

**Mental Capacity Bill (Northern Ireland) – Implications for Children and Young People**

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**Executive Summary**

CLC has a number of concerns about the proposed way forward for mental capacity and mental health law in Northern Ireland under the current consultation which we detail in this briefing. The following is an Executive Summary: –

* It is proposed that children and young people under 16 will be excluded from the scope of the Bill by virtue of their age. This will mean that under 16s will not have access to the safeguards and protections contained in the Bill. CLC believes that this is not compliant with the United Nations Convention on the Rights of the Child (UNCRC), the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the European Convention on Human Rights (ECHR) or the Bamford Review recommendations. We believe children should be included in the scope of the Bill.
* It is proposed that the Mental Health (NI) Order 1986 will be retained with some amendment for under 16s pending a Review of the Children (NI) Order 1995. This was not recommended by the Bamford Review which recognised that the Mental Health (NI) Order 1986 was not compliant with the ECHR in part. We do not believe that the Children (NI) Order is the correct vehicle to deal with the compulsory assessment and treatment of children under 16 with mental ill health. Any review will also take a very long time so it is likely the Mental Health (NI) Order 1986 will remain in place for under 16s for some time.
* The proposed amendments to the Mental Health (NI) Order 1986 for under 16s are very unclear and have not been detailed in the consultation. CLC believes that children under 16 require at least equivalent protections and safeguards to over 16s as recommended by the Bamford Review.
* The retention of the Mental Health (NI) Order 1986 for under 16s means that there will be no provision for children receiving care or treatment in the community or for children with learning disabilities.
* The Mental Capacity Bill will include conditions caused by personality disorder and drugs and alcohol within the definition of ‘mental illness’. This will not apply to under 16s.
* Under the Mental Capacity Bill it will be necessary to show a lack of capacity before a person over 16 can be formally detained for assessment or treatment. This will not be necessary for those under 16s meaning that it will be easier to formally detain someone under 16.
* The DHSSPS has suggested that amendments to the Mental Health (NI) Order 1986 will provide some safeguards and protections to under 16s who are formally detained. It is vital that all children who require hospital treatment, whether voluntary or detained have access to adequate safeguards and protections which are at least equivalent to those over 16. Otherwise for some children formal detention may appear to be preferable in order to access protections and safeguards.
* Independent advocacy should be available to all children and young people who require it both in the community and in a hospital setting. Children should be able to choose their advocate.
* The deprivation of liberty safeguards should apply to all regardless of age in compliance with Article 5 of the ECHR.
* The extension of the disregard provision to include periods of detention should apply to all children under 18 and retrospectively to anyone detained for treatment as a child.
* The Nearest Relative provisions should be amended to ensure ECHR compliance for under 16s.
* A statutory right to age and developmentally appropriate accommodation and to education should be included for all children under 18.
* The offence of ill treatment or neglect of someone who lacks capacity should be extended to everyone, regardless of age.
* A “separate project” examining the capacity of children will not address the exclusion of children who lack capacity as a result of a mental illness or learning disability from the Mental Capacity Bill. In addition while we note the proposed ‘separate project’ to consider the capacity framework relating to children and young people in the next Assembly mandate, it is uncertain whether this work will be a priority under future Ministerial arrangements.
* CLC believes that neither police stations or the Juvenile Justice Centre are suitable options as a place of safety for a mentally ill young person. We wish to see this removed from the legislation and a reduction in time for detention in the place of safety from 48 to 24 hours in line with Article 37b of the UNCRC.
* The Principles of the Bill should revert to those recommended by the Bamford Review – Autonomy, Justice, Benefit and Least Harm.
* CLC believes that the Mental Capacity Bill should not include a system of Trust Panels in relation to authorisation as the system that is proposed is flawed, will be subject to legal challenge and disadvantages the patient should they subsequently wish to challenge the authorisation to the Review Tribunal or to the High Court.
* CLC believes that it is an unsustainable position for the DoJ to exclude under 16s from the scope of the justice provisions of the Mental Capacity Bill by virtue of their age and maturity while 10 is the minimum age of criminal responsibility in Northern Ireland.
* DoJ has not adequately assessed the impact that excluding under 16s from the scope of the Bill will have for children and young people in the youth justice system in its consultation. The exclusion of under 16s from the scope of the Bill and the retention of the Mental Health (NI) Order 1986 will have significant potential for adverse impact on children and young people who come into contact with the criminal justice system. There will also be serious implications for the operation of the Police Service of Northern Ireland (PSNI), the Probation Board for Northern Ireland (PBNI), the Youth Justice Agency, including the Juvenile Justice Centre and the Northern Ireland Courts and Tribunal Service, as what is being proposed is a two tier system for those over and under 16. Children aged under 16 who are in the criminal justice system and have a mental illness and/or learning disability are one of the most vulnerable groups of children and young people in Northern Ireland and should be afforded the highest degree of protection.
* A lot of the necessary detail required to make informed comment on the consultation is not provided with many areas being left to the Codes of Practice, which have not been finalised or consulted upon. The Draft Codes of Practice must be urgently published and consulted upon.

We have a number of concerns about the compliance of the consultation with obligations on both Departments by virtue of section 75 of the Northern Ireland Act 1998. These include the introduction of new and substantially amended policies which are being consulted on for the first time as a Draft Bill despite the obligations to carry out screening at the earliest possible stage. We are also concerned about the lack of detail provided in the DHSSPS’s updated EQIA and the DoJ’s EQIA which does not assess the impact of their proposals on children in the criminal justice system. Neither DHSSPS nor DoJ have given details of the proposed mitigation of the adverse impact which will be suffered by under 16s as a result of their exclusion from the Mental Capacity Bill. There has been a failure to produce a child accessible version of the consultation document and a failure to produce an easy read version from the start of the consultation period.

**Mental Capacity Bill (Northern Ireland) – Implications for Children and Young People**

The Draft Mental Capacity Bill is a joint mental capacity and mental health piece of legislation being brought forward jointly by both the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DoJ). This is the first time anywhere in the world that the concepts of mental health and mental capacity will be combined in a single legislative framework. The Draft Mental Capacity Bill contains a number of important safeguards and protections for people aged 16 and over who lack decision making capacity due to an impairment of, or disturbance in, the functioning of the mind or brain, which impairs an individual’s ability to understand, retain, use, weigh and communicate the information needed to make a decision. The proposed gateway into the protections afforded by the Mental Capacity Bill is to be a lack of capacity, based upon a two stage test. **It is only once a lack of capacity has been established that the protections, safeguards and substitute decision making provisions of the Bill apply to the individual.**

The proposed two stage test of mental capacity will be firstly diagnostic - that a person has an impairment of, or disturbance in, the functioning of the mind or brain.

The second stage is a functional test, which considers if, as a result of the impairment or disturbance, the individual can understand the information needed to

make a decision and, if required, the person must be assisted in that understanding. The person should be able to retain the information at least long enough to make the decision. The person should be able to use and weigh the information in order to make the decision and finally the person should be able to communicate their decision. Every reasonable assistance must be given to the individual to facilitate the decision making process.

The DHSSPS and the DoJ published their joint consultation document on the proposed way forward for mental health and mental capacity law for Northern Ireland on the 27th May 2014. The deadline for responses is the 2nd September 2014. The consultation papers include a consultation document, a draft of the civil provisions of the Mental Capacity Bill, an [updated Equality Impact Assessment from the DHSSPS, an](http://www.dhsspsni.gov.uk/dhssps_updated_eqia_report_-_mental_capacity_bill.pdf) [Equality Screening document and an](http://www.dhsspsni.gov.uk/doj_-_equality_screening_paper_-_mental_capacity.pdf) [Equality Impact Assessment from the DoJ.](http://www.dhsspsni.gov.uk/doj_eqia_-_mental_capacity.pdf) It is planned that the Mental Capacity Bill will be introduced to the Assembly in early 2015 and it is expected to become law in 2017.

There are three areas of interest to CLC with regard to the current consultation on the way forward for mental health and capacity legislation in Northern Ireland. These are –

1. The proposed exclusion of under 16s from the scope of the Mental Capacity Bill and the retention of the Mental Health (Northern Ireland) Order 1986 with some amendment for this group. This will be an interim measure pending the carrying out of a review of the Children (Northern Ireland) Order 1995 to include compulsory powers of detention for mental illness,
2. The application of the Mental Capacity Bill to 16 and 17 year olds who it is proposed will come within the scope of the Mental Capacity Bill,
3. Children within the criminal justice system.

**CURRENT** **MENTAL HEALTH LEGISLATION IN NORTHERN IRELAND**

There is a recognition that the current mental health legislation in Northern Ireland, the Mental Health (Northern Ireland) Order 1986 is not fit for purpose and in places is not compliant with the European Convention on Human Rights (ECHR). A comprehensive review of mental health and learning disability was carried out in Northern Ireland – the Bamford Review of Mental Health and Learning Disability (the Bamford Review) in 2002. This Review involved the participation of most of the leading experts in the field of mental health and learning disability as members of one or more of the ten Expert Working Committees which produced detailed reports outlining their findings and recommendations between June 2005 and August 2007. The Expert Working Committees made almost 700 recommendations to adequately and effectively reform the system of mental health and learning disability in Northern Ireland and to render it human rights compliant.

It is CLC’s view that new combined mental health and mental capacity legislation, falls far short of what was recommended by the Bamford Review. The Mental Capacity Bill will provide a number of important safeguards and protections for people who lack decision making capacity although there has been a significant dilution of some of the proposed safeguards and protections in the development of the Bill which is now being consulted on. Children under 16 will be excluded from the scope of the new legislation and the Mental Health (Northern Ireland) Order 1986 will remain in place for children and young people under 16 with mental health problems. This will mean that solely on the basis of age, under 16s will not be able to access the protections and safeguards contained in the new Mental Capacity Bill which, will be afforded to those over 16 who lack capacity as a result of a mental illness or learning disability.

**Children and young people under 16**

With regard to children and young people under 16, the current consultation proposes that this group will be excluded from the scope of theMental Capacity Bill and the Mental Health (Northern Ireland) Order 1986 will be retained with some amendment as an interim measure pending the carrying out of a review of the Children (Northern Ireland) Order 1995 to include compulsory powers of detention for mental illness. **The retention of the Mental Health (Northern Ireland) Order 1986 for any of the population was not recommended by the Bamford Review, in particular children and young people for whom it recommended additional safeguards and protections not fewer.**

CLC has consistently detailed its concerns to Government with regard to the proposal to exclude under 16s from any new legislation and has emphasised the need to ensure that any new legislation is in conformity with the UNCRC, particularly Articles 2 – non-discrimination, 3 – best interests of the child, 6 – right to survival and maximum development, 12 – right to be heard and have views taken into account, 23 – right of a disabled child to a full and decent life and 24 – highest attainable standard of healthcare. In particular we fail to see how proposals to exclude children and young people under the age of 16 with mental health difficulties or a learning disability from the protections and safeguards contained within the new legislation have the best interests of the child as a primary consideration, or ensure children’s rights without discrimination, given that the exclusion will be based on no criteria other than age alone. In addition, CLC is concerned that the exclusion of under 16s from the scope of the Mental Capacity Bill is not compliant with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), in particular Article 7, which refers to the right of children with disabilities to enjoy all human rights and fundamental freedoms on an equal basis with other children and Article 12 which states that the aim of the UNCRPD is full and equal legal capacity for everyone.

**The rationale for the exclusion of under 16s from the scope of the Mental Capacity Bill is the belief of both the DHSSPS and the DoJ that the test of capacity contained in the Mental Capacity Bill cannot be applied to children in the same way as adults because of their developmental stage. CLC has argued that Article 12 of the UNCRC requires the state to actually assess the capacity of each individual child to form an autonomous opinion and that state parties cannot begin with the assumption that all children under 16 lack capacity. We have further argued that Article 12 imposes no age limit and states are discouraged from introducing age limits either in law or in practice which would restrict the child’s right to be heard in all matters affecting them.**

The consultation document states that the common law presumption of capacity cannot be extended to all children as it would simply not make sense to presume, for example, that a two year old has capacity when in reality, the reverse is true[[1]](#footnote-1). It has never been CLC’s position, nor was it recommended by the Bamford Review that there should be a presumption of capacity in very young children. The Bamford Review Report, “A Comprehensive Legislative Framework” looked specifically at the issue of Children and Young People with mental illness or learning disabilities. The Review recognised thatchildren reach decision making capacity at different stages in their development, that a small number of children and young people will require the support of specific legislation and that the proposed principles for that legislation should recognise their particular needs. Bamford recognised that the capacity of children and young people is evolving and that:

*“The implications of a capacity approach to all substitute decision-making legislation would require the same basic approach to be applied for children. While most people would agree that parents be substitute decision-makers for children up to the age of 10 or 12, consideration might be given to a rebuttable presumption of capacity between 12 and 16.*”[[2]](#footnote-2)

The “Comprehensive Legislative Framework” report recognised the need for children and young people who lack capacity to have equal access to the protections and safeguards of any new mental health and capacity legislation.

*“New capacity-based legislation would allow all the protections afforded to adults in these situations, for example, if such an assessment or treatment plan involved significant restrictions or deprivation of liberty regardless of whether the child is compliant or objecting. If parents’ views are to be over-ridden, or if the child is without parents and no parental responsibility has been given, the special needs of the child must be recognised and protected in arrangements for advocacy and representation.”[[3]](#footnote-3)*

It is clear that the approach being taken by both the DHSSPS and the DoJ is in conflict with the Bamford Review which suggested a recognition of the evolving capacity of young people which would mean that where a mature young person was deemed to have had capacity and then to have lost capacity due to a mental illness or learning disability, they should come within the scope of the Mental Capacity Bill and have access to the protections and safeguards therein.

The consultation document also states that it is proposed that a ‘separate project’ should be undertaken to consider the capacity framework relating to children and young people in the next Assembly mandate[[4]](#footnote-4). The Mental Capacity Bill provides alternative decision making mechanisms and protections for those who lack capacityand does not apply to a person who has capacity. There will therefore be no interface between the Mental Capacity Bill and the proposed separate project which will examine where a young person under the age of 16 should be afforded decision making capacity. In addition while we welcome this proposal to examine the emerging capacity of *all* children and young people under the age of 16 it is uncertain whether this work will be a priority under future Ministerial arrangements.

The process of reviewing the Children (NI) Order 1995 if it proceeds under future Ministerial arrangements will at best take several years to complete. DHSSPS representatives in an evidence session to the Committee for Health, Social Services and Public Safety[[5]](#footnote-5) stated that that the retention of the Mental Health (NI) Order 1986 for under 16s was a “temporary measure”, however they also indicated that reform of the Children (NI) Order 1995 to include provisions on the compulsory assessment or treatment of under 16s with mental ill health would potentially be a bigger undertaking than the mental capacity legislation itself and would take considerable time to complete. It is therefore extremely unlikely that a review of the Children (NI) Order 1995 will be concluded within the next Assembly mandate and it is wholly uncertain whether this work will be a priority under future Ministerial arrangements. It is therefore extremely likely that the retention of the Mental Health (NI) Order 1986 for under 16s will be an enduring feature on the Northern Ireland statute book.

In addition, CLC does not believe that the Children (NI) Order 1995 is the correct vehicle to deal with issues relating to the compulsory assessment or treatment of under 16s with mental ill health. The Children (NI) Order 1995, while it urgently requires review, covers issues such as the location and quality of care a child receives, the identity of those with parental responsibility and who and when others should have regular contact with the child. We believe the failure to include under 16s within the scope of the Mental Capacity Bill is a missed opportunity and given the importance of getting any new legislation right which deals with such important issues as the compulsory assessment or treatment of extremely vulnerable under 16s with mental ill health, that new mental health legislation will be required, rather than mental health legislation for under 16s coming within a much wider review of the Children (NI) Order 1995 with a remit for an entirely different purpose.

Both the DHSSPS and the DoJ acknowledge the insufficiency of the current legal framework in Northern Ireland and the need for legislative change[[6]](#footnote-6) as well as acknowledging the work of the Bamford Review, commenting that the Mental Health (NI) Order 1986, “…*is out of sync with the growing recognition of the right to personal autonomy.”[[7]](#footnote-7)* The Departments also acknowledge the key recommendation of the Bamford Review that,

*“There should be a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern*

*Ireland”.[[8]](#footnote-8)*

Despite the acknowledgements in the consultation document about the need for legislative reform and the unsuitability of the Mental Health (NI) Order 1986, the ‘single bill approach’ as recommended by Bamford will only apply to those over 16. Under 16s will still be subject to the provisions of the Mental Health (NI) Order 1986 and will not have access to the enhanced protections of the single bill by virtue of their age.

In the consultation document there is an extremely disappointing lack of detail on the proposals of both the DHSSPS and the DoJ in relation to under 16s and the proposed retention of the Mental Health (NI) Order 1986. Given the disproportionately high incidence of mental ill health among children and young people in Northern Ireland (see Appendix 1) and the fact that children and young people represent approximately a quarter of the population of Northern Ireland it is extremely disappointing that they are effectively being totally excluded from this process, which is described in the consultation document as a*, “…once in a generation opportunity to reform this important area of law but also an opportunity to be world leaders in doing so”[[9]](#footnote-9)*.

**CLC’s Concerns - Proposed Exclusion of Under 16s from the scope of the Mental Capacity Bill and Retention of the Mental Health (NI) Order 1986**

Under the proposed Mental Capacity Bill it will be necessary to assess an individual’s capacity and only once a lack of capacity has been established will it then be possible to apply the test for formal detention in a hospital setting.  Under the Mental Health (Northern Ireland) Order 1986, there is no requirement to establish a lack of capacity before applying the test for formal detention.  **It will therefore be easier to formally detain under 16s than those over 16.**

**CLC wishes to see under 16s having access to at least equivalent protections and safeguards to those which over 16s will have by virtue of coming within the scope of the Mental Capacity Bill. The Bamford Review was clear that, given the special vulnerabilities and developmental needs of children and young people, this group requires special rights and protections[[10]](#footnote-10).**

As proposed by the consultation, the statutory safeguards which will be contained in the Mental Capacity Bill and therefore only afforded to **over 16s**, include:

* **a** **statutory right to access advocacy services,**
* **a statutory recognition of the views of carers,**
* **protection under the creation of a new offence of ill treatment or neglect of those who lack capacity,**
* **legal protection to a person who is providing care or treatmentfor anyone who lacks capacity, and**
* **restraint safeguards which permit the use of restraint only when a person using restraint reasonably believes that it is necessary to prevent harm and that any restraint used is proportionate to the likelihood and seriousness of the harm.**

The Mental Capacity Bill will also provide **additional safeguards when an individual, who is not detained but who lacks the capacity to consent to care in either a hospital or a care home, is deprived of their liberty in their best interests**, taking account of the European Court of Human Rights judgment, *HL v United Kingdom*[[11]](#footnote-11) 2004 (the Bournewood case). The Mental Capacity Bill will include details of when and how deprivation of liberty may be authorised. **There will be no deprivation of liberty safeguards including scrutiny, monitoring of or the need to justify the deprivation of liberty of under 16s**. **Under 16s, who have their liberty deprived due to their compliant nature, as opposed to as a result of detention, have therefore no means of challenging the deprivation of their liberty; the deprivation does not have to be justified as would be the case if they were over 16 and as they are voluntary patients there are no easy means of challenging their deprivation of liberty either by way of a Mental Health Review Tribunal or to the High Court**. It is CLC’s view that the proposed exclusion of under 16s from accessing deprivation of liberty safeguards will lend itself to legal challenge. The Bournewood case made no distinction between the rights of those under and over 16 to have safeguards put in place to guard against an unjustified deprivation of their liberty as protected by Article 5 of the ECHR. CLC therefore believes that as Article 5 of the ECHR applies to everyone, regardless of age, the deprivation of liberty safeguards should be extended to all.

We understand that amendments to the Mental Health (Northern Ireland) Order 1986 may provide some statutory safeguards for children under 16 who are **formally detained** in a hospital setting for assessment and / or treatment. The fact that we do not have the details of such proposed amendments is in itself concerning. **CLC is concerned that the provision of statutory safeguards and protections only for children who are formally detained may make formal detention an attractive option for some children.** Currently less than 0.5% of children and young people who are inpatients in mental health hospitals are detained, therefore no statutory provisions may be made for the other 99.5% of under 16s who are voluntary inpatients in a hospital setting. CLC wishes to see statutory safeguards and protections for all children, both voluntary and detained in order to maximise protections for children with mental ill health in a hospital setting in line with the Bamford Review. CLC does not believe that it is acceptable to legislate in a manner which could make formal detention an attractive option for any child or young person. We urge both Departments to provide statutory protections and safeguards for both voluntary and detained young people which are at least equivalent to those for over 16s under the Mental Capacity Bill.

**The exclusion of under 16s from the scope of the Mental Capacity Bill means that there will be no provision made for under 16s who are receiving care and treatment for mental ill health in a community setting and no additional provision made for under 16s who have a learning disability.** CLC wishes to see legislative amendments under the Mental Health (NI) Order 1986 to provide for both these groups of children in a manner which is at least equivalent to that provided for over 16s under the Mental Capacity Bill.

The Mental Health (Northern Ireland) Order 1986, also **specifically excludes people disabled, “by reason only of personality disorder**” and the Bamford Review recognised that this exclusion disadvantages people with a personality disorder from accessing assessment and treatment.[[12]](#footnote-12) The Mental Capacity Bill will include ‘personality disorder’ within its scope but will not apply to under 16s. While personality disorder is not currently diagnosed during childhood, emerging personality disorder in adolescents is increasingly being recognised and **this has a significant potential to impact upon young people within the justice system given the prevalence of personality disorder amongst young offenders. One study has found that 85% of young people aged 16 to 20 in custody showed signs of a personality disorder[[13]](#footnote-13) as compared with 10% to 13% of the general population.**[[14]](#footnote-14)

With regard to admission procedures, the Bamford Review’s Report on Human Rights and Equality of Opportunity identified concerns regarding the second ground for granting an application for detention under current legislation - there is a “substantial likelihood of serious physical harm to self or to other persons”. The Review recognised the insufficiency of this ground and recommended use of a broader test such as that used in the Scottish mental health legislation - “a significant risk to the health, safety or welfare of the patient or to the safety of any other person.”[[15]](#footnote-15) It appears that the original test for detention will remain for under 16s despite this criticism and recommendation by the Bamford Review.

The Bamford Review also commented uponPatients Concerned in Criminal Proceedings or Under Sentence. Part III of the Mental Health (NI) Order 1986 provides for the powers that enable Courts to remand an accused to hospital for a report on their mental condition or for treatment. It provides for the power to make a hospital order or guardianship order or an interim hospital order. Part III also provides for transfer direction orders to transfer of prisoners to hospital for treatment and it provides for the provisions in relation to those found legally insane or unfit to stand trial. The Review had several criticisms of the Order in relation to those involved with the criminal justice system which they felt required amendment[[16]](#footnote-16) and which will now be retained only in relation to under 16s. These include:

• Powers to remand persons to hospital do not extend to the Court of Appeal and do not allow for the granting of temporary leave.

• When recommendations are made to the Court for disposals such as a hospital order there are no specified time periods within which the person should be assessed.

• Where it is recommended to the court that a person should be admitted to hospital but the individual is acquitted of the offence there are no arrangements in place to provide for appropriate assessment, treatment and care.

• There is no legal mechanism for prisoners on remand or for those who may require an interim hospital order to be transferred to conditions of high security for assessment, treatment and care.

• Prisoners who are transferred to hospital for treatment under the Mental Health (NI) Order 1986 are treated on a compulsory basis even if they are prepared to be treated on a voluntary basis.[[17]](#footnote-17)

CLC wishes to see these criticisms being addressed if not through the inclusion of under 16s in the Bill then through amendments to the Mental Health (NI) Order 1986 for under 16s.

**Proposed Amendments to the Mental Health (NI) Order 1986**

The consultation document outlines some amendments which both Departments’ are considering making to the Mental Health (NI) Order 1986 for under 16s. However there is a worrying lack of detail in respect of these amendments which mitigates against proper consultation. Further in the context of the tight legislative timetable CLC are deeply concerned that this failure to detail how the Mental Health (NI) Order 1986 should be amended for under 16s may signal an inability to properly consult and legislate on amendments to the 1986 Order contemporaneously with the proposed new Bill. Some of the proposed amendments which the Departments have signaled their intention to proceed with include:-

**1. Insertion of a Best Interests Principle** -The consultation document states that this will be similar to the best interests principle in the Mental Capacity Bill but more child focused in line with the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities[[18]](#footnote-18). The consultation document also states that it is envisaged that as part of a best interests assessment:

- the child’s views must be taken into account;

- the child must be provided, in an appropriate way, with information and advice about the matter in question;

- where practicable and appropriate persons with parental responsibility and carers must be consulted; and

- the child must be helped and encouraged to participate as fully as possible in the determination of what is in his/her best interests as far as it is practicable and appropriate to do so.

While CLC welcomes this proposal there is not enough information available to make fully informed comment. Further information, including where this clause will be placed within the Order as well as sight of the draft are necessary to comment further on this proposal. This detail deficit is very concerning.

**2. Insertion of a Duty to Consult with Independent Advocate –** it is proposed that this will operate in a similar way to how this is provided for in the Bill and linked to the determination of best interests. While this is a welcome development, CLC believes that access to advocacy for children is vital in the community when detention is being considered as an option, prior to the detention test being run as this could prevent the need for detention. It is also vital that both voluntary and detained patients have a statutory right to advocacy in a hospital setting. CLC wishes to see as broad a statutory right to advocacy as possible and the provision of advocacy for under 18s in the community where required and in particular, post discharge. CLC has a number of concerns about the dilution of the commitment to independent advocacy more generally within the Mental Capacity Bill which we address in detail at page 32. The consultation document does state that an advocate appointed for under 16s would have to be age appropriate and would have undergone the necessary training and child protection procedures. However, it does not state that under 16s should be provided with an independent advocate of their choosing. We would urge both Departments’ to making a commitment to young people being able to choose their own independent advocate, given their particular vulnerabilities, as young people may have formed relationships with independent advocates from working with a particular advocacy service on a previous occasion and may feel that that service is best suited to meet their needs.

There is also no information provided as to the type of training that will be required for independent advocates for under 16s. Articles 4 and 42 of the UNCRC stress that all professionals working with children and young people should be aware of, and receive training about, the UNCRC and children’s rights. The UNCRC Committee’s General Comment No 5 provides a detailed account of children’s rights training requirements of Governments. It notes that the Government’s target audiences for training must include, *“...all those involved in the implementation process- Government officials, parliamentarians, judiciary, and for all those working with and for children.”[[19]](#footnote-19)*

In its 2008 Concluding Observations following its most recent examination of the UK Government, the UN Committee on the Rights of the Child continued to place a heavy emphasis on the need for training in all aspects of the Convention and its application. In its 2008 Concluding Observations it recommended to the UK Government,

“…*the reinforcement of adequate and systematic training of all professional groups working for and with children, in particular law enforcement officials, immigration officials, media, teachers, health professionals, social workers and personnel of child-care institutions*”.[[20]](#footnote-20)

Training for independent advocates for under 16s should include among other things children’s rights, determining the competency of the child, how to communicate with children and equality training. We would seek clarification as to the type of training that will be required and whether or not this will be funded training.

**3. Extension of the Disregard Provision in Article 10 of the Mental Health Order, to include periods of detention for treatment -** This is a very welcome development as the obligation on young people to declare periods of detention for treatment for a mental illness for insurance and driving purposes, travel, to employers and for jury service, has an extremely detrimental impact on the child’s life and future. Given that the UNCRC defines children as, *“…every human being below the age of eighteen”[[21]](#footnote-21)* we wish to see this being extended to include 16 and 17 year olds and also operating retrospectively to include all persons who have been detained in childhood under the 1986 Order.

**4. Insertion of a provision requiring Consent AND a Second Opinion for electro-convulsive therapy for detained patients aged under 16 –** CLC has serious concerns about the use of electro-convulsive therapy on children and young people and its compliance with human and international children’s rights standards. As a minimum we wish to see an amendment to the Mental Health (NI) Order 1986 to reflect the National Institute for Health and Care Excellence (NICE) Guidance on the use of Electroconvulsive Therapy [[22]](#footnote-22) which recognises that the risks associated with Electroconvulsive Therapy may be enhanced in children and young people and states that clinicians should exercise particular caution when considering ECT treatment[[23]](#footnote-23).

**5. Amendment of Nearest Relative Provisions –** These provisions must be amended for all in order to ensure compliance with the case of *JT v UK[[24]](#footnote-24)* which dealt with the displacement of an unsuitable nearest relative. It is proposed in the consultation document that these provisions will be amended by:

1. Adding the “patient” to the list of persons with a right to apply to the county court for displacement of their nearest relative.
2. Continuing the position that any person listed by the Mental Health Order who can make an application to the county court can be appointed acting nearest relative, but that the patient cannot be appointed as his or her own acting nearest relative.
3. Adding a new ground of “unsuitability” to the existing grounds on which an application to displace the existing nearest relative and appoint a new acting nearest relative can be made; and

CLC has a number of concerns about the proposals in the consultation document with regard to the Nearest Relative as we do not believe that the proposed amendments will ensure ECHR compliance. CLC wishes to see applications by under 16s to displace an unsuitable Nearest Relative being brought to the Mental Health Review Tribunal as this will be faster and will also be in line with the similar provisions in the Mental Capacity Bill for over 16s. In addition, while this is not stated in the consultation document, we wish to see a young person being able to choose an appropriate person who is not on the current statutory list as their Nearest Relative if they are suitable and willing to act. The term, ‘any other person deemed suitable by the Review Tribunal’ should be inserted into the default list.  The displacement of the Nearest Relative should not systematically follow the default list but should be the choice of the child of a suitable person within that list, including the ‘any other person’ clause. We also wish to see, in the case of a looked after young person, an ability to displace the Trust as their Nearest Relative in favour of another suitable person of their choosing, or in the case of a young person resident in the Juvenile Justice Centre (JJC) to displace the Head of the JJC as their nearest relative in favour of a suitable person of their choosing. It is worth noting that the suitability of the Nearest Relative would be determined by the Mental Health Review Tribunal, or as is currently proposed, the County Court.

**6. Placing a duty on hospital managers in respect of age appropriate**

**accommodation (akin to clause 146) –** This is welcome but there is no further information provided regarding this proposed duty. The consultation document states that the duty will be that akin to what is proposed under clause 146 of the draft Mental Capacity Bill which places an obligation on the managing authority of a hospital to ensure that any person under 18, either a detained or voluntary inpatient who has a mental illness, should be in a suitable environment having regard to his or her age. From a children’s rights perspective it is a matter of huge concern to us that children and young people are presently not always treated in age appropriate facilities as required by Articles 37c and 3 of the UNCRC. When the Bamford Review in its report, *“A Vision of a Comprehensive Child and Adolescent Mental Health Service”[[25]](#footnote-25)*  looked at this issue it recommended that child and adolescent mental health services should ordinarily cover children and young people up to their 18th birthday and that at all times children and young people should be located in developmentally appropriate settings[[26]](#footnote-26). CLC expressed serious concerns regarding the approach advocated by the Northern Ireland Executive in its Response to Bamford[[27]](#footnote-27) with regard to the issue of age appropriate services, where the Executive stated that there should be flexibility when deciding whether young people should be admitted to adult wards.

It is CLC’s view that the detention of children with adults in non-appropriate age and developmental facilities fails entirely in ensuring the best interests of children and young people is the paramount consideration as the Government is required to by Article 3 of the UNCRC and would be in conflict with the proposed best interests principle. It is our view that at all times, without exception, children and young people under 18 should be treated in developmentally and age appropriate settings. The accommodation of children and young people in in-patient, adult wards is completely unacceptable as there are serious implications for child protection.

Healthcare professionals working on adult wards are unlikely to have been trained in child protection procedures, adult patients are unlikely to have been vetted, children may not be given the same opportunities to express their views on adult wards, particularly if staff are untrained in effective methods of communication with vulnerable children and children in adult wards may not receive the most appropriate and highest standard of treatment where staff are trained and experienced in treating adult patients only. The proposal to place an obligation on the managing authority of a hospital to ensure that any person under 18, either a detained or voluntary inpatient who has a mental illness, should be in a suitable environment having regard to his or her age is very welcome, however further clarification is required as to what this accommodation is, when and how it will be provided. We have some concerns about the use of the term “suitable” and wish to see a clear statutory duty on hospital managers to ensure that no young person is detained on an adult psychiatric ward. CLC wishes to see both Departments giving effect to this commitment within the context of the amendments to the Mental Health (NI) Order 1986 and to reflect it in a clear and robust legislative commitment to guarantee that **all** children and young people in need of inpatient mental health services at **all** times will be located in developmentally and age appropriate settings.

The consultation document also states that the Departments are also considering access to education provisions. Again, there is no further information provided about whether and how this will be translated into a legislative commitment and clarification is urgently required as to exactly what level of educational services will be provided. It is not possible to make informed comment on this proposal at present due to a complete lack of information provided in the consultation. The right of children and young people with a mental ill health to an effective education was recognised in the Bamford Report, *“Human Rights and Equality of Opportunity”*[[28]](#footnote-28) which states that,

*“The review emphasises the importance of recognising the right of every child and young person to have access to a practical and effective education…government policy or funding priorities should not disadvantage people with a mental health problem or a learning disability…particular attention needs to be paid to ensuring that children and young people with mental health difficulties or a learning disability, who present challenges to educational services because of the severity or complexity of their disability, enjoy equal access to education…children and young people with a mental health difficulty or a learning disability have the right to an effective and practical education without discrimination under Protocol 1, Article 2 and Article 14 of the ECHR as incorporated by the Human rights Act 1998.”*[[29]](#footnote-29)

In order to comply with UNCRC Articles 2 – non-discrimination, 23 - right of a disabled child to a full and decent life[[30]](#footnote-30), 28 – right to education and 29 – right to an effective education and Protocol 1, Article 2 of the ECHR, both the amendments to the Mental Health (NI) Order 1986 and the Mental Capacity Bill should ensure that all children with mental ill health continue to receive a practical and effective education, particularly if the child is detained, **up to the age of 18**[[31]](#footnote-31). This should be demonstrable by requiring the child’s educational needs to be considered in line with the best interests principle and by the provision and resourcing of an individualised education plan for every child concerned which, is monitored and reviewed regularly. CLC wishes to see the Departments’ consideration to education provisions being translated into a clear and robust legislative commitment to guarantee that all children and young people requiring in-patient care will be provided with a quality education and suitable educational facilities.

**Other amendments required to the Mental Health (NI) Order 1986**

The consultation document states that the list of proposed amendments to the Mental Health (NI) Order 1986 is not exhaustive and that work on strengthening the existing protections in the Mental Health (NI) Order 1986 for children is currently ongoing. Other areas which CLC have raised in detail with the DHSSPS and which we would like to see amended in the Mental Health (NI) Order 1986 include –

* The language of the Mental Health (NI) Order 1986 needs to be reviewed and amended and phrases which are stigmatising, such as ‘mental disorder’ need to be removed.
* Conditions caused by personality disorder, drugs and alcohol need to be included with the list of conditions currently covered by mental disorder.
* The test for detention for assessment/treatment should be amended to reflect the test proposed for over 16s under the Mental Capacity Bill, without the capacity test, as had been previously proposed for under 16s.
* There must be a right of access to the Mental Health Review Tribunal at the earliest possible stage. The Mental Health (NI) Order 1986 should be amended to allow under 16s ability to apply to the Tribunal during the assessment period rather than after 6 weeks as is the case currently.
* Article 13 of the Mental Health (NI) Order 1986 refers to renewal of authority for detention for treatment. CLC believes this Article should be amended to state that a review of detention must be carried out by 2 doctors and the renewal of authority for detention for treatment must be authorised by a Trust Panel (as available under the Mental Capacity Bill) . There must also be a right of appeal to the Mental Health Review Tribunal.
* Article 73 of the Mental Health (NI) Order 1986 relates to the automatic referral mechanism to the Mental Health Review Tribunal. This should be amended to ensure that applications are made in time to allow the Tribunal to hear the case within the year.
* Currently the Mental Health (NI) Order 1986 only permits young person to apply to the Mental Health Review Tribunal once every 6 months. This is an extremely long time in the life of a child under 16. CLC wants to see this restriction being removed and the inclusion of a provision to allow for multiple applications to be made, if necessary, with the leave of the Mental Health Review Tribunal.
* Article 121 relates to the offence of ill treatment of patients. This needs to be amended to mirror the offence of ill treatment or neglect of those who lack capacity which it is proposed will be included in the Mental Capacity Bill
* Article 130 relates to places of safety for those in need of immediate care or control. CLC believes that the Juvenile Justice Centre is not a suitable option as a place of safety for a mentally ill young person. We wish to see this removed from the legislation and a reduction in time for detention in the place of safety from 48 to 24 hours in line with Article 37b of the UNCRC which states that the detention of a child shall be used, *“…only as a measure of last resort and for the shortest appropriate period of time.”*
* The legislation should include a list of safeguards and protections which are at least equivalent to those over 16s will be afforded under the Mental Capacity Bill, including those safeguards which have not been addressed elsewhere, such as a statutory recognition of the views of carers and restraint safeguards. These safeguards and protections should apply to both detained and voluntary patients equally.

**Young People aged 16 and 17 – the mental capacity bill**

The Draft Mental Capacity Bill as currently proposed applies to those aged 16 and over, except for the following provisions which apply only to over 18s -

**Lasting Power of Attorney -** Under Clause 97(1) of the Draft Bill a lasting power of attorney can only be made Bill by a person aged 18 and over. This is similar to the situation in England and Wales. However CLC believe that there are a number of hazardous occupations in which 16 and 17 year olds are employed where it may be beneficial in those circumstances for them to have the ability to make a lasting power of attorney. It may therefore be beneficial for 16 and 17 year olds to have the ability in certain circumstances to make a valid Lasting Power of Attorney.

**Statutory Wills -** Under clause 109(2) a statutory will on behalf of a 16 or 17 year old cannot be made, this is in keeping with general laws regarding testamentary powers and dispositions.

**Legal recognition of 16 and 17 year olds as Children -** The consultation document recognises that 16 and 17 year olds are still children in law and that the Bill must ensure that the inherent jurisdiction of the High Court continues to operate in relation to a child who is 16 or 17 years old. The consultation document further states that, *“…in recognising that a 16 or 17 year old is a “child” under the Children Order and under international law, the Bill provides additional safeguards for this group of young people. For example, certain duties are placed on hospital managers in respect of the provision of age-appropriate accommodation.”*[[32]](#footnote-32) The strength of these additional safeguards gives rise to some concerns.

**Additional Safeguards for 16 and 17 year olds**

Clause 146 which is titled “**In-patients under 18: duties of hospital managers”** states -

*“146(1) This section applies in relation to any person under the age of 18 who:*

*(a) is detained by virtue of this Act in a hospital in circumstances amounting to a deprivation of liberty; or*

*(b) though not falling within paragraph (a), is an in-patient in a hospital and has or appears to have mental disorder.*

*(2) The managing authority of the hospital must ensure that (subject to the person’s needs) the person’s environment in the hospital is suitable having regard to his or her age.*

(*3) For the purpose of deciding how to fulfil the duty under subsection (2), the managing authority must consult a person who appears to that authority to have knowledge or experience which makes that person suitable to be consulted.”*

Clause 146 places a duty on the managing authority of a hospital to ensure that the hospital environment is “suitable” having regard to the 16 or 17 year olds age and **does not place an explicit statutory duty on hospital managers to ensure that no young person is detained on an adult psychiatric ward**. CLC wishes to see a clear and robust legislative commitment to guarantee that **all** children and young people in need of inpatient mental health services at **all** times will be located in developmentally and age appropriate settings and never on adult wards. In addition, clause 146(3) does not state the purpose of consulting with the suitable person or define the knowledge or experience that is required to make a person suitable to be consulted with. We address the issue of age and developmentally appropriate accommodation of children in more detail at page 16.

The consultation document refers to an additional safeguard in clause 48 of the Draft Mental Capacity Bill which places a duty on Health and Social Care Trusts to refer the cases of 16 and 17 year olds who are formally detained to be reviewed by the Mental Health Review Tribunal if the young person has not been reviewed within one year. This is a welcome safeguard as currently under the Mental Health (NI) Order 1986 persons aged 16 and over only have their cases automatically referred to the Mental Health Review Tribunal every two years. However, clause 48(1)(b) places a duty on the Health and Social Care Trust to refer the matter to the Tribunal in the case of a young person who is under 18 and whose case has not been considered within one year ending with the time when the extension takes effect. What this means is that a 17 year old who is formally detained and who has their 18th birthday during the first year of their detention will not have their case referred to the Tribunal until 2 years have passed. This is a flaw in this safeguard and must be addressed in the Mental Capacity Bill.

Under the current Mental Health Review Tribunal system it takes a minimum of 6 weeks for a Tribunal to be listed. Clause 48(2) places a duty on Health and Social Care Trusts to refer the patient’s case to the Tribunal as soon as practicable. We do not believe that this is a strongly enough worded clause. If a young person was to be referred to the Tribunal by a Health and Social Care Trust it should be done in time to have the Tribunal consider the matter within one year rather than the Trust wait until the young person has been detained for a year and then make the referral as this could amount to a deprivation of the young person’s liberty if the Tribunal regraded them. It is arguable that this could amount to a breach of Article 5 – right to liberty and security and Article 6 – right to a fair trial of the ECHR.

In the section relating to under 16s in the consultation document, it states that “*The Department is also considering access to education provisions*.”[[33]](#footnote-33) 16 and 17 year olds in hospital, as either voluntary or detained patients, should have equal access to education of a standard that is available to their peers within the community. CLC wish education provisions for children to be included in the Mental Capacity Bill to apply to all children up to the age of 18 and possibly 19 where there is a statement of special education needs which, can continue in force until the young person attains the age of 19. CLC wishes to see the Departments’ consideration to education provisions being translated into a clear and robust legislative commitment to guarantee that all children and young people requiring in-patient care up to the age of 18 or 19 as appropriate will be provided with a quality education and suitable educational facilities. It is essential that education clauses within the Mental Capacity Bill reflect this and that there is a joined up approach to education taken by the DHSSPS, the DoJ and the Department of Education. We address the issue of education of children and young people in hospital in more detail at page 17.

The consultation document emphasises that in relation to 16 and 17 year olds it is envisaged that the Bill’s Explanatory Memorandum and the Code of Practice will

set out what additional protections the Bill will provide for these young people. It would however appear that the Codes of Practice have yet to be drafted. As the acceptability of the legislative provisions is dependent on the adequacy of the Codes of Practice it is essential that the Codes of Practice are available in a timely manner and that they are subject to widespread public consultation, including direct consultation with children and young people in line with Article 12 of the UNCRC and section 75 of the Northern Ireland Act 1998. See page 23 for more detail on the Codes of Practice.

**Principles**

Clause 1 of the Draft Mental Capacity Bill sets out the principles upon which the Draft Bill is based. The consultation document states that the Draft Bill is underpinned by the principles of autonomy and best interests. Under the principle of autonomy within the Bill if someone over the age of 16 is being asked to make a decision about a particular matter then it must firstly be assumed that they have capacity unless it is established otherwise. The Draft Bill also states at clause 1 that a lack of capacity cannot be assumed based upon the person’s age, appearance, a condition of the person, or an aspect of the person’s behaviour which might lead others to make unjustified assumptions about the person’s capacity.

Clause 4 entitled, “Supporting person to make decision” sets out the practicable steps that must be taken to ensure compliance with the principle of autonomy. This clause is somewhat unclear and as the consultation document states, clarification as to how the person is to be supported will require significant detail within the Codes of Practice. It is therefore extremely disappointing that the Codes of Practice are not already drafted and being consulted on at the same time as the Draft Bill. See page 23 for more detail on the Codes of Practice.

The second overarching principle of the Draft Bill is that of Best Interests. Clause 1(7) of the Draft Bill states that,

*“The act or decision must be done, or made, in the best interests of the person who lacks capacity.”*

Clause 6 of the Draft Bill inserts a checklist of best interests to be complied with**.** Matters listed in clause 6 of the Bill include that a person’s best interests cannot be determined on the basis of age, appearance, condition, or behaviour. It further states that it must be considered whether it is likely that the person will at some time have capacity to make the particular decision for themselves. The person must be encouraged and helped (however, the level and type of encouragement and help is not defined) to participate in the determination of what is in their best interests and account must be taken of the persons past wishes and feelings (again there is no information as to how this will be achieved) or any written statement and consider the beliefs and values of the person and any other factors likely to influence the person’s decision if they had capacity. The strength to be given to the person’s past wishes, feelings and values or how these are to be established is unclear, as are the methods to be employed to obtain these. There is a clear and urgent need for much greater clarification on these issues in order to aid informed comment.

Clause 6(7) of the draft Bill puts an onus on the person trying to establish what would be in the best interests of someone lacking capacity (the intervener) where practicable and appropriate to consult with “relevant people” when making the best interests determination. Relevant people are defined as the nominated person (this will replace the role of the Nearest Relative in the Mental Health Order), the independent advocate, anyone named by the person to be consulted on the matter, anyone engaged in the person’s care or interested in their welfare, any attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney or any High Court Appointed Deputy.

Clause 6(9) states that the intervener must consider whether the same purpose can be achieved by a way that is less restrictive of the person’s rights and freedom of action. Under clause 6(10) the intervener must have regard to whether a failure to do the act proposed would be likely to result in harm to other persons with resulting harm to the person lacking capacity.

Whilst it can be seen that the two main principles of the Autonomy and Best Interests contained with the Draft Mental Capacity Bill could bring a substantial benefit to persons aged 16 and over who lack capacity they are a deviation from and fall far short of the principles based approach recommended by the Bamford Review. The Bamford Review stated that a principles based approach comprising of four overarching principles formed the, *“…basis of the Review’s proposals for legislative reform.”* These four principles were -

1. Autonomy – respecting the person’s capacity to decide and act on his own and his right not to be subject to restraint by others,
2. Justice – applying the law fairly and equally,
3. Benefit – promoting the health, welfare and safety of the person, while having regard to the safety of others, and
4. Least Harm – acting in a way that minimises the likelihood of harm to the person.[[34]](#footnote-34)

**The Draft Mental Capacity Bill is therefore based only on one remaining Bamford principle. This fundamental shift on the principles which should have formed the basis for legislative reform has never been consulted upon, despite the fact that both the DHSSPS and the DoJ are designated public bodies under section 75 of the Northern Ireland Act 1998. This consultation does not seek views on the changes to the principles of the legislation**.

In relation to the impact that the Codes of Practice have upon the principles of the legislation the Bamford Review states that,

*“Principles underpinning legislation will only have effect if they are translated into clear provisions, if there are adequate services to provide good quality treatment and care to allow them to act and intended and when all those operating the legislation have adequate education and training.* ***The impact of the principles in the Code of Practice for the 1986 Order was reduced because of delay in publication and a failure to deliver an associated training programme.******Principles must be incorporated into the new law and elaborated upon in Codes of practice. The new legislation, the Codes of Practice and related training programmes must be introduced at the same time****.”*[[35]](#footnote-35)(Our emphasis)

It is therefore essential that the Codes of Practice are published for widespread public consultation, including consultation with children and young people, as soon as possible so that they can be published at the same time that the legislation comes into force. In addition, all training provided on the Mental Capacity Bill must be accessible, widespread and accredited.

**Lack of Capacity**

The meaning of “lacks capacity” is defined in clause 2 of the Draft Mental Capacity Bill as,

*“****2.****(1) For the purposes of this Act, a person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*

*(2) It does not matter*

*(a) whether the impairment or disturbance is permanent or temporary;*

*(b) what the cause of the impairment or disturbance is.*

*(3) In particular, it does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability.”*

The above test of capacity is both issue and time specific and allows for a person to be unable to make a certain type of decision whilst still being capable of making another. A person must be unable to make the decision due to an impairment or disturbance in the functioning of the mind or the brain, neither of which are defined in the Draft Bill. The consultation document does however state that the Codes of Practice will explain that in relation to the mind the impairment or disturbance could mean a mental illness or a learning disability and regarding the brain this could mean an acquired brain injury or stroke. This further illustrates the need for the Codes of Practice to come into force at the same time as the Draft Bill and to provide clear and precise definitions and guidance. See page 23 for more detail on the Codes of Practice.

**Clause 3** of the Draft Bill defines the meaning of “unable to make a decision” and means that the person is unable to make the decision if they are unable to understand the information required to make the decision, unable to retain the information long enough to make the decision, unable to appreciate the relevance of the information and use or weigh the information in order to make the decision, or unable to communicate the decision. Under **clause 4** of the Draft Bill the person must also be supported to make the decision in question. Once a lack of capacity has been established and it is clear that the person has made no future decision making arrangements, (which appears not to apply to 16 and 17 year olds), then the alternative decision making mechanisms of the Draft Bill will apply. **The meaning of “lacks capacity” at clause 2 and the meaning of “unable to make a decision” at clause 3 of the Draft Bill are therefore the key gateway provisions into the rest of the legislation.**

The term “lacks capacity” was the subject of much scrutiny by the House of Lords Select Committee on the Mental Capacity Bill 2005. They reported that evidence presented to them indicated that patients were often assumed to lack capacity and that the onus was being put on patients to prove they had capacity rather that professionals beginning with a statutory presumption of capacity in the individual.

The House of Lords Select Committee also found that, “…*there was also evidence that a lack of capacity was sometimes assumed in order to justify a decision made by the local authority, which was often resource-led…clients have been deemed to lack capacity because the outcome is going to be that the state spends less on them”.”[[36]](#footnote-36)*

In the context of the above concern it is essential that the Draft Bill provides sufficient safeguards to ensure that the issue of capacity is not used as a way of saving money in the provision of services.

**Despite the two stage test of capacity, as set out in clauses 2 and 3 of the Draft Bill and clause 4 which relates to supporting people in decision making, it is clear that the rest of the Draft Bill provides a means of substitute, rather than supported decision making. This is clearly in breach of the DHSSPS and the DoJ’s obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and is contrary to the advices given by the Committee on the Rights of Persons with Disabilities in its General Comment on Article 12 of the UNCRPD.[[37]](#footnote-37) It is clear from this General Comment that the DHSSPS and the DoJ have misinterpreted their obligations under the UNCPRD and that in having regard to the meaning of Article 12 in a human rights based approach to capacity legislation it is necessary to move away from a model of substitute decision making to a human rights based model of supported decision making.**

**Future Decision Making Arrangements - Advance Decisions**

The Draft Mental Capacity Bill leaves the common law position in place with regard to advance decisions and does not codify the law as has been done by the Mental Capacity Act 2005 in England and Wales. Whilst it is recognised that the law in the area of advance decisions continues to develop through case law, the Mental Capacity Bill provides an opportunity to codify the law and to prevent some of the problems experienced by service users and practitioners in England and Wales with regard to advance decisions.

While not explicitly stated in the consultation document it would appear that it is the intention of the Departments that advance decisions may not be executed by a 16 or 17 year old with capacity, in line with the presumption of capacity within the Draft Bill. This is in conflict with the Bamford Review which recommended that a person from the age of 16 should be able to make a valid advance statement[[38]](#footnote-38).

The consultation document states that an effective advance decision to refuse treatment must be complied with if it is valid and applicable under the common law. This is given effect in clause 10 and for a person aged 18 and above a doctor will in theory not be permitted to override an advance decision to refuse treatment for a mental illness. The wording of clause 10 is unclear and the reference to a valid decision under the common law leaves room for uncertainty. It is essential that the Departments take this opportunity to define in statute what is meant by a valid advance decision, clarify who can make such a decision and the degree to which an advance decision must be followed and respected by all professionals in relation to both the physical and mental health treatment of an individual aged 16 and over. It is further essential that the Departments educate and make the general public aware of the availability and purposes of advance decisions.

**Protection from Liability and Safeguards**

Part 2 of the Draft Bill is entitled, *“Lack of Capacity: protection from Liability, and Safeguards”.* The language of this part of the Bill appears to place primary emphasis on the protection of the intervener from prosecution or from civil liability for the commission of an act rather than placing, as its first concern the protection of the person who lacks capacity. This is illustrated by the fact that one of the main purposes of applying the safeguards of the Draft Bill to the person who lacks capacity is that in doing so the intervener then has the benefit of the protection from liability under the Draft Bill.

Clause 8 of the Draft Bill provides the basis for the codification of the common law doctrine of necessity. The doctrine provides for situations whereby it is necessary to break the law to carry out an act or deed. In reality the doctrine of necessity has only been successfully pleaded in a few criminal defence cases. If an act was carried out that was necessary and in the person’s best interests it is unlikely that the Public Prosecution Service would recommend prosecution of the individual for the act in question where it can be shown that the defendant carried out the act under circumstances that were reasonable and where it is likely that the defence of necessity could be shown. The consultation document however suggests that many people caring for those who lack capacity rely upon the defence of necessity in their everyday work when in reality this is not the case.

The consultation document does however state that Part 2 of the Draft Bill has a wider application than the existing common law because it applies to all acts in connection with a person’s care, treatment and personal welfare. Part 2 of the Draft Bill also requires additional safeguards to be put in place in the case of a serious intervention before the intervener can rely upon the legal protection of the Bill. Except for emergency situations, where a person carries out an act and does not comply with any one of the safeguards when the draft Bill says they should apply, the intervener may be held liable for the act in question. An intervener who commits a negligent act will not have the benefit of protection from liability under the Draft Bill

and the DHSSPS will have the power to state in regulations other acts that will not be included unless authorisation is obtained from the High Court.

**General Safeguards - All acts (whether routine or serious)**

**Restraint**

Clause 11 of the draft Bill outlines the use of restraint. Under this clause anything done by an intervener which restricts a person’s liberty of movement whether they resist or not or, the use or threat of force done with the intention of securing the doing of another act, which the person resists, then the intervener must ensure that the act of restraint is a proportionate response to the likelihood of harm that will be suffered by the person and proportionate to the seriousness of the harm concerned. These conditions must be met when a person is instructing or authorising another person to carry out the act of restraint. A failure to ensure that clause 11(4) is complied with will mean that the intervener will not be able to access the protection from civil or criminal liability under the Draft Bill. If the restraint amounts to a deprivation of liberty then clauses 22 and 23 of the Draft Bill apply.

The consultation document defines harm as, *“…any harm whether physical or nonphysical and includes harm to the person who lacks capacity resulting*

*from that person’s harming others. Harm to others is therefore relevant when the intervener proposes to carry out an act of restraint under Part 2 of the draft Bill.”*[[39]](#footnote-39)

**Additional Safeguards for Serious Interventions**

Under clauses 17 – 34 of the Draft Bill certain acts must be authorised by Trust Panels. The consultation document states that a Trust Panel must authorise an act when the act is a deprivation of liberty, or is one of a number of acts that together amounts to a deprivation of liberty, the act imposes an attendance requirement or a community residence requirement or the act is, or is done in the course of, the provision of treatment with serious consequences; and the nominated person objects; and the person who lacks capacity resists; or the act is done while the person is being deprived of their liberty, or subject to either an attendance requirement or a community residence requirement[[40]](#footnote-40).

If an intervener requires authorisation from a Trust Panel they must follow the procedure set out in Schedule 1 of the Draft Bill in all matters listed above. The exception to this is where the act is the short term detention of a person who lacks capacity in a hospital in circumstances amounting to a deprivation of liberty for the purposes of examination. This authorisation is covered by Schedule 2 of the Draft Bill.

Under Schedule 1 of the Draft Bill if an application for an authorisation is made, a Trust must constitute a panel to consider the application. The application must be accompanied by medical report and a care plan. An application for an authorisation may seek authorisation for more than one “measure” depending on the circumstances of the case. Who makes the application will depend on the circumstances and the “measure” for which authorisation is being sought. The consultation document states that applications for authorisation will be heard by Trust Panels made up of 3 persons with relevant expertise. However no explanation of what amounts to ‘relevant expertise’ is given in the consultation document. The panel will be able to grant the authorisation, refuse it or to grant an interim authorisation.

Pending the submission of further evidence, in making its decision, the panel may conduct an oral hearing at which those making the application, the person lacking capacity, the nominated person and the independent advocate may give evidence. No information is given as to whether the person will have the right to be represented at the Trust panel. The panel will give its decision within 7 working days of being constituted. Where it proposes to issue an interim authorisation, that authorisation will only be valid for 28 days. Authorisations for certain serious interventions granted under Schedule 1 can last for up to six months unless revoked and an authorisation can be extended for a further 6 months and thereafter on a yearly basis.

Schedule 2 of the Draft Bill sets out the authorisation process for the short term detention of a person in hospital for examination. This does not involve an application to an HSC Trust Panel. Authority for the detention is from the making of a report which must include a medical report stating that the criteria for authorisation are met. Where the nominated person objects to the making of a report, an approved social worker must be consulted, even if it is an approved social worker making

the report.

The rest of the proposed detention process is similar to the process for detention for assessment under the Mental Health (NI) Order 1986 with the addition of the criteria for authorisation relating to lack of capacity. The authorisation can last for up to 28 days in total instead of the current 14 day period for assessment.

The Draft Bill will allow each of the five Health and Social Care Trusts to operate separately in relation to the panel authorisation process. The fact that there will not be a regional panel system will mean that different Trust Panels could decide similar issues in different ways. A panel authorisation process may also make it more difficult for a young person to challenge an intervention to the Mental Health Review Tribunal as it will already have been adjudicated upon. This panel process was not recommended by the Bamford Review and it is a new policy, which was never consulted upon by either Department in their previous consultation exercises despite the fact that both the DHSSPS and the DoJ are designated public bodies under section 75 of the Northern Ireland Act 1998 and are obliged to screen and give consideration to carrying out an equality impact assessment of new and amended policies. It is the view of CLC that the Mental Capacity Bill should not include a system of Trust Panels in relation to authorisation as the system that is proposed is flawed, may lead to a post code lottery, will be subject to legal challenge and disadvantages the patient should they subsequently wish to challenge the authorization to the Review Tribunal or to the High Court.

**Deprivation of Liberty Safeguards**

The Draft Mental Capacity Bill sets out in clauses 22 – 27 the process for applying a deprivation of liberty to a person who lacks decision making capacity. The consultation document acknowledges that to deprive a person of their liberty is a very serious matter and that in addition to the other safeguards contained within the Draft Bill a deprivation of liberty must be authorised to ensure compliance with the European Convention on Human Rights and to comply with the ruling in the Bournewood case.[[41]](#footnote-41) What actually amounts to a deprivation of liberty is difficult to define and is generally case by case specific. The consultation document states that the Code of Practice will provide guidance on the sort of circumstances that may amount to a deprivation of liberty. This again demonstrates the need for the Code of Practice to be produced contemporaneously with the Bill and to be fully consulted upon.

The clauses within the Draft Bill on Deprivation of Liberty safeguards appear to focus heavily upon providing the person who wishes to deprive another person of their liberty with protection rather than ensuring that no one is unlawfully deprived of their liberty, this is evidenced by clause 22(2) which provides the intervener with protection against civil or criminal liability if the remainder of clause 22 is complied with.

Clauses 22 and 23 are worded in such a manner as to limit they types of deprivation of liberty that can be authorised but this is based on the decision maker not being able to have access to the protection from liability contained within part 2 of the Draft Bill rather than being a positively framed duty to ensure that no person is unjustly deprived of their liberty.

The consultation document makes it clear that the types of deprivation of liberty which may be authorised are:

* The detention of a person in circumstances amounting to a deprivation of liberty in a hospital or care home in which care or treatment is available for that person;
* The detention of a person in circumstances amounting to a deprivation of liberty while being taken, transferred or returned to a hospital or care home for the purposes of the provision to that person of care or treatment; or
* The detention of a person in circumstances amounting to a deprivation of liberty in pursuance of a condition imposed during a permitted period of absence from a hospital or care home.

Given that the Draft Bill applies to all persons aged 16 and above we would suggest that the authorisation of a deprivation of liberty of a young person within a children’s home or boarding school should be inserted into the Draft Bill in order to provide protections to young people who lack capacity who are resident within these types of facilities, otherwise an application will have to be made to the High Court to allow for such matters. This will cause significant delays in the authorisation of such deprivations of liberty and may cause placement difficulties for young people who require community placements in such facilities. There will also be cost implications as it will require an application to the High Court and as discussed below there must be Legal Aid available for such matters, especially if a young person wishes to challenge a deprivation of their liberty.

The criteria which must be met for a deprivations of liberty to be authorised are set out in Schedule 1 of the Draft Bill except where it is the short term detention of a person for the examination of an illness (physical or mental). In these matters the criteria for authorisation are set out in Schedule 2. For the intervener to be able to rely upon the protection from liability in the Draft Bill the intervener must allow for the, “prevention of serious harm condition”, set out in clause 23, which requires the intervener to ensure that the deprivation of liberty is necessary to prevent serious harm to the person or serious physical harm to others and to be proportionate to both the likelihood and the seriousness of that harm.

If an individual wishes to challenge a deprivation of their liberty then they will have to bring the matter before the High Court. The House of Lords Select Committee on the Mental Capacity Act 2005 raised concerns regarding the ability of individuals who wished to challenge a deprivation of their liberty to the Court of Protection being unable to do so because of, *“…inconsistent provisions of non-means tested legal aid”.*  As it is intended for the deprivation of liberty safeguards to protect some of the most vulnerable individuals in society the safeguard is significantly weakened if legal aid is not available to all who wish to challenge a deprivation of their liberty regardless of financial eligibility for legal aid. We would urge the DoJ to urgently address this issue by legislating in the Bill for legal aid so that this challenge safeguard is available to all.

In its criticism of the legislation the House of Lords Select Committee viewed the deprivation of liberty safeguards as, *“…hugely complex, voluminous, overly bureaucratic, difficult to understand yet providing mentally incapacitated people with minimum safeguards.”*[[42]](#footnote-42) Therefore, while they are necessary they have been problematic and require reform. The Select Committee found that there were several factors which resulted in the deprivation of liberty safeguards not working in practice. They found that there was a failure to apply the principles of the Mental Capacity Act 2005 to the deprivation of liberty safeguards and stated that,

*“poor understanding of capacity assessments and best interests decision making applies in relation to the DoLS safeguards as much as it does in relation to any other best interests decision”. It was further suggested that the safeguards were often seen as “a need for authorities to set up paperwork processes to make restrictions on a person ‘legal’, rather than … actual and real safeguards for people”. Significant criticisms were made of the failure to apply the ‘less restrictive option’ principle in relation to the safeguards.”[[43]](#footnote-43)*

The deprivation of liberty safeguards as proposed in the Draft Bill only apply to those living in hospitals or care homes. There are a number of young people aged 16 and 17 who reside in boarding schools and supported board and lodgings, neither of which are covered by the deprivation of liberty safeguards as they are currently proposed. It would therefore be necessary for such a deprivation of liberty to be authorised by the high Court. Therefore, as they are currently proposed 16 and 17 year olds who live in boarding schools or supported accommodation may have their liberty unlawfully deprived as they will not be governed by the Draft Bill and as outlined above, there are barriers to challenging an unlawful deprivation of liberty for the individual.

Much of what is being proposed by the Departments in the Draft Mental Capacity Bill mirrors the deprivation of liberty safeguards in the Mental Capacity Act 2005. It is essential that the mistakes of the Mental Capacity Act 2005 are not replicated in Northern Ireland and that both Departments take cognizance of the lessons from England and Wales. The House of Lords felt that the deprivation of liberty safeguards system in England and Wales was so poor that,

*“The only appropriate recommendation in the face of such criticism is to start again.”[[44]](#footnote-44)*

**Attendance Requirements**

Trust panel authorisation is required when it is intended to impose an attendance requirement upon a person. An attendance requirement means that a person must attend at a particular place at particular times or intervals, to receive treatment which is likely to be treatment with serious consequences, or an act done to ensure the person complies with such a requirement. The criteria that must be met for an attendance requirement to be authorised are set out in Schedule 1 of the Draft Bill and in addition to this criteria, the safeguards of Part 2 of the Draft Bill must be applied as necessary. The intervener must reasonably believe that a failure to impose the attendance requirement (or failure to ensure it is complied with), would be more likely than not to result in the person not receiving the treatment. The attendance requirement whilst at first appearing to be onerous on the patient is a welcome development as it will allow for treatment in the community which would otherwise have to be provide in a more restrictive hospital environment. The system of Trust Panel authorisation for such an intervention is not suitable and a different authorisation mechanism should be put in place.

**Community Residence Requirement**

A Community Residence requirement places an obligation on a person to live at a particular location, allow healthcare professionals access to the dwelling and require the person to attend at particular places at set times for the purposes of training, education, occupation or treatment. In granting a community residence requirement the Trust panel must ensure that the criteria set out in Schedule 1 of the Draft Bill is met, that the safeguards of Part 2 of the Draft Bill have been applied as necessary and the intervener must have a reasonable belief that a failure to impose a community residence requirement would create a risk of harm to the person and it must be proportionate to both the likelihood and the seriousness of that harm. Again whilst appearing to be onerous upon the patient, the community residence requirement will allow the patient to remain in the community and receive treatment which would otherwise have to be carried out in a hospital setting. The system of Trust Panel authorisation for such an intervention is not suitable and a different authorisation mechanism should be put in place.

**Compulsory Treatment with Serious Consequences**

Trust Panel authorisation is required where treatment with serious consequences is proposed and the nominated person objects and the person who lacks capacity resists the treatment or the treatment is being carried out whilst the person is being deprived of their liberty, subject to an attendance requirement or to a community residence requirement.

Treatment under the Draft Bill includes any examination, any procedure (diagnostic or otherwise), and any therapy. Treatment with serious consequencesis defined as treatment whichis, or involves major surgery, causes the person serious pain, serious distress or serious side effects, affects seriously the options available to the person in the future, or has a serious impact on his/her day-to-day life, orin any other way has serious consequences for the person.

The criteria for authorisation for treatment with serious consequences is set out in Schedule 1 of the Draft Bill and in addition to Schedule 1 the safeguards outlined in Part 2 of the draft Bill must be applied as necessary. It must be established that a failure to provide the treatment would create a risk of serious harm to the person or a risk of serious physical harm to others. It must also be established that to carry out the treatment is a proportionate response to the likelihood and seriousness of the harm. For a Trust Panel to authorise treatment with serious consequences it would be necessary for the Panel to be made up of suitably qualified experts, the person would require to be able to attend the panel and to be appropriately represented with the ability to submit their own independent evidence and to be able to appeal the decision of the panel in a timely manner. The system of Trust Panel authorisation for such an intervention is not suitable and a different authorisation mechanism should be put in place.

**Independent Advocate**

When an act under Part 2 of the Draft Mental Capacity Bill requires authorisation or where an act although serious in nature does not require authorisation an independent advocate must be put in place.

No definition is given as to what an independent advocate is. The consultation document states that, *“…this is not a legal advocate but a person who can speak on behalf of the person who lacks capacity and who will have knowledge of the procedures involved in relation to the proposed intervention and of the persons rights under the Bill.”*[[45]](#footnote-45) Clause 35(2)(b) of the Draft Mental Capacity Bill only places a duty on the person who wishes to carry out the intervention to consult with and take into account the views of the independent advocate. This is not the recognised function of an advocate. The advocate should be in place so that the person who lacks capacity can be assisted in making their views known.

Under Part 4, clause 83 of the Bill, Health and Social Care Trusts have an obligation to make an independent advocate available in circumstances where the draft Mental Capacity Bill requires them to do so.

The wording of clauses 83(1)-(4) suggests that any advocate supplied will either be in the direct employment of a Health and Social Care Trust or will be contracted into the service by the Trust. This suggests that the choice of advocates available to an individual who lacks capacity (P) will be significantly limited and that P will not be able to select an advocate from a service of their choosing under the terms of the Draft Bill. This calls in question the availably of advocates who are truly independent under the Bill and raises significant questions regarding the strength of the safeguard of advocacy under the Draft Bill.

The appointment of an independent advocate cannot be triggered by either P or by their nominated person. Instead the appointment of an independent advocate must be carried out by “appropriate healthcare professionals” who are not clearly defined in the Draft Bill. P or their nominated person therefore cannot request the services of an advocate in order to assist them with a decision which is being made. CLC has long argued for the availability of statutory advocacy services for all children and young people who require it and we would support a position whereby all young people, regardless age could request the services of an advocate of their choice to assist them with the decision making process. As is currently proposed, 16 and 17 year olds will only have access to an advocate as outlined above and it is proposed that advocacy for under 16s will operate in a similar way for those who are detained under the Mental Health (Northern Ireland) Order 1986. This is very concerning. See page 14 for more detail on independent advocacy and under 16s.

The Draft Mental Capacity Bill at clause 86 outlines the steps which must be taken before a relevant health care professional may request that an independent advocate is appointed for P. The fact that in the Draft Bill advocacy is only available when a serious intervention is being proposed, and that both P and their nominated person are objecting and that a health care professional has requested the relevant Trust to instruct an advocate, means that there are a large number of hurdles to be crossed before an advocate is available to P for very limited purposes. This is reflective of substitute decision making as opposed to supported decision making. This is a grave concern as advocacy is recognised as vital and the earlier an advocate is involved with P the better chance that P will have in understanding and expressing their views about a particular intervention. Whilst the Draft Bill makes no provision for P themselves to request an independent advocate, clause 86 provides that P has the right to declare that no independent advocate is to be instructed in accordance with clause 87 of the Draft Bill and clause 89 provides that a person has the right to discontinue their involvement with the independent advocate. It is an essential right of the person to be able to declare that they do not wish to have the services of an advocate or to dispense with those services if they so desire. However, whilst the draft Bill allows for an ability to decline advocacy services it does not allow for the right to advocacy to be reinstated. It is unclear whether this will also be the case with regard to under 16s and clarification is required on this.

It also appears that the independent advocate will be instructed only for the single decision being considered in P’s best interests and that once that intervention has been adjudicated upon, access to the advocate will cease. The person, even if they wish to continue using the services of the independent advocate will have no statutory right to access the service. The right to access an advocate under the Draft Bill is therefore linked to one decision only, however the right of the person under the Draft Bill to dispense with advocacy services relates to all future decisions without a mechanism to re-engage with the service. There also appears to be no duty in relation to continuation of service. If a person has an independent advocate appointed to them with whom they have built a relationship of trust they may wish to use the same advocate in future matters. The wording of clause 90 provides no provision for the person to request the same advocate for future decisions. The role of the advocate, their appointment and their continuing duties require both clarification and major reconsideration.

**Rights of Review**

Clauses 44 – 52 of the Draft Mental Capacity Bill provides for the renaming of the Mental Health Review Tribunal to the Review Tribunal, details of the rights of individuals to apply to the Tribunal, states which persons may refer a case to the Tribunal, places duties on Health and Social Care Trusts to refer cases to the Tribunal and set out the Tribunals Powers in relation to the authorisation of certain interventions. The Tribunal will have the power to revoke or confirm authorisations and it will be able to vary an authorisation by cancelling one measure where the authorisation covers more than one measure.

The current method of appeal of the decisions of the Mental Health Review Tribunal is by way of an application to the Court of Appeal. It would appear from what little information is available in the consultation document that it is intended that this will remain the case. The DoJ has carried out a consultation process into the reform of the Tribunal system in Northern Ireland but we understand that the Minister has decided to delay the reform of Tribunals in Northern Ireland.

The system in England under the Tribunals Courts and Enforcement Act gives a right to challenge the decision of the Mental Health Review Tribunal to the [Upper Tribunal, Administrative Appeals Chamber](http://www.justice.gov.uk/tribunals/aa). Appeals against decisions of the Upper Tribunal can be made to the [Court of Appeal](http://en.wikipedia.org/wiki/Court_of_Appeal_of_England_and_Wales) this provides for a faster, more accessible review mechanism for patients than the current system in Northern Ireland and would be preferable. CLC wishes to see the current system being amended as a matter of urgency to allow for the most effective rights of review under the Mental Capacity Bill.

**Emergency Interventions**

When a situation is an emergency as defined by clause 65 of the Draft Bill, it is not necessary to apply the safeguards of the Draft Bill, however once the emergency has come to an end then the Draft Bill will apply to the situation. This is a necessary exclusion from the capacity based approach as it will allow for treatment which could be potentially life saving, e.g. if the person were injured in an accident doctors could provide emergency treatment without the need to assess capacity.

**Other Decision Making Mechanisms**

**High Court**

It is not proposed that Northern Ireland will have a separate Court of Protection similar to that in England and Wales. Part 6 of the Draft Bill, “*High Court Powers: decisions and deputies”*, outlines the powers of the High Court which will carry out the functions of the Court of Protection in relation to the determination of an individual’s capacity, personal welfare, care and treatment.

The House of Lord’s Select Committee in its post legislative scrutiny on the Mental Capacity Bill 2005 raised concerns with regards to the ability of individuals to access the Court of Protection in England due to restrictions on Legal Aid. We would seek guarantees from the DoJ that Legal Aid would be available on a non-means tested basis to allow individuals to challenge matters to the High Court.

**Court Appointed Deputies**

Under the provisions of the Draft Bill the High Court will have the power to appoint deputies make decisions on behalf a person who lacks capacity. Deputies will replace the system of controllers which currently exist under the Mental Health

(NI) Order 1986. A High Court appointed Deputy will be able to make decisions for a person aged 16 and over about their property, affairs and in relation to their care, treatment or personal welfare. However a High Court appointed Deputy cannot do anything which amounts to a deprivation of liberty.

**Office of Public Guardian**

Under Part 7 of the Draft Bill a new Office of Public Guardian will be created within the Northern Ireland Courts and Tribunals Service with the function of establishing and maintaining a register of Lasting Powers of Attorney and Court Appointed Deputies. It will supervise the work of the Court Appointed Deputies report to the Court on this and investigate complaints in respect of the activities of attorneys acting under lasting Powers of Attorney and enduring Powers of Attorney. The Office of Public Guardian will take over the casework of the current Office of Care and Protection.

**Offences**

The Draft Mental Capacity Bill makes provision for a number of new offences, most significantly a new offence of ill treatment or neglect (clause 133), forgery and false statements (clause 134), unlawful detention of persons lacking capacity (clause 135), assisting persons to absent themselves without permission (clause 136), assisting persons to breach residence requirements (clause 137), obstruction (clause 138) and offences by bodies corporate (clause 139).

**Clause 133 states:**

***“Ill-treatment or neglect***

***133****(1) A person (“X”) who*

*(a) ill-treats, or*

*(b) wilfully neglects,another person (“P”) where this section applies commits an offence.*

*(2) This section applies where*

*(a) X has the care of P, and P lacks capacity in relation to all or any matters concerning his or her care or is believed by X to lack capacity in relation to all or any such matters; or*

*(b) X is an attorney under a lasting power of attorney granted by P; or*

*(c) X is a deputy appointed for P by the court.*

*(3) A person guilty of an offence under this section is liable*

*(a) on summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;*

*(b) on conviction on indictment, to imprisonment for a term not exceeding 5 years or a fine or both.”*

The new offence of ill treatment or wilful neglect will apply to anyone caring for a person who lacks capacity or is believed to lack capacity, in relation to all or any matters concerning his/her care. It also applies to attorneys and deputies. Penalties include a fine or imprisonment for up to 5 years or both.

**The wording of clause 133 would suggest that the new offence of ill treatment or neglect applies only to persons aged 16 and over and that under 16s will not benefit from this added protection. It is essential that this new criminal offence should provide equal protection to those under the age of 16 as well as to those aged 16 and over.**

Section 44 of the Mental Capacity Act 2005 created an offence of ill-treating or wilfully neglecting a person who lacks capacity, or whom the offender reasonably believes to lack capacity. The offence may only be committed by certain persons who have a caring or other specified responsibility for the person who lacks capacity. The penalties are, on summary conviction up to 12 months imprisonment, a fine not exceeding the statutory maximum, or both, or on conviction on indictment up to 5 years imprisonment or a fine, or both.

The Code of Practice of the Mental Capacity Act 2005 makes it clear that the offence of ill treatment or wilful neglect of a person who lacks capacity under Section 44 also applies to children under 16 and young people aged 16 or 17. (But it only applies if the child’s lack of capacity to make a decision for themselves is caused by an impairment or disturbance that affects how their mind or brain works)[[46]](#footnote-46) It is essential in a similar way that the offence of ill treatment or wilful neglect under the Draft Mental Capacity Bill applies to under 16s as well as to those aged 16 and above.

**Excluded Decisions**

Clauses 149-150 of the Draft Mental Capacity Bill set out the decisions that do not fall within the scope of the Bill. They cover matters such as decisions on voting and consent to marriage or divorce. However unlike the Mental Capacity Act 2005 which at Section 28 has a specific exclusion regarding matters covered by mental health legislation the Draft Mental Capacity Bill does not have such an exclusion. The consultation document states that this is because the Draft Bill will revoke the Mental Health Order as it applies to persons aged 16 and over. Given that under 16s will continue to be governed by the provisions of the Mental Health (NI) Order 1986 until they reach the age of 16 provision will have to be made for those under 16s who are “transferring” from a non-capacity based approach to a capacity based approach once they turn 16 years old.

**CHILDREN IN THE CRIMINAL JUSTICE SYSTEM**

From the contents of the consultation document it appears that rather than the Draft Mental Capacity Bill containing specific clauses in relation to criminal justice, the Bill will amend existing pieces of criminal justice legislation to reflect the capacity of persons within the criminal justice system. What has been published by the DoJ is therefore a further policy statement of their proposals to date and not draft clauses. CLC would have reasonably expected at this advanced stage in the development of the legislation to have been consulted on draft amendment clauses so that it would have been possible to comment on the entire Bill and its impact on both civil society and in criminal justice. The absence of draft clauses significantly undermines the integrity of the consultation.

The minimum age of criminal responsibility in Northern Ireland is 10 and the Youth Court System operates for young people from 10 – 17 years old. However, it is clear from the proposals published by the DoJ for consultation that they only intend to apply these proposals to those aged 16 and above. The DoJ has not published any details to as to what it intends to amend within the Mental Health (NI) Order 1986 for those under the age of 16 who fall within the criminal justice system. It would appear, but it is not certain, that it is intended to retain Part 3 of the Order as it currently stands for under 16s in its entirety, however Part 3 of the Order is rarely used in practice for this age group and it therefore appears that the DoJ is proposing to retain a not fit for purpose piece of legislation for under 16s. The DoJ has also not published any information for consultation as to how the youth justice system will operate within a dual legislative framework. This is particularly important for facilties and agencies which cater for all children and young people under 18 within the field of criminal justice.

The DoJ’s first consultation in relation to the new legislative framework for mental health and capacity was carried out in July 2012. This consultation focused on the areas of public protection, principles and safeguards, operational issues, and powers of compulsion.

The DoJ published its summary of responses received document in January 2013 along with some proposals for the criminal justice system which included –

1. The procedures, principles, safeguards and protections being developed for a mental capacity legislative base would be applied.
2. This would include applying the new decision making framework where this was compatible with existing duties and powers.
3. The retention of a statutory powers base within the criminal law in terms of police, court and prisons law.
4. Police to retain their ability to take people to a place of safety.
5. Courts would retain their independence in sentencing and capacity would be taken into account – though would not of itself be determinative.
6. Courts would also have additional and alternative community based sentences available.
7. Prisons would retain their ability to transfer prisoners to and from hospital in appropriate circumstances.
8. For such transfers, the capacity based approach would be fully reflected; where there was a lack of capacity, the protections and safeguards requirements from the capacity model would be reflected; where there was capacity the person’s consent to treatment would be required.

**The Main Elements of the DoJ Proposals for People aged 16 and over**

**1. A capacity based approach to care, treatment and personal welfare with regard to prisoners.** The DoJ has stated in the consultation document that it intends to create a capacity based model for treatment within the criminal justice system for persons aged 16 and over. It is proposed that a person over the age of 16 who has capacity will be able to make a decision about their care, treatment, or personal welfare, and that decision will be respected. Where a person aged 16 and over is deemed to lack capacity then it is proposed that interventions will be carried out by implementing the principles and safeguards of the Draft Mental Capacity Bill. It is unclear from the consultation document how this will work in practice. It is also unclear how the JJC which has residents that are both under 16 and over 16 will operate in a duel system.

The consultation document states that in the day to day actives of those who work within the criminal justice system, e.g. PSNI officers and prison officers, respect will be given to the decisions of those with capacity who are aged 16 and over. However no detail is proved as to how this will operate in practice.

It is also proposed that the courts will be required to take account of the capacity of the defendant when making determinations. The criminal courts can currently make disposals such as decisions to remand or sentence a person to a treatment based disposal (such as a hospital order) without any requirement to consider capacity or consent. The DoJ’s proposals for the Draft Mental Capacity Bill will mean that courts will be required to take account of the capacity and best interests of a person aged 16 and over before they exercise their powers and where a person aged 16 and over who has capacity refuses treatment based disposals the courts will not be able to make such a disposal. This has implications for both the courts and the offender and no detail as to how this capacity based system will operate in practice has been provided. Neither have any details been provided in relation to transitions from one legislative framework to another, for example a person who is charged with an offence when they are 15 who is found guilty and sentenced at 16. It is wholly unclear whether such a young person will be governed by the non-capacity based approach of the Mental Health (NI) Order 1986 or the capacity based approach of the Draft Mental Capacity Bill. Clarification from the DoJ is urgently required to allow consultees to make informed comment.

A court, when making a treatment based order for a person aged 16 and over will also be required to consider, in addition to the criteria above, the likelihood of serious harm to the person or to others and the availability of suitable treatment, although no definition of what amounts to ‘suitable treatment’ is provided in the consultation document.

Once a court makes a treatment based remand or sentence the responsibility for the detention will transfer from the criminal justice system to the health system. Any decision regarding the treatment of the individual will then be taken in accordance with the Mental Capacity Bill, therefore if a capacitious person consents to treatment it can occur but if they refuse treatment that decision will be respected and they may be returned to prison from hospital. This proposal will mean that under 16s will be disadvantaged by their exclusion from the Mental Capacity Bill in that their refusal of treatment will not be respected.

**2. The removal of the term mental disorder from criminal justice legislation.** The term mental disorder will be removed from the criminal justice system in relation to persons aged 16 and over. As the Mental Health (NI) Order 1986 will be retained for under 16s the stigmatising term mental disorder will continue to be used in relation to under 16s within the criminal justice system, which CLC believes is not in the best interests of children and is discriminatory. The consultation document recognises that this is in direct conflict with the Bamford vision to remove the use of the term mental disorder, but no proposals have been made to remove the use of this term for under 16s in the Mental Health (NI) Order 1986.

**Criminal Powers after the Passage of the Bill**

The Courts, the PSNI and the Northern Ireland Prison Service will retain their over-arching statutory powers around detention. The capacity of a person aged 16 and over to consent or refuse treatment will be respected, this will not extend to the decision to be detained in custody. The issue of capacity, or a lack thereof, will therefore not be determinative in relation to detention within the criminal law. However it is proposed that capacity coupled with best interests will form the core principles in relation to treatment for those over 16. Therefore whilst a person may be subject to detention within the criminal justice system regardless of whether or not they retain capacity, treatment within the criminal justice system persons aged 16 and over will be based upon capacity or a lack thereof. Under 16s who may still be subject to incarceration will not have their decisions in relation to their care or treatment respected in the same way as their peers who are over 16.

Current court based disposals include prison sentences, probation orders, suspended sentences, fines, conditional and absolute discharges. It is proposed that courts will still issue prison sentences where the court believes that the prisoner does not need to be immediately sent to hospital and that appropriate treatment can be provided in the prison setting or at some point in the future by transfer from prison to hospital. It is proposed that if a defendant is found to be unfit to plead that the courts will be able to make in-patient orders, supervision orders, or treatment orders. It is proposed that a new community residence order or protection order will be created for persons aged 16 and over. It would appear that the new suite of court disposals that are being created under the Mental Capacity Bill will be unavailable to under 16s. This places under 16s at a considerable disadvantage as if a court were to deem them suitable for one of the new disposals it will be prohibited from making such an order by virtue of the age of the defendant alone. See pages 42 and 43 for more detail on these new orders.

**Interfaces**

It is proposed that when either the PSNI, the Courts, the Northern Ireland Prison Service and the Youth Justice Agency intend to intervene under the Mental Capacity Bill they must establish the following –

1. The person has a medical condition that requires intervention,
2. Examination or treatment is required,
3. Hospital is the most suitable place for providing treatment,
4. Failure to examine or treat the person poses a risk of harm to themselves or others, and either

a) That the person has the capacity to consent to examination or treatment and so consents; or

b) The person lacks capacity and the examination or treatment is in the best interests of the person.

The DoJ states in the consultation document that persons who retain capacity will be able to request treatment and consent to treatment within the criminal justice system. Prisoners who consent to treatment will be able to be transferred to hospital under prison transfer powers. The DoJ has provided no detail as to how, or if, they intend to amend the Mental Health Order to reflect this situation for under 16s.

**Places of Safety**

It is proposed by the DoJ that that PSNI should retain the power to remove a

person from a public place to a place of safety. It is proposed that the PSNI will be able to bring a person to a place of safety if -

1. the person is in a public place and it appears to the PSNI that they are in immediate need of care or control,
2. the person is unable to make a decision because of an impairment or disturbance in the mind or brain as to whether they need to go to a place of safety,
3. It is necessary to remove the person to a place of safety to prevent serious harm to the person or serious physical harm to other persons,
4. removal to a place of safety would be in the person’s best interests.

This proposal does not require a determination by PSNI Officers on the ground as to the age of the person they are considering bringing to the place of safety as the determination of capacity is unnecessary as part of the criteria to exercise the power. This is a different approach to that which was proposed by the DoJ in 2012. It is intended to retain the current list of places of safety, including hospitals and

police stations. CLC believes that police stations should never be used as a place of safety for a child. It is proposed that once the person is taken to a place of safety and their age is established that any examination which is carried out must comply with the conditions set out in the Draft Mental Capacity Bill. It would appear that the DoJ intend to retain the current practice with regards to places of safety for under 16s, providing them with less protections and safeguards than over 16s who are being brought to a place of safety.

It is proposed that if the place of safety is a hospital, the authorisation of any detention and subsequent examination, care or treatment will be on the basis of capacitous consent or substitute arrangements under the Draft Bill. It is proposed that the PSNI will cease to have any responsibility for the person as soon as a competent person at the hospital has assessed the person with a view to determining whether or not an intervention is required and whether it can be made by way of capacitous consent or other arrangements under the Bill.

If the place of safety is a police station, any detention will be treated as a separate power exercisable by a PSNI Officer and this would be subject to criteria similar to those on which the original power to remove would rely (including best interests). Detention for examination or treatment will not be authorised unless the criteria

applied and those criteria would be required to be kept under review during the person’s detention and the person released if they no longer applied.

It is proposed that there will be an ability to transfer people from one place of safety to another within a 48 hour period. The ability to move persons from one place of safety to another is welcome provided that the power is used to move persons from unsuitable places such as police stations to more suitable environments such as hospitals and not vice versa.

**The Powers of the Criminal Courts**

**Remand Powers**

It is proposed by the DoJ that courts will have, as they do now, two remand powers for examination to obtain a report, and for treatment. There is a general presumption in the criminal law in favour of bail being granted and therefore it is proposed that the powers to remand a person for inpatient treatment or examination will only be exercised when a court decides to remand the accused in custody. The court must consider at this point remanding to either prison or a hospital setting.

It is proposed that if a court is considering remanding a person into hospital for examination or treatment that –

1. the person has a medical condition and examination or treatment is required,
2. examination or treatment is available and a hospital is the most suitable place to provide that examination or treatment,
3. failure to examine or treat the person would result in harm to themselves or others; and either,

a) the person has the capacity to consent to examination or treatment and so consents, or

b) the person lacks capacity and the examination or treatment is in the person’s best interests.

The court will require medical evidence before considering whether or not to exercise the remand power. For the court to exercise the remand power for examination it must hear oral evidence from **a medical practitioner** that the accused appears to be ill and that, in their opinion, the statutory criteria are met. The remand power for treatment will not be able to be exercised by the court unless it hears evidence from **two medical practitioners** that, in their opinion, the accused has a health condition and that, in both their opinions, the criteria for making the remand is met.

If the court makes a remand the accused person will be taken to a hospital, admitted and detained there for 28 days initially and up to a maximum period of 12 weeks. If a remand to hospital is no longer required the remand as an in-patient will be terminated (e.g. the patient regains capacity and refuses treatment). The person themselves will also be able to obtain a report on their health from a medical practitioner and apply to the court for a termination of the remand.

**Sentencing**

It is proposed by the DoJ that there will be an expanded range of healthcare based disposal options open to the court when they are dealing with a person aged 16 and over. It would appear that this new suite of court disposals will not be available to courts when sentencing under 16s. These new disposals will include -

**1. In-patient treatment order** – this will be usedfor imprisonable offences where a person can be sent to a hospital rather than prison if the court is satisfied that certain criteria are met. It would be available for those who are fit to plead and convicted as well as those who are unfit to plead but found to have committed the relevant offence.

It is proposed that the criteria for an in-patient order will be –

1. the person has been convicted of an imprisonable offence,
2. the person has a medical condition and treatment is required,
3. treatment is available and a hospital is the most suitable venue for that treatment,
4. failure to examine or treat the person as an inpatient will result in harm to themselves or others; and either,

a) That the person has the capacity to consent to the examination or treatment and consents; or

b) The person lacks capacity and the examination or treatment is in the best interests of the person.

The court must be satisfied that an in-patient treatment order is the most suitable means of dealing with the person in light of all the circumstances including the nature of the offence and having regard to the other available disposal options.

An interim form of the in-patient treatment order will be available for 12 weeks with a possibility of renewal for up to 6 months so the court may reconsider the case and to allow for fluctuating capacity.

**2. A restriction order** - this is currently available and would be attached in certain cases to the full or interim in-patient treatment orderto reflect the underpinning criminal offence and dangerousness of the person. A restriction order could for example mean that a leave of absence from hospital would require the permission of the DoJ.

**3. In-patient direction order**– a court could impose an in-patient order under-pinned by a prison sentence. In these cases, the person would be returned to prison from hospital if they can no longer be treated or they regain capacity and refuse treatment. In this way detention, which may begin with an in-patient order, could not be negated by a refusal of treatment. The underpinning prison sentence would then be invoked.

**4. Community residence order** – this willreplace the guardianship order and be applicable to a convicted offender or an individual who is unfit to plead and found to have done the act, who poses a low level of risk. It requires the person to live at a particular place and allow a healthcare professional access to them where they live. It can require the person to attend particular venues for training, education, occupation or treatment. A probation officer or a social worker will supervise the person whilst the order is in place.

It would appear that with the exception of the Restriction Order, which already exists in the Mental Health (NI) Order 1986 that these new sentencing arrangements will be unavailable to courts when sentencing under 16s. This may mean that a court is faced with a young person whom it believes would benefit from one of these new disposals but the court would be prohibited from making such an order. The DoJ has not provided any detail as to whether or not they intend to amend the Mental Health (NI) Order 1986 to reflect these new sentencing arrangements which will be available to courts when sentencing person aged 16 and over. Under 16s with mental ill health within the court system will be greatly disadvantaged.

**Unfitness to Plead**

Unfitness to plead is currently determined by the common law through what is known as the Pritchard Test which relies upon mental impairment, comprehension, and decision making and requires the person to understand the charges, deciding whether to plead guilty or not, exercising their right to challenge jurors, instructing solicitors and counsel, following the course of proceedings and giving evidence in their own defence. The Northern Ireland Law Commission (NILC) carried out a review and consultation on unfitness to plead in 2013. (CLC responded to this consultation, copies of the response are available upon request)

The NILC considered that elements of a mental capacity approach could enhance the test for determining unfitness to plead and recommended that, in order to be unfit to plead, the accused must be shown to be unable to make a decision for himself in relation to a matter because of an impairment or disturbance in the functioning of the mind or brain to be unable to;

a) understand the charges brought against them,

b) follow the course of proceedings; and,

c) make certain decisions that they are required to make in relation to the trial.

The NILC recommended the adoption of the above test to the Magistrates’

Courts. The NILC did not examine the Youth Courts but the DoJ now proposes to extend the new test of unfitness to plead to the Youth Court. It is however unclear from the consultation document whether the DoJ intends to apply the test of unfitness to plead to under 16 s or just to persons aged 16 and 17 within the youth court. If it is intended to apply the test of unfitness to plead to persons aged 16 and 17 only within the youth court setting this may create difficulties for the youth courts if they are faced with a defendant who is under 16 but clearly unfit to plead. CLC made detailed comments regarding the failure of the NILC to comment upon the Youth Court system and made suggestions as to how to apply unfitness to plead to the youth court setting and we would urge the DoJ to take into account these comments.

If a person has been found unfit to plead and has been determined to have committed the act with which they are charged they must be dealt with appropriately by the court. Currently hospital orders, supervision and treatment orders, guardianship orders or absolute discharge are available in cases of unfit to plead. The DoJ proposes to retain in patient orders made by the court with the enhancement that the capacity of the individual to consent to treatment whilst an in-patient must be considered by the court. The person may also consent to in-patient treatment if they have the capacity to do so, or, if the person lacks the capacity to make decisions about their treatment it must be in their best interests.

The DoJ recognises in its consultation paper that a complication could arise on the rare occasion when a person has been dealt with as unfit to plead yet when the case is being disposed of has the capacity to refuse treatment. Unfitness to plead removes the options of criminal sanctions however a capacitous refusal of treatment would also remove in-patient or community based treatment options. Criminal justice sanctions would not be available nor would treatment based options. The DoJ is considering the option of a protection order to provide a model that would allow an unfit person who retains capacity, remains ill, refuses treatment, and is a serious risk, to be detained for protection (rather than for treatment) for an initial six month period with possible extension thereafter. The concept of a protection order has implications for the rights of the person under the ECHR as incorporated by the Human Rights Act 1998 which must be considered fully by the DoJ as this will mean that a person is being deprived of their liberty without either having been the subject of a court disposal or being compulsorily detained in hospital for the purposes of treatment of a mental illness. Such an intervention has the potential to impact upon a person’s rights under Articles 5, 6 and 8 of the ECHR.

The DoJ proposes to retain the supervision and treatment order as a disposal suitable for individuals who do not meet the criteria for an in-patient order and for whom treatment and/or supervision can be delivered in the community.

**Transfer of Prisoners**

It is proposed that the DoJ will retain its powers of transfer and return of prisoners, including young persons aged 16 and over resident in the JJC, for in-patient treatment or examination. It is intended that the criteria for transfer from prison for in-patient treatment or examination will be the same as a court considers when remanding or sentencing an offender and the information on which the DoJ will base transfer decisions will be contained in two reports from suitably qualified medical professionals. This again would appear to be based on persons aged 16 and over. No consideration appears to have been given to under 16s when making these proposals. No details have been provided as to whether it is intended to amend the Mental Health Order to reflect these transfer proposals.

It is proposed that transfer criteria will be –

1. the person has a medical condition and examination or treatment is required,
2. examination or treatment is available and a hospital is the most suitable venue for providing that examination or treatment,
3. failure to examine or treat the individual would result in harm to themselves or others; and either,

a) the person has capacity to consent to the examination or treatment and so consents, or

b) the person lacks capacity and the examination or treatment is in the best interests of the person.

It is proposed that transfer for examination be transformed into a treatment transfer subject to certain criteria and in appropriate circumstances to avoid the necessity to make a separate transfer for treatment, however the DoJ also wishes to retain a separate power of transfer specifically for examination. The DoJ believe that his will make it easier to assess a person’s illness or capacity if this is done in a hospital environment rather than in a prison[[47]](#footnote-47) environment.

It is proposed that once a person is transferred to a hospital the provisions of the Mental Capacity Bill will apply to any examination, care or treatment to be given to a prisoner who lacks capacity. If the prisoner is found to retain or regains capacity and refuses treatment then they will be returned to prison from hospital.

**The Review Tribunal**

The proposals in the consultation document appear to reflect the position in relation to the rights of review of persons aged 16 and over only. The DoJ propose to retain the use of the Review Tribunal to review the detention of those who have entered the health system through the criminal justice system. It is proposed that the time limitations for referral and review by the Review Tribunal will remain the same as at present and therefore a prisoner sentenced to detention in a hospital without restriction may apply to the Review Tribunal after six months. A relative of the patient can also apply within twelve months. A restricted patient (a patient subject to a restriction order where leave, transfer and discharge require consent from the DoJ) may apply within six months of a court order or a prison transfer, again within the next six months and annually thereafter. The DoJ can refer a restricted patient to the Tribunal at any time and must do so where a case has not been previously considered by the Tribunal within a two year period. The DoJ also proposes to reflect the review periods proposed in the Draft Bill for civil society within the criminal justice provisions. It is unclear from the DoJ’s proposals as to how it intends to amend the Mental Health (NI) Order 1986 to reflect the rights of review under the Mental Capacity Bill for under 16s. See page 46 for more detail on the review periods within the Draft Bill for civil society.

**Review Tribunal Powers**

The Review Tribunal as at present will be able to refuse or grant discharge, or to

conditionally discharge restricted patients and attach discharge conditions where appropriate. The grounds for discharge will be that the person is no longer ill or that they no longer pose a significant risk of harm to themselves or others. It is proposed that the Review Tribunal will have new powers to allow them to replace an inpatient order with a protection order in certain cases and it will have the power to review the protection order. There is a lack of detail in the consultation document as to what the Review Tribunal powers will look like in an amended Mental Health (NI) Order 1986. It is unclear as to how the Review Tribunal will operate in a duel system of a retained Mental Health (NI) Order for under 16s and a capacity based approach for person aged 16 and over. It would however appear that under 16s will be greatly disadvantaged under this duel system as the criteria that the Tribunal will consider for persons aged 16 and over will have a higher standard or proof than that which currently exists under the 86 Order. This places under 16s at a considerable disadvantage when making an application to the Review Tribunal.

**Recall**

The DoJ is proposing to retain its power to recall a patient who has been conditionally discharged but who is not complying with their discharge conditions. If a patient has been recalled, the DoJ must then refer the case to the Review Tribunal for review.

**Additional Concerns**

**There is a lack of detail in the consultation document around the impact of the DoJ proposals on 16 and 17 year olds within the justice system and for those who work in connection with this age group. There is no detail provided as to how the DoJ intends to amend the Mental Health (NI) Order 1986 for under 16s within the Justice System. We would have expected to have seen draft clauses in relation to both the justice provisions of the Mental Capacity Bill and draft clauses in relation to the amended Mental Health (NI) Order 1986. It is therefore difficult to comment upon the the implications of the exclusion of under 16s from the justice provisions of the Mental Capacity Bill when no detail has been provided as to what will be put in place as an alternative for this age group.**

**No detail has been provided as to how professionals such as PSNI Officers, Probation Officers and Youth Justice Agency employees will operate a duel system, one legislative system for under 16s and another for 16 and 17 year olds. The DoJ has not addressed in the consultation document how the Youth Court will operate in a system where the age of criminal responsibility is 10 years olds but where the Mental Capacity Bill operates from the age of 16. DoJ has also provided no details as to how young persons under the age of 16 will transfer into the capacity based approach of the Bill when they turn 16, i.e. whether they will continue to be governed by the provisions of the Mental Health (NI) Order 1986 or be governed by the terms of the Mental Capacity Bill.**

**Without seeing the draft justice clauses of the Mental Capacity Bill and the DoJ’s proposed amendments to the Mental Health (NI) Order 1986 the consultation process is incomplete. It is necessary for the justice clauses of the Bill and the amendments to the Mental Health Order to be published and to be publically consulted upon.**

**SECTION 75 OF THE NORTHERN IRELAND ACT 1998**

Throughout the process of developing the Mental Capacity (Health, Welfare and Finance) Bill, CLC has consistently expressed serious concerns at the manner in which both the DHSSPS and DoJ have discharged their statutory obligations under section 75 of the Northern Ireland Act 1998 to have due regard to the need to promote equality of opportunity between the nine equality categories of persons outlined in the legislation. We continue to have such concerns in relation to the current consultation process.

Section 75 of the Northern Ireland Act 1998 applies to the ‘policies’ of designated public authorities. Under Schedule 9 of the Northern Ireland Act 1998, designated public authorities such as the DHSSPS and DoJ are required to submit an equality scheme to the Equality Commission for approval. An equality scheme is a statement of the public authority’s commitment to fulfilling its section 75 statutory duties and should include a commitment to assess and consult on the likely impact of policies on the promotion of equality of opportunity. To properly identify adverse impacts on the promotion of equality of opportunity and address them, including by identifying areas where it is possible to further promote equality of opportunity as is required by section 75, or through mitigation of the adverse impacts and the adoption of alternative policies, it is necessary in the first instance to screen the policy. Where the potential for adverse impact or opportunities to further promote the enjoyment of equality of opportunity is identified, it is then necessary for public authorities to carry out a comprehensive Equality Impact Assessment (EQIA) on the policy proposals in line with its statutory duty and the commitments contained in its approved Equality Scheme.

The DHSSPS carried out an initial EQIA on its then proposals in 2010. For the purposes of this consultation, which contains significant new policy proposals, particularly with regards to children and young people aged under 16, the DHSSPS has ‘updated’ this EQIA. The DoJ had previously screened proposals contained within its initial consultation on the Bill in 2012, but did not conduct an EQIA at this time, a decision that CLC was critical of. The DoJ has now conducted an EQIA in relation to the current consultation process, separate from the EQIA conducted by the DHSSPS. CLC had raised serious concerns as to how both Departments have assessed the potential for adverse impact on the promotion of equality of opportunity in the previous assessments they have conducted. Regrettably, we would continue to have concerns in relation to the assessments that have been completed for the current consultation.

As we have already outlined, the current consultation contains a number of new and substantially amended policies that have not previously been subject to public consultation. This includes the position which has now been adopted by both Departments in relation to children aged under 16, the role that will be played by Trust panel’s under the legislation and the major changes that have been made to the principles upon which the Bill is based. CLC is aware that it has been the intention to introduce these new and substantially amended policies for some time.

In relation to children aged under 16, as previously outlined, the original position adopted by both Departments was that whilst the Bill would generally only apply to persons aged 16 and over, the Bill would apply to all children aged under 16 who were subject to powers of compulsory detention for assessment or treatment of a mental illness, and that all such children would be able access the protections and safeguards outlined within the Bill. However, both Departments have now decided to exclude all under 16s from the scope of the Mental Capacity (Health, Welfare and Finance) Bill and to retain the provisions of the Mental Health (NI) Order 1986 for children aged under 16. This represents a significant new policy decision, which has never been consulted upon before and which represents a major departure from the recommendations of the Bamford Review. Given the significance of this decision by the DHSSPS and DoJ, CLC is of the view that this issue should have been subject to a separate consultation process and a separate, distinct assessment of the impact that this new policy will have on the promotion of equality of opportunity.

As detailed at pages 7 and 22 major changes have been made to the principles upon which the Bill is based. The Bamford Review developed principles which it recommended should form the basis on which the new legislation was developed and implemented - Autonomy, Justice, Benefit and Least Harm. These principles formed part of the policy proposals that were considered by the DHSSPS in the EQIA it conducted in 2010, with the DHSSPS stating within this EQIA that it accepted that these core principles were appropriate and comprehensive and that they should underpin the legislation.[[48]](#footnote-48) There is now a clear deviation between the principles now proposed for the Bill by both Departments and the recommendation of the Bamford Review. Whilst the principle of Autonomy remains in place, the Justice principle has been removed and the key Bamford principles of Least Harm and Benefit have been replaced with a Best Interests principle. The consultation document also outlines a role for HSC Trust panel’s, which will be required to authorise acts in a variety of circumstances where a person lacks capacity. This again represents a new policy proposal, which is only now being subject to public consultation.

The fact that these new policy proposals are only now being issued for public consultation, and as far as we are aware, have only recently been assessed for their potential impact on the promotion of equality of opportunity as part of this consultation process, is extremely concerning. The Equality Commission’s Guidance for Public Authorities on Implementing Section 75 of the Northern Ireland Act 1998 is very clear that the section 75 statutory duties should be discharged by public authorities at the earliest opportunity in the policy development process, as part of the policy development process, rather than as an afterthought when the policy has been established.[[49]](#footnote-49) Equality considerations should be central to policy development and should be mainstreamed into all stages of policy making.[[50]](#footnote-50) The Commission is also clear that consultation with affected individuals and representative groups should begin as early as possible.[[51]](#footnote-51) The Equality Commission warns that in relation to assessment via screening that,

‘‘*Screening is more useful if it is introduced at an early stage when developing or reviewing a policy, or during successive stages of implementation (e.g. strategic review, options paper). To undertake screening after policy proposals have been developed may be inefficient in terms of time and may be ineffective if policy makers are reticent to make changes at a later stage. It may also duplicate policy development processes.*’’[[52]](#footnote-52)

Both the DHSSPS and the DoJ have undertaken within their Approved Equality Schemes to begin consultation with all stakeholders as early as possible.[[53]](#footnote-53) Both Departments have committed to following the Equality Commission’s Guidance on screening and EQIA in their Approved Equality Schemes.[[54]](#footnote-54) Both Departments commit to screening being completed at the earliest opportunity in the policy development or review process.[[55]](#footnote-55)

CLC is concerned that rather than discharging their obligations under section 75 in the manner outlined within their approved Equality Schemes, both Departments have delayed in assessing the impact of these new or substantially amended policies on the promotion of equality of opportunity. CLC is very concerned that this demonstrates a reticence on the part of both Departments to make changes to these policies and highlights that the promotion of equality of opportunity has not been mainstreamed into their development. We also have concerns that there is very little possibility of influencing key policy proposals contained in the Mental Capacity Bill such as the principles of the Bill and Trust panels at this late stage in the development of Mental Capacity Bill i.e. following a consultation on the draft Bill itself.

The introduction of these new and substantially amended policies further raises concerns as to the weight which has previously been given to the views of consultees in responding to previous consultations despite the fact that both Departments have an obligation under section 75 to take into account views expressed through consultation[[56]](#footnote-56). CLC is unaware of any consultee having previously expressed the view that all children and young people should be entirely excluded from the scope of the Bill. We are similarly unaware of any consultee having argued for amendments to the principles recommended by the Bamford Review. Both the DHSSPS and the DoJ state within their approved Equality Schemes that in making any decision with respect to a policy adopted or proposed to be adopted, they will take into account any assessment and consultation carried out in relation to the policy.[[57]](#footnote-57)

In relation to the DHSSPS’s ‘updated’ equality impact assessment and the DoJ’s current equality impact assessment, CLC has a number of concerns. In responding to the initial EQIA that was conducted by the DHSSPS in 2010, CLC was concerned by the lack of detail and information provided in the document and we did not think that the EQIA was comprehensive, with many policies not being mentioned anywhere in the EQIA. This is also a major concern in relation to the ‘updated’ EQIA, which only provides a brief overview of the Bill and contains little substantive analysis of how the proposals will impact on the promotion of equality of opportunity, or further promote equality of opportunity. This EQIA is in relation to a piece of legislation which the DHSSPS has repeatedly claimed will be the single largest piece of legislation Northern Ireland has ever produced, yet the EQIA document produced by the Department is very short and lacking in the necessary level of detail.

CLC is particularly concerned by the approach which has been taken by the DHSSPS in relation to assessing the impact that the new policy proposal to exclude children aged under 16 from the scope of the Bill entirely will have on the promotion of equality of opportunity. As the DHSSPS acknowledges in the ‘updated’ EQIA, stakeholders representing children and young people have stated that the non-application of the Bill to children aged under 16 will cause a significant adverse impact for this age group.[[58]](#footnote-58) Whilst the Department claims that it has given this issue careful consideration, it states that it finds it difficult to agree and that the reasons why the Bill cannot be applied to children must be considered. The DHSSPS states that there is already a framework in place designed to protect children and govern decision making in relation to them. That framework will remain in place when the draft Bill is enacted and the provisions and protections in it will therefore remain. The DHSSPS is of the view that this framework is complex and that it should be considered in light of the Bill through a separate project to be taken forward in the next Assembly mandate. The Department indicates a willingness to consider any proposal that results in children being better protected, which could be inserted by the draft Bill into the Mental Health Order, which will be retained temporarily for children aged under 16 pending the outcome of the review referred to above.[[59]](#footnote-59)

CLC is of the firm view that the proposed exclusion of children aged under 16 from the Bill represents clear differential adverse impact on this age group, who will not be able to access the protections and safeguards contained in the new Bill, which will be afforded to those over 16 who lack capacity as a result of a mental illness or learning disability. We have repeatedly asked the DHSSPS to elaborate on the proposed protections for children and young people who suffer from mental illness or learning disability which would mitigate against the adverse impact they will suffer as a result of not coming within the scope of the Bill, however we have yet to receive an adequate answer.

As outlined above, the process of reviewing the legal framework which already exists in relation to children and young people will undoubtedly take a significant period of time, given the scale of the task as has been acknowledged by the DHSSPS. Given this, CLC is particularly disappointed to note that the DHSSPS has not adequately considered mitigation and alternative policies for children aged under 16. The Equality Commission’s Practical Guidance on EQIA, which the DHSSPS commits to following when conducting EQIAs,[[60]](#footnote-60) states that following a judgment as to whether there is a differential impact and then a determination as to whether that impact is adverse, the public authority should then consider mitigation and alternative policies, and their likely impact.[[61]](#footnote-61) It is also clear from this guidance that consideration of mitigating measures and alternative policies is at the heart of the EQIA process and that different options must be developed which reflect different ways of delivering the policy aims.[[62]](#footnote-62)

We are concerned that the DHSSPS has not provided detailed proposals to mitigate the adverse impact which will be suffered by children if they are excluded from the Bill. CLC wishes to see children and young people receiving the maximum level of protections and safeguards possible. While we firmly believe that children under 16 should be included within the scope of the Bill, we have already made detailed proposals to the DHSSPS as to the amendments which should be made to the Mental Health Order in order to better protect children aged under 16 if the Department’s decision remains that under 16s will be excluded from the Bill. We are challenged as to why no detailed reference to such proposals is included in the consultation documents and consider this to be a major shortcoming within this current EQIA process. Whilst the main consultation document makes brief reference to amendments which are being considered for the Mental Health Order, we are of the view that the limited consideration given to this issue means that consultees have been prevented from making informed comment on whether the proposed approach of taking forward amendments to the Mental Health Order can sufficiently mitigate against the clear differential adverse impact that will be suffered by children aged under 16 as a result of their exclusion from the Bill.

The DoJ has also conducted a separate EQIA in relation to the Bill, which also examines the exclusion of under 16s. However, the DoJ is very clear in its EQIA that it does not see its role as equality assessing the current draft Mental Capacity Bill issued alongside the criminal justice consultation as this deals with the ‘civil’ consequences and such an assessment is for the DHSSPS in an area which the DoJ states is at its core, health based policy.[[63]](#footnote-63) In its assessment of the impact on the promotion of equality of opportunity, the DoJ states that at an overarching level the impact of the Bill applying only to those aged 16 and over is being addressed more strategically. They state that this includes considering options for building in additional safeguards and protections in the Mental Health (NI) Order 1986 and conducting a more fundamental review of the Children (NI) Order 1995.[[64]](#footnote-64) In considering mitigating measures, the Department states that along with DHSSPS, it has recognised the overarching impact of the draft Bill applying only to those aged 16 and over. It is stated that as a temporary measure the Mental Health Order will be retained for those aged under 16 pending the outcomes of a separate project looking at the issue of emerging capacity of children in the context of changes that may also required to the Children Order. The DoJ is working with DHSSPS in considering options for the way forward, including taking the views of key stakeholders. Options being considered include the insertion of a best interests principle akin to that in the Bill – though more child-focused; inserting a duty to consult with an independent advocate – again similar to the Bill but with an age-appropriate requirement; and amendment of nearest relative provisions. Any resulting changes could be delivered by the final Bill being brought to the Assembly. The wider project reviewing the Children Order would be delivered in the next mandate once the Bill has been enacted.[[65]](#footnote-65)

It is concerning to CLC that the DoJ does not appear to have adequately assessed the impact that excluding under 16s from the scope of the Bill will have for children and young people in the youth justice system. CLC believes that the proposed removal of under 16s from the scope of the Bill and the retention of the Mental Health (NI) Order 1986 with possible amendments will have significant potential for adverse impact on children and young people who come into contact with the criminal justice system. There will also be serious implications for the operation of the Police Service of Northern Ireland (PSNI), the Probation Board for Northern Ireland (PBNI), the Youth Justice Agency, including the Juvenile Justice Centre and the Northern Ireland Courts and Tribunal Service, as effectively what is being proposed is a two tier system for those over and under 16. Children aged under 16 who are in the criminal justice system and have a mental illness and/or learning disability are arguably the most vulnerable group of children and young people in Northern Ireland and should be afforded the highest degree of protection.

There is a very clear profile of children who come into contact with the criminal justice system which is distinct from children and young people in civil society. Most of these children come from the most deprived areas in society, they are much more likely to have mental ill health, learning disabilities, special educational needs, literacy problems, poor educational attainment, many have come from the care system, have experienced addiction and/or some form of abuse and most have a variety of unmet needs while in the community.[[66]](#footnote-66) It is vital that all children and young people who have a learning disability or mental illness in the criminal justice system have access to at least the equivalent safeguards and protections afforded to over 16s by virtue of coming within the scope of the Mental Capacity (Health, Welfare and Finance) Bill. Children within the youth justice system fall within the responsibility of the DoJ and the obligation to assess the potential impact on the enjoyment of equality of opportunity of the proposal to remove under 16s from the Bill and retain and amend the Mental Health (NI) Order 1986 for under 16s in the criminal justice system clearly falls to the DoJ also.

CLC therefore would have wished to see the DoJ carrying out a comprehensive EQIA of these policy proposals, examining in detail where adverse impact is likely to be suffered by children in the criminal justice system. We would have welcomed the DoJ then setting out detailed mitigating measures and alternative policies that it will take forward so that children and young people with a mental illness and/or a learning disability who come into contact with the criminal justice system do not suffer adverse impact by virtue of this policy proposal.

CLC is also extremely concerned, given the exclusion of under 16s from the provisions of the Mental Capacity Bill, that no child accessible version of the consultation documents have been produced despite CLC requesting these on 27th May 2014. The failure of both Departments to provide child accessible and easy read versions of the consultation documents from the beginning of the consultation process is contrary to the requirement placed on both Departments’ under their approved Equality Schemes to begin consultation with all stakeholders as early as possible.[[67]](#footnote-67)

It is vital that the direct involvement of children and young people is facilitated as part of this consultation process. These proposals will undoubtedly directly affect children and young people and so children and young people must be directly consulted with in relation to them. Such consultation is essential in ensuring compliance with section 75 of the Northern Ireland Act 1998, and also in ensuring the Government’s compliance with Article 12 of the UNCRC, which provides all children with the right to express their views freely in relation to all matters that affect them, with those views then being given due weight.

Both the DHSSPS and the DoJ are designated public bodies for the purposes of section 75 and are under an obligation to ensure that child accessible and easy read documentation is available in order to facilitate consultation with children and young people in circumstances such as these. These obligations are outlined in both Departments’ approved Equality Schemes. Both Departments state within their approved Equality Schemes that they will consider the accessibility and format of every method of consultation they use in order to remove barriers to the consultation process. Both Departments state that specific consideration will be given as to how best to communicate with children and young people, people with disabilities (in particular people with learning disabilities) and minority ethnic communities. Both Departments state that they will take account of existing and developing good practice, including the Equality Commission’s guidance ‘‘Let’s Talk Let’s Listen’’.[[68]](#footnote-68) CLC wishes to see a comprehensive programme of direct consultation with children and young people being carried out by both the DHSSPS and the DoJ in order to ensure that their views are heard and taken into account in the development of this significant piece of legislation and with regard to the legal framework for children and young people with mental illness and /or learning disability in Northern Ireland.

**Consultation and the way forward**

The publication of the consultation on the new legislative framework for mental health and capacity for Northern Ireland was published on the 27th May 2014 and the deadline for responses is 2nd September 2014. There has been no indication given as to when the Codes of Practice for the Bill will be available for public consultation. Neither has it been indicated if or when the criminal justice provisions of the Bill will be available for consultation.

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**APPENDIX 1 - CHILD AND ADOLESCENT** **MENTAL HEALTH IN NORTHERN IRELAND**

**In Northern Ireland over 20% of children under 18 years of age suffer significant mental health problems and this comprises the commonest form of severe disability in childhood**.[[69]](#footnote-69)There has been a failure to adequately resource appropriate mental health services.[[70]](#footnote-70) **In Northern Ireland in 2012/13, only £19m was allocated to Child and Adolescent Mental Health Services (CAMHS), which equates to 7.9% of the total planned mental health expenditure for that period**[[71]](#footnote-71), despite the fact that children and young people under 18 represent nearly a quarter of Northern Ireland’s population.

The Committee on the Rights of the Child in 2008 expressed its concern about the continued treatment of children in adult psychiatric wards, the small number of children with mental health problems who have access to the required treatment and care and also highlighted its concern that in Northern Ireland - due to the legacy of the conflict - the situation of children in this respect is particularly concerning. **The Committee recommended that additional resources and improved capacities be employed to meet the needs of children with mental health problems throughout the country, with particular attention to those at greater risk, including children deprived of parental care, children affected by conflict, those living in poverty and those in conflict with the law.[[72]](#footnote-72)**

**It is well recognised that factors associated with the conflict and with a society emerging from conflict have impacted severely on child and adolescent mental health in Northern Ireland.**[[73]](#footnote-73) Evidence that experience of the Northern Ireland conflict is associated with poorer mental health is strong[[74]](#footnote-74). Population based surveys show that those who experienced most violence have significantly higher rates of depression than those with little or no experience. People whose areas had been heavily affected by violence had very high rates of depression[[75]](#footnote-75). Children have been injured, killed, subject to punishment beatings, bereaved and have witnessed terrible violence.[[76]](#footnote-76) Many children remain undiagnosed and services are patchy and geographically uneven.

**The incidence of mental health problems among vulnerable groups of children and young people is disproportionately high** – these include children and young people with disabilities[[77]](#footnote-77) and those living in poverty[[78]](#footnote-78) as well as children in conflict with the law[[79]](#footnote-79) and care experienced children[[80]](#footnote-80) or those in need of safe and secure accommodation.

**There are currently no forensic inpatient paediatric psychiatric provision in Northern Ireland and only limited inpatient adolescent facilities.[[81]](#footnote-81) Almost 200 children in Northern Ireland were detained on adult psychiatric wards between 2007 and 2009[[82]](#footnote-82) and from January 2012 until December 2012 there were 91 admissions of children to adult psychiatric wards in Northern Ireland**[[83]](#footnote-83). This is despite a commitment from the Department of Health, Social Services and Public Safety in 2009 that the Department would make age appropriate mental health detention of children a priority[[84]](#footnote-84).

There is a high level of unmet need in relation to the availability of adequate CAMHS provision. This is borne out by the fact that **children and young people with anorexia and complex mental health needs often have to be moved out of Northern Ireland to access specialist mental health services which do not exist in this jurisdiction**, a clear breach of their Article 8 right to family life under the European Convention on Human Rights (ECHR). Between 2006 and 2007 there were 18 children sent for treatment for mental health conditions outside of Northern Ireland at a cost of over £1.8 million.[[85]](#footnote-85) In the financial year 2012/2013 9 children were the subject of an extra contractual referral (outside of Northern Ireland) for specialist treatment of a mental health condition at a cost of £2,241,424.[[86]](#footnote-86)

A report from the Centre for Social Justice[[87]](#footnote-87) commented that the disillusionment surrounding worklessness among young people has become a critical problem in Northern Ireland. Young people aged between 16 and 24 are particularly affected by worklessness. About 20,000 young people in Northern Ireland are economically inactive but not in full or part time study.[[88]](#footnote-88) Both the number and the rate of youth unemployment have doubled in three years.[[89]](#footnote-89) A recent study found that a third of long term unemployed young people have contemplated taking their own lives. The research found that long term unemployed young people were more than twice as likely as their peers to have been prescribed anti-depressants. One in three (32%) had contemplated suicide, while one in four (24%) had self-harmed. The report found 40% of jobless young people had faced symptoms of mental illness, including suicidal thoughts, feelings of self-loathing and panic attacks, as a direct result of unemployment[[90]](#footnote-90).

There is a disproportionate over representation of children and young people with mental health needs within the criminal justice system. The prevalence of mental health needs among young people in custody has been found to range from 46% to as high as 81%.[[91]](#footnote-91) The Mental Health Foundation’s report, “The Mental Health of Young Offenders”*[[92]](#footnote-92)* concluded that,

*“...despite a scarcity of robust data, there is general agreement in the literature that young people in the Juvenile Justice system exhibit higher levels of psychosocial and psychiatric problems than the general population – at least three times higher.”*

95% of young prisoners aged 15 to 21 suffer from a mental disorder. 80% suffer from at least two mental health problems. Nearly 10% of female sentenced young offenders reported already having been admitted to a mental hospital at some point.[[93]](#footnote-93)

Since November 2012 all children under the age of 18 in Northern Ireland within the criminal justice system have been detained at the Woodlands Juvenile Justice Centre, prior to this some young people had been detained in Hydebank Young Offenders Centre with adults. The Criminal Justice Inspection for Northern Ireland (CJINI) report, *“*[*Not a Marginal Issue - Mental Health and the Criminal Justice System in Northern Ireland”*](http://www.cjini.org/getattachment/24d6cd45-20bb-4f81-9e34-81ea59594650/Mental-Health-and-the-criminal-justice-in-Northern.aspx)[[94]](#footnote-94) focused on mental health and found that many children in the Juvenile Justice Centre had poor mental health and other negative indicators. Of the 30 children in residence on 30th November 2007, 20 had a diagnosed mental health disorder, 17 had a history of self-harm, 8 had at least one suicide attempt on record, 8 were on the child protection register and 14 had a statement of special educational needs.[[95]](#footnote-95)

Research published by CJINI in July 2012 also highlighted the profile of the children and young people detained in Woodlands Juvenile Justice Centre with regard to mental health needs. From a sample of 50 young people, 38 of whom were on remand and 12 of whom were sentenced, the Youth Justice Agency Statistics and Research Branch found that 38% of the sample had a statement of special educational needs, whilst 14% had a recognised (or in one case, suspected) learning disability. Almost all of the sample had experienced some form of trauma in their lives, such as suicide of a family member(s) or friend(s), or parental mental health needs. 23% of the sample were diagnosed with Attention Deficit Hyperactivity Disorder and a further 4% were suspected to have the disorder. Other mental health issues were also evident, such as depression. 32% of the sample had self-harmed.[[96]](#footnote-96)

CJINI also reported that many of the children who enter custody in the Juvenile Justice Centre are in poor physical and mental health as they have had limited access to, and uptake of healthcare services in their own community.[[97]](#footnote-97) A challenge identified by the child and adolescent psychiatrist in the Juvenile Justice Centre has been the availability of only limited information in relation to children at the time of admission, including their mental health history.[[98]](#footnote-98) CJINI has also identified that healthcare staff in the Juvenile Justice Centre have faced particular challenges in liaising effectively with community based CAMHS teams including access to relevant notes. This was often not helped due to a lack of compliance by children in attending appointments made with the CAMHS teams after discharge.[[99]](#footnote-99) Gaps were identified in terms of in-patient places for released children with mental health needs and a lack of provision for forensic mental health and hostel places for children who were identified as vulnerable. While many children were motivated to accept help when they were in the Juvenile Justice Centre, healthcare staff were concerned about delays in obtaining services for children with newly diagnosed mental health needs and also in ensuring their compliance in attending appointments.[[100]](#footnote-100)

1. Para 3.8, Draft Mental Capacity Bill (NI) Consultation Document, May 2014 [↑](#footnote-ref-1)
2. A Comprehensive Legislative Framework” August 2007, page 47 [↑](#footnote-ref-2)
3. A Comprehensive Legislative Framework” August 2007, page 47 [↑](#footnote-ref-3)
4. Para 3.9 [↑](#footnote-ref-4)
5. 22nd January 2014 [↑](#footnote-ref-5)
6. Para 1.4, *Op cit,* 1 [↑](#footnote-ref-6)
7. Para 1.4, *Op cit,* 1 [↑](#footnote-ref-7)
8. Para 1.6, *Op cit,* 1 [↑](#footnote-ref-8)
9. Joint Ministerial Foreword, *Op cit,* 1 [↑](#footnote-ref-9)
10. Page 47, *Op cit* 3 [↑](#footnote-ref-10)
11. HL v UK 45508/99 (2004) ECHR 471 [↑](#footnote-ref-11)
12. Page 16, *Op cit* 3 [↑](#footnote-ref-12)
13. Lader, D. (2000). Psychiatric morbidity among young offenders in England and Wales. London:

ONS [↑](#footnote-ref-13)
14. National Institute for Mental Health. (2003). Personality Disorder: no longer a diagnosis for

exclusion. Policy implementation guidance for the development of services for people with personality

disorder London: NIMHE. [↑](#footnote-ref-14)
15. Page 16, *Op cit* 3 [↑](#footnote-ref-15)
16. Page 18, *Op cit* 3 [↑](#footnote-ref-16)
17. Page 18, *Op cit* 3 [↑](#footnote-ref-17)
18. Para 3.11, *Op cit* 1 [↑](#footnote-ref-18)
19. Para 53 [↑](#footnote-ref-19)
20. CRC/GBR/CO/4 paragraph 21 [↑](#footnote-ref-20)
21. Article 1, UNCRC [↑](#footnote-ref-21)
22. TA 59, Guidance on the use of Electroconvulsive Therapy, Issued April 2003, Modified October 2009 [↑](#footnote-ref-22)
23. Para 1.3, *Ibid* [↑](#footnote-ref-23)
24. 26494/95 (2000) ECHR 133 [↑](#footnote-ref-24)
25. July 2006 [↑](#footnote-ref-25)
26. Paras 4.43 and 4.44 [↑](#footnote-ref-26)
27. Delivering the Bamford Vision – The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability, Draft for Consultation, June 2008 [↑](#footnote-ref-27)
28. 2006 [↑](#footnote-ref-28)
29. Page 21 [↑](#footnote-ref-29)
30. Article 23 of the UNCRC specifically refers to the rights of mentally disabled children and strongly promotes integration and participation in education. Pursuant to Article 23 of the UNCRC state parties are required to recognise that a mentally disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance, and facilitate the child’s active participation in the community. Recognising the special needs of a disabled child, assistance is required to be provided free of charge, whenever possible and should be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child’s achieving the fullest possible social integration and individual development including his/her cultural and spiritual development. [↑](#footnote-ref-30)
31. Or possibly up to the age of 19 where there is a statement of Special Educational Needs in force – see page 21 [↑](#footnote-ref-31)
32. Draft Mental Capacity Bill (NI), Consultation Document, May 2014, page 38 [↑](#footnote-ref-32)
33. *Ibid,* Page 38 [↑](#footnote-ref-33)
34. Page 4, *Op cit* 3 [↑](#footnote-ref-34)
35. Page 5, *Op cit* 3 [↑](#footnote-ref-35)
36. Mental Capacity Act 2005: post-legislative scrutiny, House of Lords, 13th March 2014, page 36 [↑](#footnote-ref-36)
37. General Comment 1 Article 12: Equal Recognition Before the Law, 19th May 2014 [↑](#footnote-ref-37)
38. Page 47 *Op cit* 3 [↑](#footnote-ref-38)
39. Para 2.38 [↑](#footnote-ref-39)
40. Para 2.53 [↑](#footnote-ref-40)
41. HL v. THE UNITED KINGDOM - 45508/99 [2004] ECHR 720 [↑](#footnote-ref-41)
42. Page 96, *Op cit* 36 [↑](#footnote-ref-42)
43. Page 96, *Op cit* 36 [↑](#footnote-ref-43)
44. Page 7, *Op cit* 36 [↑](#footnote-ref-44)
45. Page 28, *Op cit* 32 [↑](#footnote-ref-45)
46. Code of Practice, Mental Capacity Act 2005, paragraph 12.5 [↑](#footnote-ref-46)
47. While the consultation document does not say that this will apply to the Juvenile Justice Centre (JJC), we assume that it will as 16 and 17 year olds are within the scope of the Bill and will be detained in the JJC [↑](#footnote-ref-47)
48. ‘Mental Capacity (Health, Welfare and Finance) Bill, Equality Impact Assessment, 2010, DHSSPS, para.6. [↑](#footnote-ref-48)
49. ‘Section 75 of the Northern Ireland Act 1998 – A Guide for Public Authorities’ Equality Commission for Northern Ireland, 2010, p.13 and 51. [↑](#footnote-ref-49)
50. *Ibid*, p.8. [↑](#footnote-ref-50)
51. *Ibid*, p.38. [↑](#footnote-ref-51)
52. *Ibid*, p.51. [↑](#footnote-ref-52)
53. ‘Equality scheme for the Department of Health, Social Services and Public Safety’ Approved by the Equality Commission for Northern Ireland on 28thMarch 2012, Para.3.2.3. ‘Equality Scheme for the Department of Justice’ Approved by the Equality Commission for Northern Ireland on 28th March 2012, para.3.5. [↑](#footnote-ref-53)
54. *Ibid*, para 4.3 and para.4.3. [↑](#footnote-ref-54)
55. *Ibid*, para. 4.5 and para.4.5. [↑](#footnote-ref-55)
56. 9(2) Schedule 9, Northern Ireland Act 1998 [↑](#footnote-ref-56)
57. *Ibid*, para3.2.13 and para.3.14. [↑](#footnote-ref-57)
58. ‘Updated Equality Impact Assessment – Draft Mental Capacity Bill’ Department of Health, Social Services and Public Safety, May 2014, para.3.3. [↑](#footnote-ref-58)
59. *Ibid*, para.5.37 – 5.41. [↑](#footnote-ref-59)
60. ‘Equality scheme for the Department of Health, Social Services and Public Safety’ Approved by the Equality Commission for Northern Ireland on 28th March 2012, para.4.3. [↑](#footnote-ref-60)
61. ‘Section 75 of the Northern Ireland Act 1998: Practical Guidance on Equality Impact Assessment’ Equality Commission for Northern Ireland, February 2005, p.26. [↑](#footnote-ref-61)
62. *Ibid,* p. 30. [↑](#footnote-ref-62)
63. ‘Equality Impact Assessment: Extending Mental Capacity Legislation to the Criminal Justice System’ Department of Justice, February 2014, para.3.16. [↑](#footnote-ref-63)
64. *Ibid*, para.9.38. [↑](#footnote-ref-64)
65. *Ibid*, para.15.2 – 15.5. [↑](#footnote-ref-65)
66. See for example ‘Early Youth Interventions – An inspection of the contribution the criminal justice agencies in Northern Ireland make to preventing children and young people from entering the criminal justice system’ Criminal Justice Inspection Northern Ireland, July 2012, p.9 – 11. [↑](#footnote-ref-66)
67. Equality Scheme for the Department of Health, Social Services and Public Safety, Approved by the Equality Commission for Northern Ireland, 28th March 2012, para.3.2.3. Equality Scheme for the Department of Justice Approved by the Equality Commission for Northern Ireland on 28th March 2012, para.3.5. [↑](#footnote-ref-67)
68. Equality Scheme for the Department of Health, Social Services and Public Safety, Approved by the Equality Commission for Northern Ireland, 28th March 2012, para.3.2.4. Equality Scheme for the Department of Justice Approved by the Equality Commission for Northern Ireland on 28th March 2012, para.3.6. [↑](#footnote-ref-68)
69. “*Health of the Public in Northern Ireland”* Chief Medical Officer, 1999 [↑](#footnote-ref-69)
70. O’ Rawe, A. (2003) An Overview of Northern Ireland Child and Adolescent Mental Health Services Belfast: Children’s Law Centre. [↑](#footnote-ref-70)
71. Freedom of Information Request from the Health and Social Care Board, dated 8th April 2013 [↑](#footnote-ref-71)
72. United Nations Committee on the Rights of the Child, Concluding Observations United Kingdom, CRC/C/GBR/CO/4, 20thOctober 2008a, para. 56 – 57. [↑](#footnote-ref-72)
73. A Vision for a Comprehensive Child and Adolescent Mental Health Service – The Bamford Review November 2005 pp 15-16 [↑](#footnote-ref-73)
74. Miller et al., 2003; O’Reilly and Stevenson, 2003; Muldoon et al., 2005 [↑](#footnote-ref-74)
75. Suicide and Young People: the case of Northern Ireland - Mike Tomlinson School of Sociology, Social Policy and Social Work Queen’s University Belfast 4th October 2007 [↑](#footnote-ref-75)
76. Geraghty, T. ‘Getting It Right?’ Children’s Law Centre and Save the Children 1999. pp 53-54 and Smyth, M. ‘Half the Battle: Understanding the Impact of the Troubles/Conflict on Children and Young People in Northern Ireland’ INCORE. 1998. [↑](#footnote-ref-76)
77. A Vision for a Comprehensive Child and Adolescent Mental Health Service – The Bamford Review November 2005. [↑](#footnote-ref-77)
78. General Consumer Council Northern Ireland 2002 [↑](#footnote-ref-78)
79. Northern Ireland Human Rights Commission (NIHRC) ‘In Our Care’ March 2002 p91; Criminal Justice Inspectorate Northern Ireland (CJINI) ‘Inspection of the Juvenile Justice Centre’ October 2004 pp115-117; Department of Health, Social Services and Public Safety (DHSSPS) ‘Young People in Regional Care Centres and Youth Justice’ October 2004 p24. [↑](#footnote-ref-79)
80. Social Services Inspectorate ‘Secure Care Report’ June 2002; NICCY/QUB Research 2004 p89; Teggart, T. and Menary, J ‘An Investigation of the Mental Health Needs of Children Looked After by Craigavon and Banbridge Trust’ in Childcare in Practice Volume 11 (1) p39. [↑](#footnote-ref-80)
81. The Belfast Health Trust provides a regional in-patient service which currently has capacity for 25 young people. [↑](#footnote-ref-81)
82. RQIA's Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland Updated 23 February 2011 [↑](#footnote-ref-82)
83. Response to CLC Freedom of Information Requests to the five Health and Social Care Trusts [↑](#footnote-ref-83)
84. Commitment by the Department of Health, Social Services and Public Safety Officials in Letter to CLC from Dr Maura Briscoe, 18th February 2009, at Mental Helth and Mental Capacity Legislation Roundtable – Law Centre NI 27th February 2009 and CLC Mental Health Seminar, 21st October 2009 [↑](#footnote-ref-84)
85. Response to CLC Freedom of Information request [↑](#footnote-ref-85)
86. Response to Freedom of Information Request from the Health and Social Care Board dated the 29th May 2013 [↑](#footnote-ref-86)
87. Breakthrough Northern Ireland, September 2010 [↑](#footnote-ref-87)
88. Ibid p12 [↑](#footnote-ref-88)
89. Ibid p12 [↑](#footnote-ref-89)
90. The Prince’s Trust Macquarie Youth Index, January 2014 [↑](#footnote-ref-90)
91. *“The Mental Health of Young Offenders”* Mental Health Foundation Hagell; 2002 [↑](#footnote-ref-91)
92. Hagell; 2002 [↑](#footnote-ref-92)
93. ‘Not a Marginal Issue: Mental health and the criminal justice system in Northern Ireland’, Criminal Justice Inspection Northern Ireland, March 2010 [↑](#footnote-ref-93)
94. Northern Ireland Criminal Justice Inspectorate “Not a Marginal Issue: Mental Health and the Criminal Justice System”, March 2010 [↑](#footnote-ref-94)
95. *Ibid*, p. 50 [↑](#footnote-ref-95)
96. ‘Early Youth Interventions: An inspection of the contribution the criminal justice agencies in Northern Ireland make to preventing children and young people from entering the criminal justice system’, July 2012, p. 9-11. [↑](#footnote-ref-96)
97. ‘An announced inspection of Woodlands Juvenile Justice Centre’, Criminal Justice Inspection Northern Ireland/Regulation and Quality Improvement Authority /Education and Training Inspectorate, November 2011, para. 7.3. [↑](#footnote-ref-97)
98. *Ibid*, para. 7.6 – 7.14. [↑](#footnote-ref-98)
99. *Ibid*, para. 7.15. [↑](#footnote-ref-99)
100. *Ibid*, para. 7.28. [↑](#footnote-ref-100)