that information);

(b) ensuring that the matter in question is raised with the person:

(i) at a time or times likely to help the person to make a decision; and

(ii) in an environment likely to help the person to make a decision;

(c) ensuring that persons whose involvement is likely to help the person to make a decision are involved in helping and supporting the person.

[Clause 4(2)]

For serious interventions, a formal assessment of capacity is required which must include a written statement ***"specifying any help or support that has been given to P, without success, to enable P to make a decision in relation to the matter."*** [Clause 12 (4) (d)]

1.3 Lack of capacity

For someone to be found to lack the capacity to make a decision, a two stage process to determine a lack of capacity must be applied. The first stage is that the individual whose capacity is being assessed

must have an ***"impairment of, or disturbance in the functioning of, the mind or brain"*** [Clause 2(1)]. This could be, for example, a mental disorder, a learning disability, being under the influence of a mind-altering substance or being unconscious. This is sometimes referred to as the 'diagnostic' test, but it is not necessarily a 'medical' test or diagnosis.

The second stage of the process is the 'functional' test. The person lacks capacity if, as a result of the impairment or disturbance in the functioning of his/her mind or brain, the person:

(a) is not able to understand the information relevant to the decision; or

(b) is not able to retain that information for the time required to make the decision; or

(c) is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or

(d) is not able to communicate his or her decision in any way (whether by talking, using sign language or any other means).

[Clause 3(1)]

1.4 Best Interests Principle

If a reasonable belief is formed that an individual does not have the capacity to make a particular decision, even with support, then the potential substitute decision maker ('D') needs to determine what is in the individual's ('P') best interests. In doing so, D must not make the determination ***"merely"*** on the basis of:

6 (2) (a) P's age or appearance; or

(b) a condition of P's, or an aspect of P's behaviour, which might lead others to make unjustified assumptions about what might be in P's best interests.

[Clause 6(2)]

In deciding on what is in P's best interests, D must ***"consider all the relevant circumstances"*** and must take the following steps:

6 (4) That person must consider:

(a) whether it is likely that P will at some time have capacity in relation to the matter in question; and

(b) if it appears likely that P will, when that is likely to be.

(5) That person must, so far as practicable, encourage and help P to participate as fully as possible in the determination of what would be in P's best interests.

(6) That person must take into account, so far as they are reasonably ascertainable:

(a) P's past and present wishes and feelings (and, in particular, any relevant written statement made by P when P had capacity);

(b) the beliefs and values that would be likely to influence P's decision if P had capacity; and

(c) the other factors that P would be likely to consider if able to do so.

(7) That person must:

(a) if it is practicable and appropriate to do so, consult the relevant people about what would be in P's best interests and, in particular, about the matters mentioned in subsection (6); and

(b) take into account the views of those people (so far as ascertained from that consultation or otherwise) about what would be in P's best interests and, in particular, about those matters.

[Clause 6(4) to 6(7)]

Clause 6 (8) clarifies that ***"the relevant people"*** in Clause 6 (7) means:

- someone who P specifically wants consulted with;
- a carer or someone else with an interest in P's welfare;
- a nominated person;
- an independent advocate;
- an attorney; and
- a court appointed deputy.

Further steps which must be taken in a determination of P's best interests are:

(9) The person making the determination must, in relation to any act or decision that is being considered, have regard to whether the same purpose can be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.

(10) That person must, in relation to any act that is being considered, have regard to whether failure to do the act is likely to result in harm to other persons with resulting harm to P.

(11) If the determination relates to life-sustaining treatment for P, the person making the determination must not, in considering whether the treatment is in the best interests of P, be motivated by a desire to bring about P's death.

[Clause 6(9) to 6(11)]

2. Interventions and associated safeguards

Rather than providing legal powers to act, the Bill is framed in terms of providing protection from civil or criminal liability for D as long as certain conditions are met. Part 2 of the Bill details the steps that D must take to be protected from liability when carrying out an act in connection with the care, treatment or personal welfare of P. In general, additional safeguards are required to be in place in proportion to the seriousness of the intervention. Particular defined interventions also require specific safeguards.

2.1 All interventions

All interventions must be in keeping with the principles (including that support for capacity must be provided) and must meet the criteria detailed in Part 1, namely:

(i) ***that P lacks capacity in relation to the matter; and***

(ii) ***that it will be in P's best interests for the act to be done.***

[Clause 8(1)(d)]

Throughout the Bill, any reference to P lacking capacity assumes that all practical help and support have been given to P without success.

D is only protected from liability if D ***"reasonably believes"*** the capacity and best interests requirements have been met and if D is the appropriate person to make the decision.

In any event, D is not protected from any liability for negligence if there would have been negligence in a situation where an individual had the capacity to consent.

2.2 Emergency interventions

For any intervention, if the situation can reasonably be defined as an ***"emergency"***, D will be protected from liability if s/he takes action without necessarily complying with the safeguards ordinarily required for that intervention.

A situation is only defined as an emergency if:

(a) ***D knows that the safeguard in that section is not met, but reasonably believes that to delay until that safeguard is met would create an unacceptable risk of harm to P; or***

(b) ***D does not know whether that safeguard is met, but reasonably believes that to delay even until it is established whether it is met would create an unacceptable risk of harm to P.***

[Clause 65(2)]

The risk of the delay in establishing whether a safeguard can or should be met is considered ***"unacceptable"*** if:

(a) ***the seriousness of the harm that could be caused to P by such delay, and***

(b) the likelihood of the harm,

are such as to outweigh the risk of harm to P of not complying with the safeguard.

[Clause 66(3)]

2.3 Acts of restraint

An act of restraint is defined as one which:

(a) is intended to restrict P's liberty of movement, whether or not P resists; or

(b) is a use of force or a threat to use force and is done with the intention of securing the doing of an act which P resists.

[Clause 11(2)]

D must comply with an additional safeguard if P is to be restrained. The restraint condition states that, at the time the act is done, D must reasonably believe:

(a) that failure to do the relevant act would create a risk of harm to P; and

(b) that the relevant act is a proportionate response to –

(i) the likelihood of harm to P; and

(ii) the seriousness of the harm concerned.

[Clause 11(4)]

An act of restraint should not be confused with a deprivation of liberty. Additional safeguards are required to be complied with if the act is more appropriately defined as a deprivation of liberty, rather than as an act of restraint.

2.4 Additional safeguards for serious interventions

A ***"serious intervention"*** is defined in the Bill as an intervention in connection with the care, treatment or personal welfare of P which:

(a) consists of or involves major surgery;

(b) causes P serious pain, serious distress, or serious side-effects;

(c) affects seriously the options that will be available to P in the future, or has a serious impact on P's day-to-day life; or

(d) in any other way has serious consequences for P, whether physical or non-physical.

[Clause 63(1)]

The two safeguards outlined below (formal assessment of capacity and nominated person) must be followed for all serious interventions including any treatment that requires a second opinion and any intervention or act that requires a Schedule 1 or 2 authorisation.

2.4.1. Formal assessment of capacity

When a serious intervention is being considered, a formal assessment of capacity must be carried out by a suitably qualified person, who could be D if appropriate (at present suitably qualified is not defined; this will eventually be contained in DHSSPS regulations). If that person deems P to lack capacity, then a written ***"statement of incapacity"*** must be produced which includes:

(a) ***recording the fact that the assessment was carried out, by whom it was carried out and when;***

(b) ***certifying that, in the opinion of the assessor, P lacks capacity within the meaning of this Act in relation to the matter in question;***

(c) ***specifying which of the things mentioned in section 3(1)(a) to (d)*** [the elements of the functional test of capacity – see section 1.3 of this paper] ***P is, in the assessor's opinion, not able to do in relation to that matter because of an impairment of, or a disturbance in the functioning of, P's mind or brain; and***

(d) ***specifying any help or support that has been given to P, without success, to enable P to make a decision in relation to the matter.***

[Clause 12(4)]

2.4.2 Ensuring that a nominated person is in place and consulted with

If a nominated person is in place for P when D determines whether the serious intervention would be in P's best interests, D must both consult and take into account the views of the nominated person.

The detail around the role of the nominated person is set out in Part 3 (clauses 70 to 82). P will have the power to appoint a nominated person of his or her choice in writing – providing P has the capacity to do so - which will have to be witnessed by a prescribed person. The nominated person must also give his/her consent in writing.

If P has not previously appointed a nominated person, then the Bill at Clause 74 provides a list of who should be considered by D to be the default nominated person in ranking order:

(a) ***P's carer within the meaning given by section 76;***

(b) ***P's spouse or civil partner;***

(c) ***a person within subsection (4);***

> ***{(4) A person is within this subsection if:***
>
> ***(a) the person is living with P as if he or she were P's spouse or civil partner, and has been so living for a period of at least 6 months; or***
>
> ***(b) if P is living in a hospital or a care home, the person had been living with P as if he or she were P's spouse or civil partner for a period of at least 6 months when P was admitted.}***

(d) ***P's child;***

(e) ***P's parent;***

(f) ***P's brother or sister;***

(g) P's grandparent;

(h) P's grandchild;

(i) P's aunt or uncle;

(j) P's niece or nephew;

(k) a person within subsection 5

{(5) A person is within this subsection if the person:

(a) is someone with whom P lives and has been living for a period of at least 5 years; or

(b) if P is living in a hospital or care home, is someone with whom P had been living for a period of at least 5 years when P was admitted.}

[Clause 74(3)]

An individual is deemed to be P's carer if he or she:

(a) is aged 16 or over; and

(b) provides (or, where P has been admitted to a hospital or care home, did provide before P's admission) a substantial amount of care for and support to P:

(i) on a regular basis; and

(ii) on a domestic basis.

[Clause 76(1)]

A person who provides care on the basis of employment or as a volunteer for an organisation cannot be considered to be P's carer for the purposes of the Bill.

The Bill makes provision for an individual with capacity to declare people to not be considered as his or her nominated persons should the situation arise (Clause 76). It also gives the Review Tribunal the power to appoint and revoke a nominated person (Clauses 79 to 82). The conditions for an application to be made to a Tribunal to appoint a nominated person are:

(a) the person who is P's nominated person is not suitable to be so;

(b) there is no-one who is P's nominated person;

(c) it is not practicable to establish whether P has a nominated person;

(d) someone is P's nominated person, but it is not practicable to establish who that is.

[Clause 79(2)]

The nominated person has specific powers in the Bill, namely:

- he or she can object to a course of treatment for P with serious consequences, which may require it to be authorised by a HSC Trust panel if the health professionals still believe it necessary **[Clause 17]**;
- he or she can contest any compulsory interventions that requires a Schedule 1 or Schedule 2 authorisation by referring it to the Review Tribunal **[Clause 79].**

2.5 Interventions requiring a second opinion

A second opinion in the form of a certificate from another doctor is required to authorise the following treatments:

(a) electro-convulsive therapy;

(b) any treatment with serious consequences which is also treatment specified for the purposes of this paragraph by regulations

(c) any treatment with serious consequences where, at the time of the act-

(i) the questions whether it is in P's best interests is finely balanced; and

(ii) the circumstance are such as may be prescribed.

[Clause 14(1)]

Clause 15 states that a second opinion from a doctor is also required to authorise the continuation of medication that is deemed to have serious consequences if it has been administered for over three months.

Any doctor tasked with providing a second opinion:

(a) is not a person connected with P (within the meaning of section 158);

(b) is appointed for the purposes of this section by RQIA; and

(c) has been asked by RQIA, following a relevant request, to provide an opinion as to whether it would be in P's best interests for P to have the treatment.

[Clause 16(5)]

In doing so, the Bill requires the doctor to: examine P in private; examine P's relevant health records; consult with people concerned with P's treatment; and to send a copy of the certificate to the RQIA (Regulation and Quality Improvement Authority). **[Clause 16(2)-(4)]**

2.6 Interventions requiring a formal authorisation process

The Bill creates two authorisation processes which must be followed if certain serious interventions need to be made in relation to P's care and/or treatment. These are:

- authorisation by a HSC trust panel for certain serious interventions (through Schedule 1 of the Bill);
- a report to authorise short-term detention for examination in hospital (through Schedule 2 of the Bill).

If authorisation is not received by D when the Bill states it is necessary for him/her to do so, then D will not be protected from liability for that action.

For any intervention that requires a Schedule 1 or Schedule 2 authorisation, an independent advocate must be instructed to represent and support P (see section 2.6.3 in this paper).

Any Schedule 1 or Schedule 2 authorisation can also be appealed at Review Tribunal (see section 2.6.4 in this paper).

2.6.1 Schedule 1 authorisation by a HSC trust panel

Schedule 1 outlines the authorisation process required for certain interventions by a panel appointed by the relevant health and social care trust. Panels will have three members but their precise make-up will be made through future regulations by DHSSPS.

An application to receive authorisation for an act from a HSC trust panel should be made by an approved social worker or ***"a person of a prescribed description who is designated by the managing authority of a hospital or care home in which P is an in-patient or resident as a person who may make applications under this Schedule".*** [Future regulations will provide more detail on this].

[Schedule 1, Para 4(2)(b)]

Any application must:

(a) be in the prescribed form;

(b) include a medical report;

(c) include a care plan;

(d) include prescribed information about the views, on prescribed matters, of P's nominated person and such other persons as may be prescribed; and

(e) include such other information as may be prescribed.

[Schedule 1, Para 5]

A Schedule 1 authorisation expires after six months (Schedule 1, Para 14). It can be extended beyond the initial period of authorisation for an additional six months (Clause 38 and Schedule 3) and subsequently for periods of one year after that. Extensions are dependent on the criteria for detention still being met and the required safeguards still being in place.

The following interventions require a Schedule 1 authorisation plus additional safeguards to be in place:

2.6.1.1 Treatment with serious consequences

Treatment with serious consequences is defined in the Bill as treatment which:

(a) causes the person to whom it is given serious pain, serious distress, or serious side-effects;

(b) is major surgery;

(c) affects seriously the options that will be available to that person in the future, or has a serious impact on his or her day-to-day life; or

(d) in any other way has serious consequences for that person, whether physical or non-physical.

[Clause 18(1)]

There are two situations which require authorisation from a HSC Trust panel in order to expose P to treatment with serious consequences:

1) When the nominated person reasonably objects to the treatment and ***'at the time the act is done, D reasonably believes that the prevention of serious harm conditions are met'*** **[Clause 17 (3b)]**.

The ***"prevention of serious harm conditions"*** are that:

(a) failure to provide the treatment in question to P would create a risk of serious harm to P or of serious physical harm to other persons; and

(b) carrying out that treatment is a proportionate response to:

(i) the likelihood of such harm; and

(ii) the seriousness of the harm concerned.

[Clause 19(1)]:

2) When P resists a compulsory treatment with serious consequences (even if the nominated person does not object).

2.6.1.2 Deprivation of liberty

Any act that amounts to a deprivation of liberty for P must be authorised and meet the prevention of serious harm condition. This applies whether P is compliant with the detention or not.

Authorisation for detention can be done through one of two ways:

(a) by a panel under Schedule 1, or

(b) by the making of a report under paragraph 2 of Schedule 2 (authorisation of short-term detention for examination etc), [This is a separate authorisation process discussed in section 2.6.2]

[Clause 23(4)]

An act is defined as a deprivation of liberty if it consists of:

(a) P's detention in circumstances amounting to a deprivation of liberty in a hospital or care home in which care or treatment is available for P;

(b) P's detention in circumstances amounting to a deprivation of liberty while P is being taken, transferred or returned to a hospital or care home for the purposes of the provision to P of care or treatment; or

(c) P's detention in circumstances amounting to a deprivation of liberty in pursuance of a condition imposed in accordance with section 26 (permission for absence from hospital or care home).

[Clause 22(3)]

Again, after determining that P lacks capacity and that detention for care and treatment would be in P's best interests, a prevention of serious harm condition must be met; namely:

(a) failure to detain P in circumstances amounting to a deprivation of liberty would create a risk

of serious harm to P or of serious physical harm to other persons; and

(b) the detention in question is a proportionate response to:

(i) the likelihood of such harm; and

(ii) the seriousness of the harm concerned.

[Clause 23(5)]

2.6.1.3 Requirements to attend for certain treatment

"The imposition on P of a requirement to attend at a particular place at particular times or intervals for the purpose of being given particular treatment which would be likely to be treatment with serious consequences" **[Clause 28(1)(a)]**, must be authorised by a HSC trust panel (through Schedule 1) and meet the receipt of treatment condition.

The receipt of treatment condition is that at the time the act is done D reasonably believes that:

(a) failure to impose the requirement, or

(b) where the requirement is already imposed, failure to ensure that P complies with the requirement, would be more likely than not to result in P's not receiving the treatment.

[Clause 28(5)]

2.6.1.4 Community residence requirements

A community residence requirement is ***"a requirement imposed on P by an HSC trust for P to live at a particular place"*** **[Clause 31(1)]**.

Additional requirements may be imposed on an individual, namely:

(a) a requirement for P to allow a healthcare professional access to P at a place where P is living;

(b) a requirement (or requirements) for P to attend at particular places and times or intervals for the purpose of training, education, occupation or treatment.

[Clause 31(2)]

"Treatment" in this context does not include ***"treatment with serious consequences"*** which instead must be authorised through an ***"attendance requirement"*** as detailed above.

A community residence requirement must be authorised by a HSC trust panel (through Schedule 1) and meet the ***"prevention of harm condition"***.

The ***"prevention of harm condition"*** in this case is that at the time the act is done D reasonably believes that:

(a) failure to impose a community residence requirement would create a risk of harm to P;

(b) imposing such a requirement would be a proportionate response to –

(i) the likelihood of harm to P; and

(ii) the seriousness of the harm concerned;

[Clause 30(4)]

2.6.2 Schedule 2 authorisation of short-term detention in hospital

The second type of authorisation is for short-term detention in hospital for examination and is detailed in Schedule 2 of the Bill. The intervention is considered in the Bill to be a type of deprivation of liberty. A report must be made by an ***"appropriate healthcare professional"*** in order to authorise this intervention which is then given to the managing authority of the hospital. An appropriate healthcare professional is considered to be either an approved social worker or ***"a person of a prescribed description who is designated by the managing authority of the hospital specified in the report under paragraph 2 as a person who may make reports under that paragraph"*** **[Schedule 2, Para 3(2)]**. More detail about the latter role will be revealed in future regulations emanating from the Bill.

The criteria for authorisation of short-term detention are that:

(a) ***P has an illness or there is reason to suspect that P has an illness;***

(b) ***failure to detain P in a hospital in circumstances amounting to a deprivation of liberty, for the purposes of examination or of examination followed by other treatment or care, would create a risk of serious harm to P or of serious physical harm to other persons;***

(c) ***detaining P in the hospital in circumstances amounting to a deprivation of liberty, for those purposes, would be a proportionate response to –***

(i) ***the likelihood of such harm; and***

(ii) ***the seriousness of the harm concerned;***

(d) ***P lacks capacity in relation to whether he or she should be so detained; and***

(e) ***it would be in P's best interests for him or her to be so detained.***

[Schedule 2, Para 2(4)]

The report must:

(a) ***include a medical report;***

(b) ***include a statement by the person making the report under this paragraph that in that person's opinion the criteria for authorisation are met;***

(c) ***include prescribed information about the views, on prescribed matters, of P's nominated person and such other persons as may be prescribed;***

(d) ***include such other information as may be prescribed; and***

(e) ***state that the report authorises the detention, in circumstances amounting to a deprivation of liberty, of P in a specified hospital for the purposes of examination or of examination followed by other treatment or care***

[Schedule 2, Para 2(5)]

An individual can only be detained under a Schedule 2 authorisation for a maximum of 28 days.

2.6.2.1 Disregard of short-term detention

An individual who has only been subject to a Schedule 2 authorised short-term detention does not have to disclose that information in any circumstance other than as part of legal proceedings.

Where a question seeking information with respect to the previous health or circumstances of a person who has been subject to short-term detention is put to that or any other person, otherwise than in legal proceeding:

(a) the question is to be treated as not relating to the relevant detention and the answer may be framed accordingly; and

(b) the person questioned shall not be subjected to any liability or otherwise prejudiced in law by reason of any failure to acknowledge or disclose the relevant detention in answering the question.

[Clause 27(3)]

2.6.3 Instruction of Independent Advocate

For any of the acts that require formal Schedule 1 or Schedule 2 authorisation, the HSC trust must instruct an independent advocate to support P (except where P declares that no independent advocate be instructed). The role and process of instruction of an independent advocate are detailed in two parts of the Bill: clauses 35 and 36 (Part 2) and clauses 88 to 92 (Part 4).

D will only be protected from liability when an act requiring a Schedule 1 or Schedule 2 authorisation is proceeded with if the ***"independent advocate conditions"*** have been met. These are:

(a) at the time when D determines whether the act would be in P's best interests, there is an independent advocate who is instructed under section 88 to represent and provide support to P; and

(b) in determining whether the act would be in P's best interests, D consults and takes into account the views of the independent advocate to the extent required by section 6(7) and (8) (duty to consult where practicable and appropriate and to take views into account).

[Clause 35(2)]

The role of an independent advocate is to represent and provide support to P in the determination of whether the proposed act would be in P's best interests **[Clause 88]**.

This involves:

(a) providing support to P so that P may participate as fully as possible in any relevant decision;

(b) obtaining and evaluating relevant information;

(c) ascertaining P's past and present wishes and feelings and the beliefs and values that would be likely to influence P's decision if P had capacity;

(d) ascertaining what alternative courses of action are available in relation to P;

(e) informing persons responsible for determining what would be in P's best interests of the independent advocate's conclusions;

(f) informing P's nominated person (if any) of matters relevant to the nominated person.

[Clause 84(3)]

The Bill also makes provision to allow DHSSPS to make future regulations that specify the circumstances that an independent advocate may challenge a decision taken regarding P.

2.6.4 Rights of review for Schedule 1 and Schedule 2 authorised interventions

The Mental Health Review Tribunal will be renamed the ***"Review Tribunal"*** **[Clause 44(1)]**

P or P's nominated person may apply to the tribunal to appeal a Schedule 1 or Schedule 2 authorised decision at any time within an initial period (6 months of a Schedule 1 authorisation or any subsequent period of extension; 28 days of a Schedule 2 authorisation).

The Attorney General, Department for Health or the Master (Care and Protection) on the direction of the High Court may also refer cases to the Review Tribunal.

Health and Social Care Trusts have a duty to refer a case to the Review Tribunal if:

(a) the period of an authorisation under Schedule 1 is extended under Chapter 6 of this Part (including Schedule 3); and

(b) the Tribunal has not considered P's case within 2 years (or, if P is under the age of 18, one year) ending with the time when the extension takes effect.

[Clause 48(1)]

A Tribunal that is considering the legitimacy of a Schedule 1 authorisation may:

(a) revoke the authorisation;

(b) if the authorisation authorises more than one measure within the meaning given by subsection (2), vary the authorisation by cancelling any provision of it which authorises a measure; or

(c) decide to take no action in respect of the authorisation.

[Clause 49(1)]

The role of the Tribunal is to determine whether the criteria for a Schedule 1 authorisation of a measure relating to P have been met:

The Tribunal:

(a) may vary an authorisation under subsection (1)(b) only if it is satisfied that the criteria for authorisation are met in respect of each of the measures that will remain authorised by the authorisation;

(b) may decide as mentioned in subsection (1)(c) only if it is satisfied that the criteria for authorisation are met in respect of each measure which is authorised by the authorisation.

[Clause 49(3)]

A Tribunal that is considering the legitimacy of a Schedule 2 authorisation may not vary it, only:

(a) revoke the authorisation; or

(b) decide to take no action in respect of the authorisation.

3. Future planning

3.1 Advance decisions to refuse treatment

A person who may be worried about losing capacity at a future date may make his or her wishes about treatment clear in advance through an advance decision to refuse treatment or through a written statement detailing treatment preferences.

D is not protected from liability if the decision involves ***"carrying out or continuing treatment that conflicts with an effective advance decision to refuse treatment which has been made by P"*** **[Clause 10(1)(b)]**. The advance decision must be made at a time that P has capacity.

In this section ***"an effective advance decision to refuse treatment"*** means a decision which, under the common law relating to advance decisions, has the same effect as if at the material time P:

(a) ***refused consent to the treatment's being carried out or continued; and***

(b) ***had capacity to refuse that consent.***

[Clause 10(2)]

Provision is made as part of the ***"best interests"*** steps that D must take into account ***"any relevant written statement made by P when P had capacity"*** **[Clause 6(6)(a)].** While D must pay particular regard to this in any best interests judgement, D is only bound to comply with such a written statement if it is considered an effective advance decision to refuse treatment. A written statement that expresses treatment preferences does not have the same statutory footing.

3.2 Lasting Powers of Attorney

The Bill allows for the creation of a lasting power of attorney (LPA) by which a person (the donor) confers decision-making power on one or more individuals to make decisions about all or any of:

(a) ***the donor's care, treatment and personal welfare;***

(b) ***the donor's property and affairs.***

[Clause 93(1)]

An LPA must be registered with the Public Guardian (more information on this is provided in section 5 of this paper).

The LPA may have the power to make decisions about the donor's property and affairs even if the donor retains capacity, if he or she has provided consent for the LPA to do so. However with regards to the donor's care, treatment and personal welfare, the authority ***"does not extend to making such decisions in circumstances other than those where the donor lacks, or the attorney reasonably believes that the donor lacks, capacity"*** **[Clause 94(1)(a)]**.

An LPA is bound by the capacity and best interests principles of the Bill in the same way as any other substitute decision-maker **[Clause 1(2)-(7)]**. If the LPA does not follow these, then he or she would not be protected from liability.

Even though an LPA has the authority to give or refuse consent to the provision of a treatment for P, this ***"does not authorise the giving or refusing of consent to the provision of life-sustaining treatment, unless the instrument contains express provision to that effect"*** **[Clause 94(2)(b)].** Any authority for an LPA to give or withhold consent to carrying out or continuation of treatment is subject to there being an effective advance decision to refuse the treatment in question that was made by the donor after (or at the same time as) the execution of the relevant instrument. Further detail on the relation between advance decisions and the powers of LPAs is provided in Clause 95 (2) to (6).

People who currently have enduring powers of attorney will continue to do so, but no more will be created after the Bill is passed.

4. High Court powers

The Bill gives the High Court the power to make declarations with regards to P, namely:

(a) whether that person has or lacks capacity to make a decision specified in the declaration;

(b) whether that person has or lacks capacity to make decisions on such matters as are described in the declaration;

(c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.

[Clause 106 (1)]

If it is determined that P lacks decision making capacity, the court has two choices. It may:

(a) by making an order, make on P's behalf a decision or decisions that P lacks capacity to make in relation to the matter or matters; or

(b) appoint a person (a "deputy") to make decisions on P's behalf in relation to the matter or matters

[Clause 107(2)]

The deputy has similar powers to an LPA; the key difference being that an LPA is chosen by P when P has capacity and a deputy is created for P when P lacks capacity. When determining whether or not it is in P's best interests to have a deputy appointed, the court must pay regard to the principles that:

(a) a decision by the court is to be preferred to the appointment of a deputy to make a decision; and

(b) the powers conferred on a deputy should be as limited in scope and duration as is practicable in the circumstances.

[Clause 107 (4)]

Both the court and any court-appointed deputies are bound by the principles (capacity and best interests) of the Bill.

Applications by the following people can be made without permission to the court regarding matters that relate to the application of the Bill:

(a) by a person who lacks, or is alleged to lack, capacity;

(b) if such a person has not reached 18, by anyone with parental responsibility for that person;

(c) by the donor of a lasting power of attorney to which the application relates;

(d) by a person who is an attorney under a lasting power of attorney to which the application relates;

(e) by a deputy appointed by the court for a person to whom the application relates; or

(f) by a person named in an existing order of the court, if the application relates to the order.

[Clause 115(1)]

5. The Public Guardian

The Bill creates a Public Guardian which will take over the current case management functions of the Office of Care and Protection. The responsibilities of the Public Guardian will be:

(a) establishing and maintaining a register of lasting powers of attorney;
(b) establishing and maintaining a register of orders appointing deputies;
(c) supervising deputies appointed by the court;
(d) directing a Court Visitor to visit—
  (i) a person who is an attorney under a lasting power of attorney,
  (ii) a deputy appointed by the court, or
  (iii) a person granting a lasting power of attorney or for whom a deputy is appointed ("P"), and to make a report to the Public Guardian on such matters as the Public Guardian may direct;
(e) receiving security which the court requires a person to give for the discharge of functions;
(f) receiving reports from persons who are attorneys under lasting powers of attorney and deputies appointed by the court;
(g) reporting to the court on such matters relating to proceedings under this Act as the court requires;
(h) dealing with representations (including complaints) about the way in which an attorney under a lasting power of attorney or a deputy appointed by the court is exercising his or her powers;
(i) publishing, in any way the Public Guardian thinks appropriate, any information the Public Guardian thinks appropriate about the discharge of the Public Guardian's functions.

[Clause 118]

Authorities which have a caring responsibility for an individual who lacks capacity are duty bound in clause 119 to inform the Public Guardian if it is appropriate for the court to make a decision regarding that individual's care, treatment, personal welfare or property and affairs. If this results in an investigation the Public Guardian has the power to ***"arrange for the institution of proceedings before the court"***. **[Clause 120 (4)]**

5.1 Court Visitors

The draft Bill allows the Department of Justice to create panels of Court Visitors who can scrutinise the performance of attorneys and deputies and report to the Public Guardian. There are two types of Court Visitor:

- a Special Visitor who:

  (a) is a medical practitioner or appears to the Department of Justice to have other suitable qualifications or training; and

(b) appears to the Department of Justice to have special knowledge of and experience in relation to persons with impairment of or disturbance in the functioning of the mind or brain.

[Clause 121(2)]

- a General Visitor (does not need to have a medical qualification).

A Court Visitor may get access to any record relating to P's health, care, treatment or personal welfare and may interview P in private.

6. Research

Part 8 of the Bill provides safeguards for the involvement of people who lack the capacity to consent to taking part in a research project.

Research involving those who lack the capacity to consent to it must be connected with:

(a) an impairing condition affecting P; or

(b) its treatment.

[Clause 123(2)]

The research must also:

(a) have the potential to benefit P without imposing on P a burden that is disproportionate to the potential benefit to P; or

(b) be intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition.

[Clause 123(4)]

If the research falls in category (b) above then there must be reasonable grounds for believing:

(a) that the risk to P from taking part in the project is likely to be negligible; and

(b) that anything done to, or in relation to, P will not—

(i) interfere with P's freedom of action or privacy in a significant way; or

(ii) be unduly invasive or restrictive.

[Clause 123(5)]

Clause 124 gives an obligation on anyone who is aiming to carry out research in relation to P, to consult with a nominated person/carer/attorney/etc. in order to ascertain whether P would give consent if P had the capacity to do so. If it is deemed that P would not have consented then the research should not take place.

Additional safeguards are added in Clause 125:

Nothing may be done to, or in relation to, P in the course of the research –

(a) to which P appears to object (whether by showing signs of resistance or otherwise) except where what is being done is intended to protect P from harm or to reduce or prevent pain or discomfort; or

(b) which is the carrying out or continuation of treatment of P and would be contrary to –

(i) an effective advance decision to refuse treatment which has been made by P, or

(ii) any other form of statement made by P and not subsequently withdrawn, of which the person conducting the research project ("R") is aware.

[Clause 125(2)]

If P indicates (in any way) a wish to be withdrawn from the project P must be withdrawn without delay.

[Clause 125(5)]

7. Transfer between jurisdictions

The Department of Health may authorise the transfer of a detained person from Northern Ireland to another UK jurisdiction providing the following conditions in clauses 127 and 128 are met:

(a) P lacks capacity in relation to the question whether he or she should be removed

(b) it would be in P's best interests to remove P there; and

(c) arrangements have been made for admitting P to a hospital in which care or treatment which is appropriate in P's case is available for P.

Whenever P is admitted to the hospital in the jurisdiction, P then comes under that jurisdiction's Mental Health/Capacity legislation. P must be given notification in advance and has a right to apply to the Review Tribunal to appeal the authorisation.

If P is transferred to a hospital in Northern Ireland from elsewhere in the UK, then a number of procedures must be followed as detailed in clauses 129 and 130:

1. Regulation and Quality Improvement Authority (RQIA) must be notified;
2. the Trust must arrange for a medical report to be made within 28 days of admission which should also be forwarded to RQIA;
3. authorisation is deemed to have been granted on P's arrival if it was made under English and Welsh or Scottish mental health legislation (but not from another country's equivalent legislation).

Clauses 131 and 132 of the draft Bill give the Department the power to make future additional regulations regarding transferring people between jurisdictions; both within the UK and outside of it.

The precise detail of a transfer involving a country outside of the UK, for example the Republic of Ireland, will be made through future regulations but will have to follow broadly the same process as detailed above.

8. Offences

The draft Bill creates a number of criminal offences in order to protect people who lack capacity:

- ill-treatment or neglect **[Clause 133]**;
- forgery, false statements etc **[Clause 134]**;
- unlawful detention of persons lacking capacity **[Clause 135]**;
- assisting persons to absent themselves without permission **[Clause 136]**;
- assisting persons to breach residence requirement **[Clause 137]**;
- obstruction **[Clause 138]**;
- offenses by bodies corporate **[Clause 139]**.

9. Miscellaneous provisions

Clauses 140 and 141 give DHSSPS the power to make regulations for dealing with P's money and valuables when P is an in-patient in hospital or a resident in a care-home. They also create an offense for contravention of the regulations.

(2) Regulations may:

(a) permit the relevant authority to receive and hold money and valuables on behalf of P;

(b) permit the relevant authority to spend that money or dispose of those valuables for the benefit of P;

(c) impose requirements as to the manner in which money or valuables received under the regulations is to be held;

(d) require the relevant authority to keep prescribed accounts and records in relation to the management of P's money and valuables;

(e) require the relevant authority to make an annual return containing prescribed information to RQIA.

[Clause 140(2)]

Clauses 142 and 143 provide guidance to D when spending money on behalf of P when P lacks capacity and it is in P's best interests.

Clause 144 provides an obligation on HSC trusts to appoint a sufficient number of approved social workers.

Clause 145 authorises HSC trusts to contribute to the financial maintenance of people who come under the powers of the draft Bill.

Clause 146 confers a duty on hospital managers to ensure that age-appropriate accommodation is provided to anyone under 18 who is detained in a hospital or is an in-patient in hospital and has, or appears to have, a mental disorder.

Clause 147 amends the Carers and Direct Payments Act (NI) 2002 to allow direct payments to be made to a suitable person in order to secure the provision of services on behalf of someone who lacks the capacity to consent to it him/herself.

Clause 148 gives effect in Northern Ireland to the Convention on the International Protection of Adults.

Clauses 149 and 150 relate to matters excluded from the Bill:

Nothing in this Act permits a decision on any of the following matters to be made on behalf of a person –

(a) consenting to marriage or a civil partnership;

(b) consenting to have sexual relations;

(c) consenting to a decree of divorce being granted on the basis of two years' separation;

(d) consenting to a dissolution order being made in relation to a civil partnership on the basis of two years' separation;

(e) agreeing for any purposes of the Adoption (Northern Ireland) Order 1987 to the making of an adoption order;

(f) discharging parental responsibilities in matters not relating to a child's property;

(g) giving a consent under the Human Fertilisation and Embryology Act 1990;

(h) giving a consent under the Human Fertilisation and Embryology Act 2008.

[Clause 149(1)]

(1) Nothing in this Act permits a decision on voting at an election for any public office, or at a referendum, to be made on behalf of a person.

[Clause 150(1)]

Clause 151 makes it clear that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 13 of the Criminal Justice Act (Northern Ireland) 1966 (encouraging or assisting suicide).

10. Supplementary provisions

Clause 152 gives DHSSPS a duty to produce one or more codes of practice in relation to the Bill:

(a) ***for the guidance of persons assessing whether a person who is aged 16 or over has capacity in relation to any matter;***

(b) ***for the guidance of persons acting in connection with the care, treatment or personal welfare of another person who is aged 16 or over..***

(c) ***for the guidance of nominated persons;***

(d) ***or the guidance of independent advocates;***

(e) ***for the guidance of panels constituted under Part 2 of this Act*** [HSC trust panels who consider Schedule 1 authorisations]***;***

(f) ***for the guidance of persons appointed as attorneys, or as replacements for attorneys, by a lasting power of attorney or an instrument executed with a view to creating such a power;***

(g) ***for the guidance of deputies appointed by the court;***

(h) ***for the guidance of persons carrying out research in reliance on any provision made by or under this Act ...***

(i) ***with respect to such other matters concerned with this Act as the Department thinks fit.***

Clause 153 creates a statutory duty for people in key roles to have regard to any of the code of practice that is relevant to them.

Clause 154 gives a Justice of the Peace the power to issue a warrant for the forcible return of an individual to a hospital or care home.

Clause 155 explains further the requirement to consult with and inform a nominated person.

Clause 156 gives DHSSPS the power to make future regulations through the Act.

Clause 157 explains that secondary legislation emanating from the Bill must be subject to the "negative resolution" procedure in the NI Assembly.

Clauses 158 to 160 provide a list of key definitions for the Bill.

11. Schedules

These have been cross-referenced with the relevant clauses of the Bill as described earlier in this Policy Briefing. However, a brief summary of each is provided below:

- Schedule 1 explains in detail the application process, criteria and decision making process for a HSC Trust panel authorisation.
- Schedule 2 explains the authorisation process for a short-term detention.
- Schedule 3 explains how applications for extension to a Schedule 1 application are to be made.
- Schedule 4 makes amendments to the Mental Health Order to include references to the Mental Capacity Act and the Review Tribunal.
- Schedule 5 describes the process of registering to create a lasting power of attorney.
- Schedule 6 allows for existing enduring powers of attorney to continue to operate when the Bill takes effect.
- Schedule 7 creates further supplementary provisions regarding the property and affairs of individuals who lack capacity.
- Schedule 8 relates to jurisdictional requirements for the operation of the Bill.

Contact Law Centre (NI)

Central office

124 Donegall Street, Belfast BT1 2GY
Telephone: 028 9024 4401
Textphone: 028 9023 9938
Email: admin.belfast@lawcentreni.org

Western area office

9 Clarendon Street, Derry BT48 7EP
Telephone: 028 7126 2433
Email: admin.derry@lawcentreni.org

Advice line

Monday to Friday, 9.30 am to 1.00 pm, 9024 4401 and 7126 2433

Follow us on Twitter

@LawCentreNI

Website

www.lawcentreni.org

Law Centre (NI) offers legal services to practitioners and policy development in community care, employment, immigration, mental health and social security. We also offer training courses for practitioners and information through our publications and website. We hold regular legal practitioner meetings where practitioners can exchange expertise and receive important updates.

Law Centre (NI) OISC Lexcel Practice Management Standard Law Society Accredited Law Centre® INVESTORS IN PEOPLE Bronze