



Northern Ireland
Assembly

Ad Hoc Joint Committee on the Mental
Capacity Bill

**OFFICIAL REPORT
(Hansard)**

Roundtable Discussion with International
Academics/Experts

29 June 2015

NORTHERN IRELAND ASSEMBLY

Ad Hoc Joint Committee on the Mental Capacity Bill

Roundtable Discussion with International Academics/Experts

29 June 2015

Members present for all or part of the proceedings:

Mr Alastair Ross (Chairperson)
Mr Patsy McGlone (Deputy Chairperson)
Mrs Jo-Anne Dobson
Mr Alex Easton
Mr Seán Lynch
Mr Raymond McCartney
Ms Rosaleen McCorley
Mr Edwin Poots

Witnesses:

Mr Alex Ruck Keene	39 Essex Chambers
Professor Phil Fennell	Cardiff University
Ms Caroline Bielanska TEP	Independent Consultant
Professor George Szmukler	King's College London
Professor Julian Hughes	North Tyneside General Hospital
Professor Wayne Martin	University of Essex

The Chairperson (Mr Ross): I welcome Professor George Szmukler, from the Institute of Psychiatry, King's College London; Professor Wayne Martin, director of the Essex autonomy project, University of Essex; Professor Phil Fennell, professor of law at Cardiff University; Ms Caroline Bielanska, solicitor, mediator, lecturer and independent consultant; Professor Julian Hughes, honorary professor of philosophy of ageing at Newcastle University; and Mr Alex Ruck Keen, a barrister at 39 Essex Chambers. I encourage people to keep their introductory comments to five minutes to facilitate discussion at the end, which will hopefully be more useful for us. Professor Szmukler will go first and then make some comments at the end, I gather. The Floor is yours.

Professor George Szmukler (King's College London): I express my gratitude for being asked to meet the Ad Hoc Committee. This is a groundbreaking piece of legislation. I strongly support it. My comments will be mainly about the law as applied to persons with mental illness. Some issues relating to people with intellectual disabilities or dementia may require different emphases.

As recognised in the Bamford review, conventional mental health legislation discriminates against people with mental illness, and I want to go into that and to look at the principles underlying the Bill. How does conventional mental health legislation discriminate against people with mental illness? We accept that people with a physical disorder can make decisions that are seriously detrimental to their health, provided that they have capacity to make decisions for themselves. We support the principle that people have the right to determine what should be done to their bodies and to themselves. That principle is called autonomy in this context.

By contrast to the necessary role of the decision-making capacity of patients with a physical disorder, the rules are entirely different for a mental disorder. There are two requirements for involuntary treatment. The first is that the person suffers from a mental disorder, usually defined, if at all, very loosely and with permeable boundaries. There are a number of historical examples of disorders being created to deal with people who are a threat to the social order. Secondly, there must be a risk to the health or safety of the patient or a need to protect others. I will come to the protection of others later on.

It is clear that these criteria fail to respect the autonomy of the person in the same way as the decision-making best interests. In fact, under mental health legislation nearly everywhere in the world one does not need to inquire into the reasons for the patient not wanting the treatment. Nor does one necessarily look at the perspective of the patient on what is in their best interests. It is usually the clinical team that takes the decision about what is best for the patient.

Research has shown that even among the most ill patients admitted to acute psychiatric wards, 40% to 60% preserve decision-making capacity, and quite a number are admitted on an involuntary order. Work has also shown a high degree of agreement between assessors on whether a person has capacity.

I will give a case study from the Court of Protection last year to show the difference. The lady concerned suffers from schizophrenia. She had been on a number of compulsory orders and was on a community treatment order, meaning that if she did not take her treatment she could be recalled to hospital for involuntary treatment. She also suffered from diabetes, hypertension and was a heavy smoker. She developed gangrene of the leg and, by the time the case came to the High Court, she had lost the foot. The wound, however, was unresolved, and she refused treatment for the gangrene. The case was referred to the High Court, and the experts said that there was a risk of the gangrene spreading and that it could be fatal. However, the court ruled that she had capacity and that her refusal for surgery stood. The situation was that, as far as the mental disorder was concerned, she had no say — I do not know whether she had capacity or not — but, when it came to the physical disorder, capacity was important.

Let us turn it around and say that the same principles applying to acute mental disorder apply to gangrene. She had a physical disorder; there is no doubt about that. She would have been treated, because, as one expert said, every surgeon in the land would have amputated. How many of us would stand for a system where our wishes about treatment, even if we had capacity, were irrelevant and where if the doctor thought you needed treatment, you would have treatment?

The other element is treatment for the protection of others. Here, people with mental disorders are singled out — uniquely, I think — for detention, albeit in a hospital or perhaps in police cells, on the basis of the risk that they are deemed to pose to others prior to their having committed any offence. I do not think that there is any other group in society where the risk of harm before having committed an offence is sufficient for that person to be detained. This is a form of preventive detention restricted to those with a mental disorder.

If we were to take, at any one time, all the people who exceeded a certain threshold of risk in the community, then the percentage of those who have a mental disorder would be tiny. Less than 5% would have psychosis: the evidence is that it relates to between 2% and 3% of people who commit serious offences. Yet, it is that small percentage of people on whom the torch is shined for preventive detention. That seems to me to be very clearly discriminatory against people with a mental disorder. The principle has to be that if we are to have preventive detention for people on the basis of risk, then it should apply to everyone and not just people with mental disorder, or we do not have preventive detention legislation that applies to anyone at all. That does not mean that the potential dangerousness of the person is unimportant — of course it is important — but it would become important in relation to the best interests assessment of the person.

I will stop at this point, because I want to look at some of the forensic aspects, but I think that there are broader issues that need to be discussed first. However, I will come back to some of the issues concerning offenders.

The Chairperson (Mr Ross): Thank you, and thank you for sticking to the time limit: that is greatly appreciated. Wayne is next and then we will move on to Phil.

Professor Wayne Martin (University of Essex): Thank you, Mr Chairman, and thank you for the invitation to present evidence today.

My name is Wayne Martin and I head the Essex Autonomy Project. For the last 12 months or so, we have been providing technical research support to UK Government bodies, particularly in connection with the UN Convention on the Rights of Persons with Disabilities. We submitted a report to the Ministry of Justice last year on the Mental Capacity Act 2005, and I am now leading a research team that includes my colleague Alex Ruck Keene that is taking a three-jurisdictions approach: looking at England and Wales; at the Adults With Incapacity (Scotland) Act 2000 in Scotland; and looking at the emerging legislation here in Northern Ireland. That work is continuing, but I wanted to offer a few of our preliminary results today.

I have circulated a document to members in which we make some specific suggestions about changes to language. The way I think about this is that mental capacity legislation is a device whereby a society seeks to find the proper balance between two sometimes competing imperatives: the imperative to protect vulnerable people, and the imperative to empower people and respect their autonomy. Often, these two aims go hand in hand — one can both empower and protect by doing the same thing. However, inevitably, there are circumstances where those two imperatives come into conflict, and every society must find a way of setting the rules to adjudicate those disputes.

I do not think that there is any one right answer about how it should be done. Different societies, drawing on their traditions, values and cultural traditions, will find different ways of adjudicating those disputes, but there are some framework conditions that are established. Some are ethical considerations about our ethical duties to protect vulnerable people, and others are legal obligations under international law and the respect for human rights. So, we are looking for a way of adjudicating those two imperatives in a way that fits within the local culture and traditions, as well as within those boundaries of international law and ethics.

Our group welcomes the introduction of this Bill. We see it as an important step forward in Northern Ireland to have a statutory basis for these concerns. We also see it as an important step forward internationally. When one looks comparatively at what has happened in other jurisdictions with this kind of legislation, we share George's view that this is a groundbreaking piece of legislation. We very much welcome it. That is not to say it is perfect in its present form, and there are areas where we think it could be improved.

For now, my focus will be on two areas where we believe the Bill could be improved. One has to do with the concept of "special regard", in clause 7(6). The other has to do with the groundbreaking provisions for support in clause 5. I will touch briefly on those and then conclude.

As regards "special regard", the context is a situation where P, the adult or individual in question, lacks decision-making capacity in the matter at hand. They are not able to make a decision for themselves, so a best interests decision needs to be made on their behalf. The question is this: how does one construct that decision? In particular, what is the proper role for P's own views — P's will and preference, in the language of international law — in arriving at a decision about what is in their best interest? To be clear, P is not going to make the decision for himself, but he might well have views about what is the right decision. So the key question is this: what is the proper role for those views?

Clause 4(6) of the Mental Capacity Act in England and Wales requires the best-interests decision-maker to consider P's wishes, feelings, beliefs and values. To "consider" is the operative verb. In our 2014 report for the Ministry of Justice, we found that that provision fails to satisfy the requirement of the Convention on the Rights of Persons with Disabilities (CRPD), the relevant UN convention. That convention requires that states' parties adopt safeguards that will respect the will and preferences of disabled persons. So, "respect" is a higher standard than mere consideration.

How is this matter approached in the current version of the Northern Ireland Bill? Let us start with the draft Bill that was circulated for comments some months ago. There, the requirement was that the best-interests decision-maker "take into account" the wishes and feelings of P. In the revised Bill now under consideration, the requirement has been strengthened in clause 7(6) to require that the best-interests decision-maker:

"have special regard [for] P's ... wishes and feelings ... beliefs and values".

That is a step in the right direction but we are worried that that notion of "special regard" is insufficiently well-defined. It needs to be articulated further and we urge the Committee to think about ways in which that might be specified more exactly in law.

The approach that we recommend is to establish a rebuttable presumption in favour of acting in accord with P's will and preferences. I refer you to our handout for the exact language, which is on page 2. I will not go through it in detail but we are happy to discuss it. I should add that on this matter, I worked closely with Alex Ruck Keene in developing this proposed language.

Adopting this amendment would be a step towards compliance with the CRPD. It would help to establish a legislative example for other nations and, most importantly, would ensure respect for P's wishes, feelings, will and preferences, thereby striking the right balance between empowerment and protection. I can come to the details of that proposal later if the Committee has the time and interest in exploring it.

I will now move to clause 5 and the matter of support. This is an area where the Bill makes a real advance over statutes that we find in other nations, including in England and Wales. The Mental Capacity Act includes a principle of support but, in my view, it has been ineffective in ensuring that people are supported in exercising their decision-making capacity.

The principle there is that people ought to be supported to make their own decisions, wherever possible. However, the Mental Capacity Act fails to specify what form that support would take. It also fails to say who should provide that support. It is in the passive voice and is vague, and, as a consequence, has not had much impact in practice in our view.

Clause 5 addresses the first problem. It really unpacks that notion of support and gives some specificity. We very much welcome that specification. I very much hope that something akin to that will be incorporated in due course into the legislation in England and Wales.

One of the results of our research at the Essex Autonomy Project is the thought that, when making decisions for ourselves, we often rely on other people. Capacity is often distributed across relationships. It takes place in a community of decision. We can provide in our written testimony some citations to our research results in that area. In assessing capacity, one needs to take account of those relationships: distributed capacity and decision communities. We are proposing that the provisions for support be modified to take that matter into account. In particular, we want to ensure that the provisions of support ensure that persons whose capacity is being supported have access to persons who might help them to exercise their capacity. Also, they should have the opportunity to exclude people from decision-making processes where they feel that that person is inappropriate or not supportive. It is not an absolute right of exclusion, but it is at least a provisional right of exclusion. Then — *[Interruption.]*

Mr McGlone: Sorry. Excuse me.

Professor Martin: Finally, on the question about who should provide support, the Mental Capacity Act in England and Wales does not specify the answer to that question. Clause 5 here does not really answer the question about who should provide it, either, but there is an opportunity to specify that with a minor addition to clause 9, which is really about the limitations of liability. Our thought is that, if someone is claiming that protection from liability on the basis of a best-interest decision-making procedure, they need to be held to account in having followed those provisions of clause 5 in having provided available means of support. Those are some of the specific changes that we are suggesting to strengthen and render more precisely some parts of the Bill.

The Chairperson (Mr Ross): Thank you very much.

Professor Phil Fennell (Cardiff University): Thank you, Chairman. It is a great pleasure for me to be here as well. I have followed this since the Bamford report was issued in 2007. That does not seem that long ago, but it obviously is. It is great to see a Bill having finally emerged. I really welcome the opportunity to comment on it.

The aspect of the Bill that I want to look at dovetails with what Wayne said about supports for decision making. I want to focus very much on the nominated person provisions. They offer a really exciting opportunity to provide the sort of decision-making support that Wayne talked about. Under the Bill, if there is going to be a serious intervention, the nominated-person condition must be met. That means

that there must be a nominated person in place before there is a serious intervention. Secondly, that nominated person must be consulted about what would be in the best interests of the person concerned. Those are, in my mind, very important, particularly if you look at the fact that P — the person allegedly lacking capacity — can choose who their nominated person is; they can make a written instrument that enables them to choose who their nominated person is. They can also, falling in with what Wayne said, say who they do not want to be their nominated person and who they would wish to be excluded from the process of choosing a nominated person. To my mind, that is an excellent development.

The explanatory notes somewhat oversell the nominated person; they say it provides a superior set of safeguards to those provided by nearest relatives under the Mental Health Order. If you are thinking about the power to object to detention and things like that, then I do not think they are a superior set of safeguards. If the concept of best interests was amended in the way that Wayne and Alex suggested, it would provide excellent support for P when they are looking at what the wishes and preferences of P might have been, what they might have wanted and what their values were. If you do not do what Alex and Wayne suggest, then the nominated person safeguard would be a lot weaker. The reason for that is that any qualifying person — a qualifying person is to be defined in regulations, but can include all kinds of people, such as the manager of a care home and professionals identified in the regulations — can apply to the tribunal to have somebody displaced as the nominated person for having acted, are acting, or are proposing to act, not in the best interests of P.

If the concept of best interests is very paternalistic — in other words, what we think is best for you rather than what you might want — then the ability of the nominated person to stick up for the wishes and feelings, and the will and preferences, of P will be correspondingly weakened. It is therefore very important that, if we are going to run with this nominated person concept, the nominated person is somebody who can support what P actually wants or would have wanted and provide that strong evidence. The regulation-making power provides that regulations will be made governing the formalities of appointing a nominated person. That is the first point I wanted to address.

My second point is about another supporting person: the independent mental capacity advocate. Health and social care trusts will be required to have enough advocates to advise people and support P and to put forward P's views on what is in P's best interests. The two supporting people are therefore very much focused on best interests. I think that we need to shift that slightly — a bit more than slightly — towards will and preferences.

Thirdly, and this relates to both people, I have a great fear that the Bill is overly complex. If I were training independent advocates to support people, I would be very concerned about the legal complexity and density of some of the terminology. Remember that we are talking about people who may well lack mental capacity to make decisions. I have an immense capacity to absorb detailed legal stuff, and I found the Bill: well, I had to apply a lot of cold towels to the head — *[Laughter.]* — in the course on understanding what was happening. It is quite important that we look at the clarity of the terminology, in light of the fact that the Bill includes many regulation-making powers and leaves a great deal to regulations. Quite a bit of the detail will be prescribed in regulations. That is a general point. I will perhaps stop there. There are other things that I would like to say about human rights, but Alex is going to cover those. If there is time, I might join in again.

Ms Caroline Bielanska (Independent Consultant): Thank you very much, Mr Chairman, for inviting me to address the Committee.

I will focus on lasting powers of attorney (LPA). The regime that seems to be proposed is mirrored very much on what has happened in England and Wales. The premise of that is very much bedded in the fact that enduring powers are somehow flawed and that, therefore, we need to change the way it operates. That is not to say that I disagree or agree with that statement but I would say that, in trying to resolve some of the perceived problems with the enduring power of attorney (EPA) regime, you end up with a system that could create a huge amount of complications.

At the moment, in England and Wales, our lasting powers of attorney forms are very big. If you were having a husband and wife making both types of powers, they would have to look through 100 pages of documents. If you are thinking about trying to empower people who may have some cognitive impairment, it is, for many, an obstacle too far.

If I were to try to make some suggestions, I would look very much at the safeguards that are absolutely necessary and whether they achieve what you think you want them to achieve. For example, one of the safeguards proposed is that the donor can choose someone to be notified of the

impending registration of the power. The idea is that the person notified could raise an objection on the registration process with the public guardian on the grounds, principally, that the donor did not really know what he was doing; lacked capacity; there was fraud or undue pressure; or, potentially, the attorney is not going to be making good decisions or decisions in the donor's best interests.

Whilst this is a perceived safeguard, it probably does not come to fruition, because the donor can choose not to have anyone notified, and so bypass it. He could choose someone who is not going to raise an objection. The person who is potentially going to raise an objection has very little grounds to challenge in practice, because he would be challenging the certificate provider — and, usually, that is the best evidence you have got as to capacity, no pressure, etc — or that the attorney, who is not yet acting, will not make a good decision. It means that, for the court to overturn it, there would have to be very good reasons. The court would probably be quite reluctant to go against the wishes of the donor; if we are looking at the preferences and will of the donor, they should actually be respected. So I do not think having that as part of the safeguard serves any purpose whatsoever.

Registration is an important safeguard. That is probably where we have the distinction between the EPA regime and the LPA regime. With the LPA, you have to register as part of creation; EPA is on the onset of incapacity. Looking back to our own law society's submission to what was proposed, it wanted to keep the EPA regime but, if it were asked today, it would not necessarily agree with that. Principally, the benefit of early registration is that the public guardian is in a position to supervise and to at least ask questions. There are countless numbers of EPAs which should be registered and are not, and there is no mechanism in place to have those resolved. Therefore, we suspect that there are a lot of people who are being financially abused under enduring powers without an easy recourse to resolution.

The certificate provider's role has been seen as very important as a safeguard, but one of the shortcomings that we find in England and Wales is that it is entirely possible for the donor to sign the power, have it witnessed by someone separate to the certificate provider, and then, sometimes weeks or even months later, for it to be taken to someone else to countersign. A few months previously, the person actually knew what they were doing. That is not a particularly good safeguard in the case of someone with fluctuating capacity or a person who is already under the influence of someone. It does not really operate as a safeguard.

There are other issues to do with the gap and the differences between EPAs and LPAs, which I am happy to expand on later; but I will not take up the Committee's time with that at the moment.

There was only one other thing that I really wanted to mention in connection with best interest. I think that it is quite odd that we have a process in place to engage with P, to encourage and support him to make a decision and to involve him in the process where he lacks capacity, but no one has the responsibility to tell him what the decision is when it is made.

Professor Julian Hughes (North Tyneside General Hospital): Like the other speakers, I am grateful to you for inviting me, and I am also excited on your behalf by the prospects of this Bill, which seems very innovative. I will base my comments on, first, some research that we did, which I will describe very briefly, and, secondly, on the recommendations by the Nuffield Council on Bioethics in their report, 'Dementia: ethical issues'. I ought to say that I was on the working party for the report and am deputy chair of the Nuffield Council; so you will have to take the recommendations in that light.

I will start with a quick sketch. What we were looking at was people such as the following. An elderly lady is known to have dementia. Over the course of the week, she becomes more confused and bizarre. She starts burning things on the cooker, leaving her door open, wandering out and getting lost. She eventually wanders out in the middle of the night, not very well dressed, and she is picked up by the police, near a major road, and taken to hospital. Fairly quickly, a diagnosis of some sort of infection is made. The infection is treated, but she is still confused because of her pre-existing dementia. At that point, the question is raised about whether it is reasonable for her to go home or not. Does she have the capacity to make a decision about her place of residence? That is what we were looking at on medical wards.

To summarise very briefly, and of course I will send in written comments, what we found was that assessments of capacity were usually made fairly informally and were not recorded very well. For the most part, they reflected the clinician's perception of what was going to be best, so there was a real conflation of capacity assessments and best interests. Overall, clinicians were worried by risk. That was the thing that was driving them, even in their assessments of whether or not the person had

capacity. When it was found that the person did not have capacity, by and large, that person would end up in care.

I will just comment quickly on what I mean by informal. The judgements were not really based on a legal test. They were often based on comments by people visiting the ward, such as that the lady did not know where the toilet was on the ward and so on. There were lots of little soft bits of information that somehow came together and made people believe that the person lacked the capacity to make this very specific decision about whether to go home.

My comments to you are mainly about the implementation of the Bill when it becomes an Act. I suppose that most of my suggestions might be to do with the code of practice and the importance of thinking about that. As you know, the House of Lords in their Select Committee on the Mental Capacity Act 2005 commented on the bad implementation of the Act or the problems with the implementation of the Act, rather than on what lay behind it. They said that the problems were to do with risk-averse social workers and paternalistic clinicians. I think that both things are probably true, but there is something else, which is just that some of these decisions are very complex, and they are very complex because they often involve clashes of values. It is not extremely easy to make some of these decisions about whether someone has capacity.

I note that in clause 4(1)(c), in the criteria for assessing capacity, the Bill states that the person must be able to "appreciate the relevance" of the information as well as weigh it. I think that that adds another layer of complexity, which may be good but may just lead to problems. It may be interpreted as simply making sure that the person is also risk-averse; so, if they do not see the risks or are not persuaded by the risks, they will be said not to have capacity.

One thing that you might want to think about is specifying, in the code of practice, the information that people need to know when you are assessing their capacity. For something such as residence capacity, it is not very clear what needs to be known. We have suggested that the person needs to know why a change of residence is being proposed, what is being proposed and any other options and likely consequences. Those sorts of things might need to be specified in a code of practice.

Another issue that emerged in our work was worries about the use of the independent mental capacity advocate (IMCA). People who had an IMCA were much better off than those who did not, because families were not aware of all of the background thoughts and so on that an IMCA can be aware of because they have access to notes and so forth. I think that you have covered that quite well through the powers that your independent advocate would have. I am thinking of an example where somebody with dementia, who is facing the prospect of being placed in a care home, is likely to be deprived of their liberty and, therefore, would immediately get an independent advocate. That is good, and I think that it is better than what would happen under the Mental Capacity Act 2005 in England and Wales. However, I still suggest that we have to recognise that there may be examples where it could be argued that there is no actual deprivation of liberty, yet the person is still vulnerable in a manner that would warrant the use of an independent advocate — think of someone who has borderline capacity and has considerable pressure on them to accept long-term care.

I wanted to highlight two things from the Nuffield Council's report. First, and this relates to your clause 12 on acts of restraint, it made a recommendation about the phrase "a proportionate response". Basically, it said that that needs a little more clarification: what is a proportionate response? A lot of concern is emerging in the area where I work now about the notion of forced care. That is care for people who are, say, in a care home and have faecal and urinary incontinence; they must be cared for, but they will resist, so some force has to be used. We do not really know what is going on, on the ground, for the sometimes not-very-skilled care workers who are not paid very much and who have to decide what would be proportionate in terms of the force that they might want to use.

Secondly, the Nuffield Council's report made several recommendations to do with research. All of the recommendations were on the side of making sure that somebody who would have wanted to be involved in research should be able to be used in research. The Nuffield Council recommended perhaps having non-binding advance statements on research. It recommended that serious consideration should be given to enable lasting powers of attorney explicitly to be extended to include decisions over research. It also thought that the code of practice should give clear guidance on procedures to be followed when capacity is lost during research, so that the person is not just automatically pulled out of it.

One final, brief point was on the lack of comment about advance decisions to refuse treatment. I know that these are covered in common law, but I cannot help but anticipate legal battles over whether an

effective advance decision to refuse electroconvulsive therapy or even to refuse antidepressants and antipsychotic medication might be regarded as providing life-sustaining treatment or as acts that prevent serious deterioration in the person's condition. Therefore, I think that it might be unhelpful not to give more guidance on these sorts of points.

Mr Alex Ruck Keene (39 Essex Chambers): Thank you very much for the invitation to speak. I am really glad to be here, because what is being proposed is incredibly exciting. I come at this being lucky to wear two hats, in the sense that I practise, appearing in the Court of Protection on behalf of Ps, and I also spend a lot of time training doctors and social workers up and down England and Wales. I therefore see the Bill from different perspectives. You have a very exciting opportunity on the mental capacity side, which is really the bit I am going to focus on, to build on what we got right in the Mental Capacity Act and to bolster what we did not get quite right.

First, I will speak very briefly to the amendments that Wayne and I suggested. They try to give effect to what we mean when we talk about making sure that someone is properly supported to take a decision and — the bit I am particularly interested in, in connection with best interests — what is meant by the Convention on the Rights of Persons with Disabilities when it refers to having respect for will and preferences. I will send to the Committee an article I have just written with a student, Cressida Auckland, on what we mean by respect, which traces the evolution of case law in England and Wales, where the courts are grappling with whether we should be identifying someone's wishes and feelings and what needs to be done if we are not going to follow them.

I will give you just one example of a case I am involved in at the moment. The man has been street-homeless and alcoholic most of his life. There was some temporary engagement with psychiatric services, but no real involvement with social services, meaning that no state authority was really involved. No one ever took the view that this man did not have capacity to make decisions about his drinking. He got an acquired brain injury in an unknown incident and was put in a care home. The justification for him being there is that he does not have capacity, so it is said, to make decisions on when not to drink and needs to be stopped from drinking, not on a sort of overt social control basis, but on the basis that he will harm himself otherwise. Everyone knows that all he wants to do is to carry on drinking. The rationale given ultimately by the Court of Appeal was, "No, we can't accord with your wishes and feelings. We know what you want, but we can't deal with that. It is necessary to protect you." We are taking the case to the European Court of Human Rights and saying that is just not good enough. That may actually be the best interests decision for that person, but when we know what the person wanted and what they want, respect demands a proper explanation.

The challenge is, through the language of the Bill, to make decision-makers — either informal decision-makers or, at the end of the day, the court — grapple with that. It is about trying to get the balance that Wayne identified between the two principles of empowerment and protection. I wanted to emphasise those points, because I think that they are absolutely at the heart of creating legislation that gets the balance right, which we did not quite manage to do in the Mental Capacity Act. Frankly, for my part, I sincerely hope that this passes, because then we can look at it and say, "This is what they have done. This is how it is working. Can we please think about it and take it a stage forward?". That would ratchet matters up in the UK gradually.

I will just mention a couple of points where I would like to caveat. This is not to detract from my enthusiasm. First, you might just want to think — if I can put it that way — about schedule 9, which I am sure you have spent lots of time poring over. Schedule 9 is the equivalent of our schedule 3 to the Mental Capacity Act, which is about recognising and enforcing foreign protective measures. It would appear from Hansard that our schedule 3 was the subject of very little analysis as it went through Westminster. I have been involved in several cases — in fact, ironically, most of the reported cases — and what has become very clear is that, possibly inadvertently, a piece of legislation was passed requiring the Court of Protection in England and Wales to recognise and enforce a measure taken in respect of any adult anywhere in the world by either a court or an administrative authority, if the adult has an "impairment or insufficiency of his personal faculties" preventing him from protecting himself. This is a lot wider than a provision that he lacks capacity to take the decision.

There is also the question of whether or not a decision to impose the measure is taken on what in England and Wales would be recognised as a best interests basis. For instance, I had a case recently where the court said that the fact that someone could be considered to have decision-making capacity in England as to whether or not to be detained in a psychiatric facility and receive treatment there and is objecting, does not count as a ground for not recognising and enforcing the measure. So, there is very limited ground to stop a foreign order from placing someone in an English psychiatric institution and, by extension, a Northern Irish psychiatric institution. You have the opportunity to pause and think

that you do not necessarily need to do that except in relation to other countries that have signed the underlying Hague convention, which is what we are trying to give effect to. So, please, just pause and think.

My last point is about deprivation of liberty. You have to grapple with it because of the judgement of the European Court of Human Rights in *HL v UK*, commonly known as the *Bournewood* case, which says that we have to have a formal framework for dealing with people who do not have capacity to consent to admission for care and treatment. For far too long, fascinating as it is for lawyers arguing about what deprivation of liberty is, it has not been a good use of public money. You might just want to think about whether there is some way that you could write into the Bill, or the Act as it comes in, something that is not just saying that a deprivation of liberty is a deprivation of liberty for the purposes of article 5. We have tried that, and hundreds of thousands, if not millions, of pounds of public money has been spent paying people like me to argue about it — to my personal benefit but not to the benefit of society more generally.

I may have missed something, and I would certainly be interested to talk about this with the civil servants later, because I know that they have been working hard on this Bill. However, it looks to me like you have the ability to say that someone can be deprived of their liberty on the basis of a lack of capacity, but for the purposes of the European Convention, you have to have someone who can be deprived of their liberty only if they are of "unsound mind", which is the test that article 5 requires. Article 5(1)(e) says that you can detain someone on the basis of mental disorder, which is the exception that we have, only if there is objective evidence of a mental disorder of a nature and degree warranting detention. Unless I have entirely missed something, I do not think that the Bill quite provides for that, which it would need to. That leads you into a straight clash with article 14 of the Convention on the Rights of Persons with Disabilities, which states that you are not allowed to detain people on the basis of disability. There is, frankly, nothing you can do about that. Given that the European Convention is framed in the way that it is, and given the way in which legislation in this jurisdiction has to be compliant with the ECHR, you are rather bound to go with the article 5 route.

I certainly have other things to say, but I just wanted to make those opening observations.

The Chairperson (Mr Ross): Thank you very much. George, do you have something that you want to say about public protection orders, just before we open up for discussion?

Professor Szmukler: Yes, if that is OK. This fusion proposal stretches autonomy to protect against discrimination against people with mental illness. I pointed out, though, that the protection of others is not much talked about in relationship to discrimination, but it is clearly there within conventional mental health legislation. We are trying to get away from that, I think.

Most of the forensic parts are pretty good. Those dealing with police detaining people in public places, and hospital directions, are generally reasonable, as are transfers, remands and so on. The area that I am not clear about, and I do not know what the intention behind it is, concerns the public protection orders. It seems to me that there, there might be some discrimination that I would think is not acceptable.

People with an impairment or disturbance in the functioning of the mind can be detained under a public protection order if they present a risk of serious harm to others. It is a detention without time limit. It is reviewed after six months and then annually, so it could go on for a very long time.

The other point that worries me is that there are three categories of people who can fall under the public protection order. First, there are people who lack capacity and for whom treatment is in their best interests. It is entirely reasonable that they should be in a hospital or an institution that provides care and treatment. Secondly, there are people who have capacity and who voluntarily agree to treatment. Again, it is reasonable for them to be in an institution that provides care and treatment. However, the third category is in relation to clause 238, which states that the treatment possibilities are exactly as if the person were under Part 2. So, there would be people who have capacity and who reject treatment, who are being detained for an indeterminate period but not accepting the treatment that is nonetheless available. That is problematic. What is the health interest that is being served by having people like that in a health setting? That worries me.

Maybe I am worrying unnecessarily, because a lot depends on the tools the criminal justice system has. There is the Criminal Justice (Northern Ireland) Order 2008, which provides for three kinds of sentences that are relevant to this. The first is a discretionary life sentence, which means that somebody who has committed a serious offence but presents a high risk of serious harm to others can

be given a discretionary life sentence. That means a custodial period and licence thereafter forever with the possibility of recall. Secondly, there is an indeterminate sentence, which is available under that order, from my reading of it, although I am not a lawyer; I am a psychiatrist. That sentence is something like the public protection order. Thirdly, there is an extended sentence, whereby somebody who presents a risk is given the sentence for that offence and then a period of supervision or licence afterwards.

It seems to me that, if we are not to be discriminatory, we need to draw some parallel between the public protection order and the criminal justice orders. So, the kinds of people who are on the public protection orders, and the level of risk they present, should be the same as those who are on the indeterminate sentence order, for example. Then, the argument that there is discrimination against the person with a mental disorder would not be a reasonable one. From the point of view of the United Nations Convention on the Rights of Persons with Disabilities, it is very important that there is not discrimination against people with mental disorder. The risk factors are very similar for people with mental disorder and those without mental disorder. The mental disorder itself plays little role in determining the risk of future offending. People with a psychosis, without an antisocial personality or drugs and substance abuse, are very modestly increased in their likelihood of committing an offence.

So, there is a possibility of dealing with this, but, as it stands, the public protection order does not get away from quite serious discrimination against people with mental disorder, because it treats them differently even though they present the same risk as other people.

The public protection issue is a great worry to the public, and politicians need to really grapple with it. There are sufficient possibilities for protecting the public within the existing framework. For example, the hospital direction provides a period of detention followed by supervision, as I mentioned, for people who present a risk to others. It does that in the same way as it would for a non-mentally disordered offender: there is a time limit and the sentence is clear. Secondly, there is the possibility, although I am not clear about it, that the court decides that the person, despite having committed a serious offence, can be sent to a hospital and come completely under the control of a responsible clinician. So, it is the same as the provision for involuntary treatment under Part 2. Thirdly, you might introduce something around an indeterminate sentence for somebody who has committed a very serious offence and the risk is deemed to be extremely high that parallels an indeterminate sentence under the Criminal Justice Order.

The Chairperson (Mr Ross): I thank everyone very much for their opening comments. We will have a discussion now. I remind everyone that the discussion will only work well if it is conversational. Sometimes members are very well behaved in this institution and ask for permission to speak, but that is not what we want today. So, let us have a free-flowing conversation. Obviously, if it gets out of hand, I will step in. Please chip in and have a conversation. There will be about 45 minutes of discussion, after which I will ask whether there are any closing comments that people want to make if they feel that anything has been missed or that there is anything useful to be said at the end. I will open it up. Patsy and Alex have issues that they want to raise.

Mr McGlone: I have a bit of a conundrum in relation to clause 5. My perspective on it is that, in your amendments, you are asking someone who may lack the mental capacity to make a decision about their mental incapacity. That is my conundrum. I have some involvement, albeit limited, with constituents, and, often, the person they most need is the person they most want to push away from them. For example, it could be the elderly lady who you refer to who has dementia and does not want to leave her home and sees this as a plot by her family to put her into a nursing home, but she needs to be in a nursing home for mental and physical health support. She sees that as a plot to push her into the nursing home and to get hold of her farm, her home or whatever it might be. That can be going on here. It is that kind of conundrum that I have difficulty with, in so far as that person is at the point where you are determining that they do not have, or potentially will not have, the mental capacity to make a decision, yet you are accepting that they have the mental capacity to make a decision about who should be the arbiter about their capacity, if you get where I am coming from.

Mr Easton: Can I come in on the same point? Professor Fennell, if you do not understand the Bill, you can imagine how difficult parts of it are for us.

The Chairperson (Mr Ross): And we have no wet towels.

Mr Easton: I would probably use ice cubes, to be honest with you.

My remark is directed to Wayne as well. To touch on what you said, if somebody has the capacity to choose a person to come in and represent them, how do they fit into the Bill in the first place if they are able to make that decision? On the other bit about them being able to decide that they do not want somebody to be at some sort of assessment or hearing or whatever it is going to be called, surely that could be open to abuse where they are going to say, "Nobody is acceptable to me", and that could go on and on with delays. Excuse me for being ignorant, because I am not an expert on this, but can it be explained to us how that would all work, in your view?

Professor Fennell: The Bill has a scheme for how it would work. The Bill basically allows a person while they are still capable. So, this is really only going to benefit people who know that they have a diagnosis of Alzheimer's or bipolar illness, and they know that, at some stage in the future, they will lose capacity, and they will want somebody to represent them. So, it is something that you would do while you still have capacity. I have produced a written memo on it, so I will not go into clause numbers and all that, but the formalities in the Bill are that, basically, if you want to do this, you have to do it in writing and you have to sign it. Regulations can say that if somebody is physically unable to sign, something else would be acceptable, although I think "physically unable" might be a bit of a limitation. You can exclude people that you do not want, like the son who wants your farm, or you might think, "Well, I don't want him because he has been a pain in the neck for the last 20 years. I don't want him anywhere near", but you would have to have capacity. The signature has to be witnessed by what the regulations will say is a "qualified person", who is able to say that the person was not under any undue influence, that they understood the effect of what they were doing and that they understood that the nominated person would be able to get access to details of what is happening to them if they are going into hospital, being treated or whatever. So, the idea is not that you would be able to choose the person at the point when you have already lost capacity; the idea is that you would plan ahead. Many people do that; that is the point of having lasting power of attorney. In this case, it is about choosing a person whom you would want the authorities to consult at the relevant time. However, you need to have the ability to do that when you do it and it needs to be in writing.

Mr McGlone: I just want to tease that out. You are the experts and you know that people can lapse and move into different stages of awareness. However, if you take steps to exclude an individual, whether they are at a varying level of mental capacity or not, they may be the wrong person to exclude. Who is the arbiter? In other words, who is at arm's length? That person may be exactly the person whom they need to be involved in the process, objectively so. However, emotionally, depending on whether they are emotionally imbalanced, they may feel that it is the wrong person.

Professor Fennell: Yes, but when you appoint somebody that is called an appointment; when you say that you do not want somebody, that is called a declaration. The review tribunal will be able to police all these things so that if you declare someone unsuitable and they are really the only person who is suitable, the tribunal would review that. A qualifying person would be able to make an application to the tribunal for that to happen.

Mr McGlone: I have just one small point, Chairperson, and then I will leave it. The efficiency with which a tribunal or an appeal mechanism kicks in is very important because a person could have deteriorated, or, indeed, improved, by the time the tribunal comes round, depending on the condition for which they are being treated at the time. The efficiency with which an appeal mechanism moves would be crucial.

Professor Fennell: Yes, it would be crucial. That is one potential concern, because the review tribunal will be taking on quite a mammoth task. If somebody lacks capacity and is unable to make their own application to the tribunal, the detaining authority has to tell the Attorney General. I could be wrong, because I have only had a week to look at this, but my understanding of the Bill is that appeals will be brought on behalf of people by the Attorney General and there will be people who will be appealing against their detention. The tribunal will, potentially, be dealing with these nominated persons issues.

A great deal will depend on what is in the regulations. The review tribunal is the one that you have under the Mental Health (Northern Ireland) Order 1986, as I understand it. Issues of detention and deprivation of liberty and nominated persons all go to the tribunal; issues of treatment will go to the High Court, as far as I can tell, unless the HSC panel deals with them satisfactorily. A lot will depend on the resourcing of the tribunal and its ability to deal with what could be, potentially, quite a high caseload.

Professor Martin: I will add a few comments on this and then hand over to Alex to expand on them. First, just for clarification, it is very important to read our proposals about clause 5(2) in light of clause 5(1). This is a circumstance where we do not know whether "P" has capacity or not and the law is saying, rightly, that all practicable means of support need to be provided. We do not yet know whether this person has capacity. It is not a case where somebody is already known to be lacking in capacity; that changes the stakes dramatically.

The second point is that we need to strike the right balance in many of these areas, because we have cases where somebody might be excluding the wrong person — the person whom they need. At the same time, however, there are cases like the case of Mrs A, whom we dealt with in England and Wales. The scenario is that Mrs A is in an abusive relationship, and assessors are trying to assess her capacity, and Mr A will not get out of the way. When Mrs A is asked a question, Mr A answers on her behalf. One needs to strike a balance between the two.

The crucial thing in the parenthetical in clause (d) is the way in which we propose to strike that balance. A person has a provisional right to exclude Mr A in such a situation. However, if proper grounds exist in respect of why Mr A's presence is essential to secure the interests of the person, he can come back into the conversation. As a practical matter, I think that you can have both. The assessor can have a conversation with Mr A in the other room, and that will help a lot. Right now, however, it can be very difficult to manage. After that conversation, let us bring him back in and we can have a further conversation. However, that provisional exclusion could be very important in such contexts.

Mr Ruck Keene: I want to emphasise that, to my mind, this goes wider than just a nominated person. It is trying to grapple with a requirement that we have signed up to that will make our legislation compatible with the Convention on the Rights of Persons with Disabilities. There is a debate about what exactly we have signed up to and what exactly those obligations are. One of the critical things that it tells us is that we must be a lot slower to say that someone lacks capacity to take decisions and a lot better and a lot more creative about saying, "Hold your horses; let's think of ways to do it". One of the critical elements, as Wayne emphasised, is that there will be circumstances in which having someone else around is, actively, the right thing to do to secure that person's ability to — in practical terms, although it should not be — pass the capacity test, because it is always meant to be presumed that the person has capacity, and it is for others to disprove. In reality, however, it is, quite often, seen as a capacity test. So, they have a supporter.

Equally, and critically, there will be times when someone should be able to say, "I know my capacity is being challenged by the medics", sorry for picking on Julian, "but I don't want this particular person around.". That might be equally important. You are absolutely right to pick up that there is a tension, but we think that if we recognise that tension and make it express, it can at least get filtered through to the code of practice or into how things are done, and people will be able to give us a clearer answer further down the line and say, "These are the steps that we took.". You are absolutely right: there is a tension.

Professor Szmukler: We always seem to think that a tribunal needs to be three people, but in some countries such investigations are done by a single legal member. What do my lawyer colleagues think of that? I wonder whether some of the functions of the tribunal could be conducted as a single legal person tribunal, with an appeal possible to the full tribunal.

Professor Martin: It would have to be a "monobunal".

Mr McGlone: That is right.

Professor Szmukler: In terms of resources, it might work quite satisfactorily. People develop a lot of skill and knowledge in a particular area.

The Chairperson (Mr Ross): I presume that all of you are supportive of the concept that we are talking about. It is an innovative approach; it is exciting and all that kind of stuff. The fact that nobody else in the world has done it sounds alarm bells in our ears. You will have been involved in other jurisdictions that have looked at the possibility of doing this, I presume. What advice can you give us about why other people did not move ahead with it? Why did they think that it was too challenging or too complex? Why do you think that we in Northern Ireland will be able to do it?

Professor Hughes: I want to start off, because I think that I am the least well informed to say anything about it, so others can expand on what I say. One thing that strikes me is that the mess that we have got into in England around deprivation of liberty safeguards emphasises that it is not terribly useful to have two bits of legislation. We have a new code of practice for our Mental Health Act. It has a nice little chart that tells us when to use deprivation of liberty safeguards and when to use the Mental Health Act. However, everybody gets very confused about it and finds it difficult to know which Act to use, and worries about it. On that basis, it would be much more helpful if you had just one bit of legislation.

Professor Martin: George is the expert on fused law, but I will just add a few comments on the matter.

I do not think that you are alone; legislatures around the world are turning their attention to mental health and mental capacity legislation. In part, that is occasioned by the passing and adoption in 2006 by the United Nations of the CRPD. All the signatory nations have committed to reviewing their legislation.

Some of the features in the Bill one finds in jurisdictions in Australia, Canada and elsewhere in the Commonwealth. On the capacity side, you are in the advantageous position where the Mental Capacity Act and the Adults with Incapacity Act in Scotland have been on the books and adjudicated on over a period of years. The changes here are incremental changes and improvements, building on the experience in those jurisdictions.

The big innovation here is in fusing law. Here, I agree with Julian that one of the things that we found — and we have documented this and published research — is that the two legal traditions generate what we call antinomies, or contradictions. The Kerrie Woollorton case is one such example. Kerrie Woollorton goes to A&E in Norwich, just before the Mental Capacity Act comes into effect, I think. She has a history of psychiatric disorder and has drunk 350 ml of antifreeze.

What do you do in that situation? If you view it through the prism of the Mental Health Act, she has a psychiatric disorder and is clearly a danger to herself and you intervene. However, she has an elaborate note pinned to her body saying that she does not want care; she came to the hospital for aid with the pain and because she did not want to die alone.

Everybody on the scene assesses her and says that she has capacity. Follow the Mental Capacity Act, and it looks as if I have to refrain from treatment. Put yourself in the position of the A&E personnel in Norwich on a Saturday night. You are caught in a bind of contradictory imperatives.

The Mental Capacity Act is a recent development in law and takes a human rights perspective on these matters. It has taken a while to think through all the ramifications, but we have come to realise that you cannot just make do with these side-by-side pieces of legislation; you need to find a way to unify them.

Here, the movement towards fusion along the lines that George has been urging for some years is a sensible and prudent approach. You can find elements moving in that direction in tribunal decisions in England and Wales. There is a sort of back-door fusion on its way in England and Wales as well.

Professor Szmukler: The fact that mental health law discriminates against people with mental illness is not being recognised. Why is it not being recognised? It is a law that has been there. The criteria have, basically, been there since the eighteenth century; they have not changed despite all the Acts that we have had. Why have they not changed? I gave you the example of the lady. We would not tolerate going to a doctor who says, "Well, look, you've got cancer of the such-and-such and these are the side effects", and you say, "Well, actually, I don't want those side effects". "No, it is in your health interests, and you will have the treatment whether you like it or not."

The people who have been subject to mental health legislation have not had a voice in our society since the seventeenth century or maybe since the beginning of the eighteenth century. They have been subject to terrible discrimination, and it is only very recently that the patient voice has emerged as a group voice, an organisational voice. They are insisting on their human rights in a way that was not possible in the past. That is important.

India has a mental health Bill based on capacity. There are a lot of people in India, so that is a fairly large state.

Professor Fennell: The thing that we must not get away from is that we are talking about a Bill that will allow people to be detained and treated without their consent and have interventions imposed on them in the community. Although we are trying to introduce recognition of people's will and preferences and so on, it still is a Bill that does these things.

Just to put a counterpoint to what George has been saying, I have a concern about schedule 2, which is on short-term detention procedures. There are two detention procedures in the Bill. One is covered by schedule 1, which is for six months; the other is covered by schedule 2, which is for up to 28 days. Schedule 1 requires you to lack capacity by reason of an impairment or a disturbance in the functioning of the mind or the brain to be able to decide whether you should be detained or not and has the five criteria. Schedule 2 has five criteria as well, but you can be detained under schedule 2 if you have any illness, and any illness is defined as anything that would benefit from nursing or care and treatment, I think. Straightaway, you are into a problem with what Alex was talking about earlier: where is there a requirement for objective medical evidence of a true mental disorder? This is illness generally.

That needs to be looked at. At various points throughout the Bill, you can be detained if you lack capacity due to an impairment in the functioning of the mind and the brain; in schedule 2, you can be detained if you have an illness; in the mentally disordered offenders provisions, you can be detained if you have a disorder — not a mental disorder but a disorder. Disorder is not defined anywhere in the Bill, so if we are to employ these definitions, we need to be very clear about why exactly we are doing that. Moreover, there is a requirement in one of the schedules — I think that it is schedule 1 — that a person shall not be detained under schedule 1 if they could be detained under schedule 2 first.

I think that those points need to be looked at. I have a larger paper, which I will send to you, about how you might square that with article 5 of the European Convention on Human Rights. I think that Alex made a point about there being two human rights approaches: one is the European Convention on Human Rights, which is directly enforceable in our courts; the other, the UN Convention on the Rights of Persons with Disabilities, is more aspirational. It says, in article 14, that any detention on grounds of any disability, including mental disability, is contrary to the UN convention. The European Convention lets you detain people if they have a mental disorder, but the UN Convention does not. Some very complex navigation needs to happen, recognising the UN Convention but complying with the European Convention at the same time.

Professor Hughes: Again, forgive me for butting in on legal matters, but it seems that schedule 2(2)(3) starts off by saying:

*"The criteria for authorisation are that—
(a) P has an illness"*

That sounds right, but sub-paragraph (d) says:

"P lacks capacity in relation to whether he or she should be so detained"

Does the capacity thing not come back in at that point?

Professor Fennell: Capacity is there, and capacity is due to an impairment of, or disturbance in, the functioning of the mind or brain. That could come about as a result of something other than a mental disorder. The European Convention case law says that there has to be objective medical evidence of a true mental disorder. I know quite a few people who have epilepsy, and if you told them that they could be detained, they would shoot you. *[Laughter.]* Well, they probably would not shoot you, but they would "hunt you", as we say in Northern Ireland.

Mr Ruck Keene: I echo what Phil said: there is a definite issue with article 5 and article 14, and greater brains than mine cannot grapple with it. I heard Lady Hale, who is one of the Supreme Court justices, giving a lecture not so long ago in which she said that the two are, frankly, incompatible. That was an open lecture, and her tentative suggestion was that the only way out is a fusion, capacity-based approach.

In the global field, you are ahead, although, as George said, there is a Bill in India. In part, that is just a function of how cycles happen. We have had the UN Convention on the Rights of Persons with Disabilities, different issues have arisen, and you had the Bamford review. Legislation like this has a very long hinterland. You are where you are, but I strongly suspect that there will be other legislatures

looking to you, and if they are not already there they will be there very soon. The Bill's provisions are certainly not out on a limb; it is ahead, but it is not out on a limb.

Professor Martin: I want to add a caveat about the bind between different international obligations. There are some areas where there are conflicts. Phil has published on that, and they are difficult situations. In Northern Ireland it is pretty clear, as others have said, that the European Convention is the one that one must follow in cases of conflict.

I want to enter a caveat about the idea that the UN Convention on the Rights of Persons with Disabilities precludes detention and involuntary treatment. In our work for the Ministry of Justice, we distinguish quite sharply between the views of the Committee on the Rights of Persons with Disabilities, which issued a statement saying "never under any circumstances" and the requirements of the convention itself. Further work is required to tease that out.

I also note that the Human Rights Committee of the United Nations has said that involuntary treatment and detention should be used as a last resort and when it is necessary and proportionate and so on, which is much more in keeping. The jury is still out on what the convention requires.

The Chairperson (Mr Ross): Caroline mentioned the LPA and EPA. The Law Society of Northern Ireland held an event at the Assembly and seemed to suggest that enduring power of attorney works reasonably well and that, if anything, it could be extended to health and well-being or that EPA and LPA could run in parallel. You seem to be suggesting that that is not something that would be particularly useful and that you might have changed your mind. I am curious about the experience in England and Wales.

We want to have people making a declaration about what would happen if they lacked capacity. The Law Society of Northern Ireland suggested that, because the LPA would be much more expensive and complicated, if we did not have an EPA option people would not do anything at all, which would be the worst scenario. I am curious and want to look at that area a bit closer.

Ms Bielanska: The simplicity of the EPA regime is wonderful in the sense that it worked in England and Wales for a very long time very successfully. Where it has raised its ugly head is in relation to the point of registration, because the public guardian has no power to investigate unregistered enduring powers. If there was a way in which you could keep the regime but require registration — which was not done on the basis of an incapacity and the public guardian was able to investigate — that might work.

As far as health and welfare powers are concerned, there are relatively few of them created: about 80% of powers are financial, and 20% concern health and welfare. They are very different beasts. With property affairs, you have a designated decision-maker, whereas with health and welfare, even when you have the authority, you will still have doctors, social workers and care providers involved and making decisions. So, the operation of it is very different. But, yes, if you had the will to do it, I think that it would be entirely possible. On the benefit of having registration, most lawyers, prior to the introduction of our Mental Capacity Act, were probably singing from the same hymn sheet as the Law Society here, which was, "Why change it? It works OK." I think that is pretty much the case.

The Chairperson (Mr Ross): Has there been any evidence that people have been put off from the lasting power of attorney due to the cost?

Ms Bielanska: No, although you would think so, given that there is a huge volume of papers to go through. There are now in excess of one million LPAs registered. The Office of the Public Guardian (OPG) is registering about 400,000 a year. Pretty much after the first year, the number of EPAs that were being registered started to dip quite dramatically, and now it is the smallest part of the OPG's operation.

When people make lasting powers, they are not a product that you desire; they are triggered by a need, which is usually due to a diagnosis or an event. They are often prompted by someone else saying, "You need to do this." I think that it would be possible to blend LPAs. To my mind, there would be a benefit in doing that and in looking at what we thought was wrong with the EPA regime. EPAs registered often within a short time of creation beg the question of whether the person had capacity. However, if we are talking about a framework, we are empowering people to make the decisions that they are able to make and, if they have the right support mechanisms, then maybe having certificate providers is superfluous to the purpose. For me, the key is the registration.

Mr McCartney: I thank everyone for their contributions. This session is being recorded by Hansard, so we will be able to go back over it. There are a couple of things that I would like to raise with you. Having listened to people this afternoon, a number of observations were made about the Bill as it is now tabled, which is the Bill that will go forward and which we will, ultimately, vote through or not. Professor Fennell talked about it being overly complex. I think that he said that the legal terminology was far too complex. I think that most of us on the Committee would agree. However, it is possible that it was necessary for the Department to do it in that particular way, so we have to deal with it.

A number of observations were made this morning, and we have to determine whether those are proper or improper for us as we go forward. Someone made the observation that there were regulation-making powers post the Act, and we have to determine whether that is a good thing or a bad thing and how we curtail or prevent it from happening. Someone else made the observation that there is the possibility that people can be detained even though they have not committed an offence, because they lack capacity and are deemed to pose a risk to others. Is that a good thing to have in place? How do we protect ourselves so that we do not vote something through that could be open to challenge? The European Convention was alluded to. Another observation is that, in the Bill as tabled, no one has a responsibility to tell a person the decisions that have been made about them. That strikes me as something that we should have in the Bill.

Considering those observations, how do we protect ourselves, and how do we ensure that whatever passes through the Assembly and comes out the other end has taken account of the pointers and direction that you have given us?

Professor Fennell: Can I say something about the regulatory powers, since I raised that issue? You cannot escape the fact that you need powers to make delegated legislation, and you need powers to make regulations. The problem that I had, particularly with an earlier draft, was that some things were being left to regulations that I think ought to have been in the Bill. I will give one example of that. There is a provision in clause 55(4), I think it now is, that says that regulations shall, in particular, address the point that, if somebody is detained, they are to be given information about the fact that they have been detained, and they are to be given information and support about challenging that detention. That was going to be left to regulations but, as a result of earlier consultations, it is now in the Bill.

The thing to look out for is not so much the large amount of regulation-making powers; it is that the power to make regulations is extremely broad. There is one that says that regulations may be made for prescribed purposes, conferring "prescribed powers" on "prescribed persons", or something like that. That is quite a wide opening gambit for a regulatory power.

As for detaining people if they pose a risk to other people or themselves, that is in nearly all mental health legislation that I can think of across the world. In Northern Ireland, there has been an attempt to retain something that is in the Mental Health Order, which is the concept of "serious physical harm", but it has been broadened by adding "other harm" to it. It is actually quite a bit wider than "serious physical harm". Harm to P, who is the person, can include harm to P because he is going to hurt other people. If I go out and clock somebody, that will be bad for me because I will be arrested, or they might clock me back. To prevent harm to me, I need, perhaps, to be restrained or detained. Those powers are all in the Bill. I do not think you can escape that, because what you are replacing is the Mental Health Order and adding into it the Mental Capacity Act. George is now going to shoot me down. *[Laughter.]*

Professor Szmukler: The point that I am trying to emphasise about risk is that it should be non-discriminatory. I am not arguing for or against preventative detention. Somehow, states are moving more and more to preventative detention. All I am arguing for is that the law treats people with and without mental disorder in the same way so that, if there is preventative detention for people with mental disorder, people without mental disorder who are equally risky should be treated in the same way. That is why I suggested that the public protection orders be brought into alignment with existing criminal justice legislation sentencing possibilities. If they can be brought into alignment, there will not be an issue. At the moment, as far as I can see, they are not in alignment. I can see the potential for them to be brought into alignment so that there will be an indeterminate sentence for people who exceed a certain level of risk that is regarded as intolerable.

If they have mental disorder, they will go down the mental disorder treatment route. If they do not, they will be detained in some other fashion, and perhaps those who go down the mental disorder

route, when they recover from their incapacity, might continue with voluntary treatment on a longer term basis, then they might go on some sort of supervision order, as would the person with an indeterminate sentence. At some point, somebody will say, "We do not think he or she is risky enough to detain, so we will let that person out on licence with certain conditions, and if they break those conditions we will deal with that." I do not see why one cannot have the same kind of structure for preventative detention to cover people both with and without a disturbance in the function of their mind.

Mr Ruck Keene: The complexity of it is a structural inevitability, given what is being done. One only has to look at the length of the Mental Health Act in England, the length of the Mental Capacity Act, and combine the two. This feeds very heavily into what Julian said — Phil has said it in a different way — which is that this is only the beginning of the story. If you pass anything like this, it is not going to work unless the resources are available for implementation, training and for code of practice. The House of Lords told us that we had really comprehensively mucked up our implementation, and it would be a bigger ambition here.

If I can, I very strongly urge you not to follow the lead of what we did in England. Follow the lead of what they did in Scotland, where they had a proper implementation group set up to deal with the implementation of the Adults with Incapacity (Scotland) Act 2000. They had a group of people to champion and challenge and to say, "This goes across all of the different Ministries and Departments; you need to get it right." You cannot get away from recognising the scale of what needs to be done thereafter, including producing some kind of easy-read version of, at least, the principles. As Phil said, this will address a group of people whose capacity is said to be in doubt. Basic human respect demands that they have an idea of what this is actually about.

Professor Fennell: A real danger is regulatory overload. You need a regulatory system to control the very extensive powers that professionals and people will get, but you do not want it to be so complicated that it becomes extremely expensive and cumbersome, and starts to suck resources away from front-line services. That is a very important balance, which has been got seriously wrong in England.

We are currently carrying out deprivation of liberty assessments on people, at great expense, when there is no alternative to them being where they actually are. To me, there is something seriously wrong with that. When you devise a regulatory system, I think that it has to be something that will protect people's rights and uphold their rights to stay out of an institution where possible and proportionate, but that does not become too draining of resources in the legal and regulatory world.

The Chairperson (Mr Ross): There are two issues that we have identified with officials. The first is the level to which the Bill relies on regulations being made or codes of practice that we do not yet have sight of, and that there might not be the same level of scrutiny over. It is something that we have flagged up and we are a little bit nervous about, including the Henry VIII clause that is in the Bill. Some of us who are on the Justice Committee dealt with a similar clause in the Justice Bill and had a bit of disagreement with the Department of Justice. Cost is also an area of concern because I think that there is a level of expectation, particularly among the charities and some of the interested parties, that we get this right. If we pass a Bill and its cost means that we cannot implement it, I think that puts us in a very difficult position, because we will be letting a lot of people down.

Ms McCorley: Go raibh maith agat, a Chathaoirigh. I wanted to raise the issue of the under-16s, which has already been flagged as a concern. Do you have any particular views on that that you think that we should be aware of?

Professor Fennell: There is a provision in the Bill, and I did not focus on it as closely as perhaps I should have, for an age-appropriate environment, is there not? I think that that is vital and necessary for young people. My fundamental bottom line is that there should be places where young people, if they need care in a hospital, can get that care somewhere that is geared towards young people and not in an adult ward. Such a duty exists in the UK, but it is subject to clinical need.

We have sometimes had massive problems, certainly where I live in Wales, where young people, particularly with psychosis, are being sent out of area to be cared for in places that are at great distance from their homes. At such a time, you would want the support of your family and your loved ones around you. To have to travel 150 miles or 200 miles to visit your child or your sibling who is in hospital is very worrying.

I think that young people and children should have the right to challenge their detention if they are detained, but the most important thing is to ensure that it is not in the frightening environment of an adult ward, where there may be other people who have serious mental health problems of their own and who may not be as sensitive to the needs of young people.

Ms McCorley: I suppose the point is that the Bill proposes to provide very comprehensive safeguards and protections. What has been said is that children under 16 will not be safeguarded and protected in the same way. What they have said is that other legislation that covers children will be updated and amended, but —

The Chairperson (Mr Ross): Yes, they rely on the 1986 Mental Health Order. There was reference to children in terms of the criminal justice side of things, but I think that a lot of charities have identified the fact that under-16s are not included in the mental capacity side of things as a potential shortfall.

Mr Ruck Keene: You are into very tricky territory, legally and philosophically, with under-16s and how the judicial focus is beginning to turn. When you are talking about someone under 16 who cannot make decisions because of their maturity, and then move into 16- and 17-year-olds, the law, at least in England and Wales, has that kind of cut-off, so that you start looking to, for instance, the presumption of competence, as they call it, to consent to medical treatment. How do you grapple with some of these things? There are a couple of cases in the pipeline, which achieved the rather dubious shorthand of "baby Bournemouth", about looking at what the deprivation of liberty means and how you talk about it in relation to someone who is under 16, or then 16 or 17. I can understand why one just says that, in relation to the capacity side, there is something different between an under-16-year-old and a 16- or 17-year-old. When I was looking at it, I read some of the comments, but I can understand why it does make some conceptual sense to say that there is something different, perhaps not about every 16-year-old, partly because I can see a group of people who may be around that age sitting behind you. That does not apply to every 16-year-old and 15-year-old, but, societally, there is a logical difference or philosophical difference.

Mr McGlone: What are the implications? We spoke earlier about clause 5 and the appropriate person — the person that they wanted to be present at the assessment and how that would open up parental responsibilities versus that individual wishing to have, as they see it, the right person present and acting for them.

Mr Ruck Keene: Can I submit something in writing about that, because I have to disentangle parental responsibility there? The reason I am exercised about the issue — I raised it just now — is because we have a case on the brew about what parental responsibility means when you are talking about a 16- or 17-year-old and what parental responsibility allows you to do. There is some slightly — I am going to use a technical term here — dubious European Court of Human Rights case law that talks about that. It is going to have to be looked at. I will make sure that I address that in my written evidence.

Mr Lynch: I have one quick question for you, Alex. You said that you train doctors. Do you train the doctors to assess capacity?

Mr Ruck Keene: Yes. I provide, as it were, the legal framework. I would not dream of being able to talk about the clinical side, but capacity is a strange thing, because it is a legal definition of a thing that exists in the real world. This legislation, as with pretty much all legislation, divides the world into boxes according to whether you are or are not capacitous.

The Chairperson (Mr Ross): I am conscious of the time. We have about 10 minutes before we move upstairs for lunch, and I do not want to hold anybody back. Do you have any closing comments or one piece of advice that you would like to give us on how we can move this process forward as we enter the Committee Stage? I invite you to respond in whatever order you want.

Professor Szmukler: My comment is not directly on the Bill, but on implementation. A group of people at King's College London, which is my university, take a piece of legislation and convert it into a computer assistant program. It could relate to whether or not the Mental Capacity Act covers somebody in a care home and, if it does, what is necessary. It works only for logical statutes so we were told that our Mental Health Act was impossible, because it is so inconsistent and difficult to follow, but it was thought that the Mental Capacity Act could lend itself to that kind of programming. If that were possible, you would put in basic information, and then it will tell you what further information

you might need and whether you might need to consult a lawyer. It is worth thinking about in terms of implementation, down the road, of a logical piece of legislation. It has got to be logical.

Mr McGlone: We could call it "Christopher", as in the Enigma machine. *[Laughter.]*

Professor Szmukler: It works for citizenship in the UK. They have developed a program that works.

The Chairperson (Mr Ross): Are there any other closing comments?

Professor Hughes: I will be a dinosaur, compared with George. I want to talk about implementation and emphasise something about the paperwork that might be used. In England and Wales, with our Mental Health Act and our Mental Capacity Act, we were very familiar with the pink bits of paper that we have for the Mental Health Act, which, despite what George has just said, did lead us through the process of thinking that we had to go through, and it was fairly clear. When the Mental Capacity Act came in, there were no pieces of paper. When we were doing our research, we found that absolutely everybody had invented their own pieces of paper, which broadly followed the precepts of the Mental Capacity Act, of course, but it was chaos. Now, especially with the deprivation of liberty safeguards, we see lots more bits of paper coming from some sort of central authority. We are now drowning in them. Getting that clear — whether it is computer based or paper based — is incredibly helpful.

Professor Fennell: As is getting your easy-read versions. We are working on that at Cardiff. We are working on making people's legal rights accessible to service users and people who are potentially going to be a P in this system. I have difficulty with a person being a P and another person being a D, because I think that, it straight away, puts D as somebody who is doing something and P as somebody who is having something done for them. However, I do not think you can really escape that. I notice that you have also got, in Part 10, an A, who is the accused person, and, if you are appointing your nominated person, you are an X. There is a quite a bit of the alphabet used.

Professor Martin: In conclusion, in this area of law, it is crucial to recognise something that has taken us a while to recognise, which is that persons who are lacking in capacity, persons who are suffering from major psychiatric disorders, or people who are risks to themselves or others have will, preferences, wishes and desires. A lot of the hard work is thinking about how to take those into account properly. I think there is an opportunity here to really clarify that and to make a very positive step forward in this intrinsically difficult area of law.

Ms Bielanska: I want to expand on what Phil has just said about information for P. There should be information for all the people who support P, whether it is the informal carers or the paid staff, and it is about their understanding and trying to navigate what can, at times, feel very esoteric.

Mr Ruck Keene: All that I would add is that it is terribly easy to listen to the siren voice of protection. It is always much easier to say, "Right, let's do something." Actually, what we are learning, very painfully, is that, sometimes, the right thing is not to do anything. That is a very difficult thing to grapple with in the context of people who appear to be doing things that are very troubling. You have a real opportunity to redress that balance on the capacity side.

The Chairperson (Mr Ross): OK. Thank you all very much. This has been very useful. We look forward to written submissions as we get into the Committee Stage.