**SUBMISSION ON ASSISTED DECISION MAKING (CAPACITY) BILL, 2013 BY THE MENTAL HEALTH COMMISSION**

## 1. Introduction

The Mental Health Commission (the Commission) welcomes the presentation of the Assisted Decision Making (Capacity) Bill 2013 (the Bill) by the Minister for Justice and Equality. The Commission notes the purpose of the Bill as set out in the Long Title and the Explanatory Memorandum and that it *"changes the existing law on capacity, shifting from the current all or nothing status approach to a flexible functional one whereby capacity is assessed on an issue- and time-specific basis."*

The Commission endorses the functional approach taken by the Bill to the question of capacity. The Commission notes the intention of the Bill to allow for different categories of assistance for persons based on their "*ability to understand the nature and consequences of a decision…in the context of the available choices at the time the decision is made*". [1] The Commission also notes and welcomes the presumption of capacity in favour of "*relevant persons"* contained in Part 2 of the Bill on 'Guiding Principles'.

The Commission is aware of the urgency attached to the enactment of the Bill and has therefore confined itself to issues with which the Commission is particularly concerned. Following a brief description of the functions of the Commission, a number of general observations are made followed by more specific comments regarding certain provisions of the Bill.

## 2. Mental Health Commission

The Commission is responsible for regulating and monitoring mental health services in Ireland as defined by the Mental Health Act, 2001 (MHA 2001). The Commission was established in April 2002. The Commission is an independent statutory body and its functions are set out in the MHA 2001.[2] These are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under the MHA 2001. The Commission is responsible for the arrangement and administration of Mental Health Tribunals.

[1] Assisted Decision-Making (Capacity) Bill 2013, s 3

[2] Mental Health Act 2001, s 33

The Commission is well placed to offer observations in relation to this Bill. As an organisation, the Commission has seen first-hand the operational challenges which can emerge when implementing legislation of this kind. The Commission is familiar with the issues which may arise when interpreting complex legislative provisions. This is borne out by some of the litigation which has been brought on behalf of patients detained under the MHA 2001 and in which the Commission has been involved.

The Commission is also familiar with the subject matter of the Bill. While there is a distinction between mental capacity and mental health, there is also considerable overlap between the two.

## 3. Voluntary Incapacitated Patients

Pursuant to section 2 of the MHA 2001, a "*voluntary patient*" means "*a person receiving care and treatment in an approved centre who is not the subject of an admission order or renewal order".* [3] Some voluntary patients in approved centres have impaired capacity and may be incapable of asserting their rights as truly voluntary patients. There are also many people who are resident in a variety of other mental health and social care settings who are similarly incapacitated and unable to assert their rights without support and safeguards. People in these circumstances have become known as *'voluntary incapacitated patients'*, '*incapacitated compliant patients'* or the '*de facto detained'*.

The Commission has previously raised concerns regarding voluntary incapacitated patients in its Submission on the Review of the Mental Health Act 2001[4] in which it recommended:

> *"The definition of voluntary patient should be reviewed and revised to reflect those who have capacity to consent and freely do so. This is in line with the Human Rights Commission's (2011) recommendations.*
>
> *The 2001 Act or capacity legislation should be amended to provide appropriate safeguards for the incapacitated complaint patient. There is a need for synergy between both mental health legislation and capacity legislation."*

[3] MHA 2001, s. 3 - *(1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where –*

*(a) Because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or*

*(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could only be given by such admission, and*

*(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent*.

[4] December 2011, www.mhcirl.ie/Publications/MHC_Submissions

The Commission has not been alone in expressing such concerns. In February 2012, following the receipt of over 70 written submissions, the Joint Committee on Justice, Defence and Equality held public hearings in relation to the Scheme of the Mental Capacity Bill, the pre-cursor to the current Bill. The Commission took part in this process. The issue of voluntary incapacitated patients was raised by a number of bodies including the Human Rights Commission (which also produced a policy paper covering this issue in February 2010), the Law Society of Ireland, Amnesty International Ireland, the Alzheimer Society of Ireland, Mental Health Reform, the Centre for Disability Law and Policy NUI Galway, the Health Service Executive, and more recently, the College of Psychiatrists.

In April 2012, the Department of Health published its Interim Report of the Steering Group on the Review of the Mental Health Act 2001[5] in which it stated, *inter alia*:

> *"The reality is that many of the voluntary patients in approved centres lack the capacity to consent to admission and treatment. Thus they are voluntary patients, not because they have consented to admission, but rather because they have not objected. They are what has become known as the 'compliant incapacitated' – they are de facto detained yet do not enjoy the protections provided to involuntary patients in the Act. (Protection for incapacitated voluntary patients is provided in common law). We thus have the situation where many patients who lack or have fluctuating capacity, remain for lengthy periods in our approved centres without external review of their admission, detention or capacity. Similarly treatment decisions for voluntary patients are made without external oversight.*
>
> *It is anticipated that many of the shortcomings in the 2001 Act which arise because of capacity issues will be addressed by the proposed Capacity legislation which is at an advanced stage of preparation by the Department of Justice and Equality…..The Group met with the Department of Justice and Equality and there is a shared understanding that the revised Mental Health Act must dovetail with the Mental Capacity Bill."*[6]

Unfortunately, from the Commission's standpoint, the Bill makes no specific reference to voluntary incapacitated patients. Section 67 of the Bill does refer to "*any proposal to detain (within the meaning of the European Convention on Human Rights)"*.[7] It is not clear what the effect of this provision will be. However, it is clear from decisions emanating from the European Court of Human Rights (ECtHR) over the last decade that, as a matter of Convention law, many voluntary incapacitated patients fall within the definition of "detained". See for example the Court's decisions in *H.L. v. United Kingdom*[8] and *Stanev v. Bulgaria*[9].

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[5] 27 April 2012, www.dohc.ie/Publications

[6] Ibid, para 3.4

[7] ECHR Act 2003, s. 2(1)- *In interpreting and applying any statutory provision or rule of law, a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions*.

[8] [2004] ECHR 471

Conversely, in *EH v. St Vincent's Hospital and Others*[10] , the Supreme Court rejected an argument, based on the ECtHR's decision in *H.L*. that the definition of "*voluntary patient"* in the 2001 Act had to be taken as meaning a person who freely and willingly consented to remaining in hospital.

The Commission believes the proposed wording of section 67 of the Bill may revive the argument as to whether a voluntary incapacitated patient is, in fact, a "*voluntary patient*" pursuant to section 2 of the 2001 Act and may result in a conflict between the two enactments which will have to be decided by the Courts.

Furthermore, as stated above, the Commission is aware that the issue of voluntary incapacitated patients goes beyond approved centres and that, not unlike the applicant in *Stanev* who was resident in a social care home, such persons may be found in a variety of mental health and other social care settings.

The Commission submits that all voluntary incapacitated persons should be afforded procedural safeguards overseeing their deprivation of liberty and treatment so that the State may be fully compliant with Convention law and the UN Convention on the Rights of Persons with Disabilities (CRPD). The Commission further submits that this issue should be addressed in this Bill rather than under the review of the MHA 2001. This would provide for an approach that embraces the principle of the least restrictive alternative and avoid potential unintended consequences whereby such people may find themselves subject to detention under the MHA 2001.

## 4. Advance Healthcare Directives

The Commission notes the Government's intention to incorporate legislative provisions for Advance Healthcare Directives into the Bill at Committee Stage. The Commission fully supports the introduction of Advance Healthcare Directives into Irish law and submits that they should apply equally to all persons including those detained under the MHA 2001. However, it is obvious that there will need to be compatibility between the provisions introduced at Committee stage and Part 4 of the MHA 2001.

The Commission believes that recognition of Advance Healthcare Directives is a fundamental step towards a recovery based model. The Commission has stated previously:

> *"the essential components of a recovery oriented service are person-centred and the empowerment of the person accessing the service. For mental health care to be person- centred it needs to be delivered in a manner that is respectful of the person's life story. Person-centred care focuses all outcomes on the person's life – social, psychological, physical, cultural, sexual and spiritual – and provides the supports needed to maximize autonomy, choice and self-determination. A person-centred and empowering service is also manifest by the active involvement of the person in his/her own care and treatment, which respects the person's right to move forward at his/her*

[9] Application No. 36760/06, 17 January 2012

[10] [2009] 2 ILRM 149

*own pace. As recovery belongs to the service user, it is the service user who defines what recovery is and what it entails, in the context of their lives".*[11]

The Commission intends to make a substantive submission on the subject of Advance Healthcare Directives in response to the public consultation launched by the Department of Health on the 4th of February 2014.

## 5. Interface between the Bill and the MHA 2001

(1) Part 9 of the Bill is a cause for concern to the Commission for the reasons set out below:

*a) Panel of Independent Consultant Psychiatrists*

Section 66 of the Bill provides for the establishment of *"a panel of suitable consultant psychiatrists willing and able to carry out independent medical examinations for the purposes of this Part"*. The Commission already has in place two panels of consultant psychiatrists; one panel to conduct independent medical examinations under section 17 of the MHA 2001 and one panel to sit on Mental Health Tribunals.

In the case of both Part 9 of the Bill and the MHA 2001, these panel members are tasked with establishing whether an individual is suffering from a *"mental disorder*" as defined by the MHA 2001. In the circumstances, it is submitted that it may not be necessary to establish a third panel of consultant psychiatrists to perform the same task and the Commission is available to assist in any way it can.

*b) Review of detention orders in certain circumstances (approved centres)*

Section 68 of the Bill provides for the review of detention orders where a person is detained "*on the order of a wardship court"*. Subsections 2 and 3 provide for the continued detention of persons "*where the person concerned is suffering from a mental disorder"*. Again, pursuant to section 65, *"mental disorder"* has the meaning assigned to it by section 3 of the MHA 2001.

It appears that the effect of this provision is to create two separate and distinct reviewing mechanisms for persons detained in approved centres notwithstanding their being detained on precisely the same basis i.e. "*mental disorder"*.

Furthermore, the Commission submits that the protections afforded under the MHA 2001[12] are considerably more robust than those proposed by section 68 of the Bill, when each are examined in detail. If the Commission is correct in this submission, then section 68 may be vulnerable to constitutional challenge as currently drafted.

[11] A Recovery Approach within the Irish Mental Health Services A Framework for Development, Mental Health Commission (2008)

[12] MHA 2001, ss 17 and 18

c) *Review of detention orders in certain circumstances (non-approved centres)*

Section 69 of the Bill effectively replicates section 68 except that it deals with persons detained, on the grounds that they are suffering from a mental disorder, in "*non-approved centres*". However, this would appear to conflict with section 67 of the MHA 2001 which states:

*"**67**.-(1) Subject to sections 12 and 22, a person suffering from a mental disorder shall not be detained in any place other than an approved centre.*

*(2) Where, in relation to a centre, there is a contravention of this section, the person carrying on the centre shall be guilty of an offence."*

Thus, it would appear that section 69 of the Bill will need to be re-drafted in order to avoid this conflict.

(2) The Commission welcomes sections 27(8)[13] and section 41(7) of the Bill referring to section 69 of the MHA 2001 and the regulations made thereunder regarding seclusion and restraint.

(3) The Commission notes section 104 of the Bill.

(4) The Commission notes the use of the term "mental health facility" within the Bill[14] and suggests that same should be defined.

## 6. Informal decision-makers

The Commission notes sections 53 and 54 of the Bill in relation to informal decision-makers. The Commission recognises that these provisions have been carefully worded with a view to avoiding any potential for abuse. Nevertheless, the Commission has some concerns as to how broadly section 53(1) to (3) might be interpreted and submits that care will need to be taken to ensure that these provisions do not undermine the more formal arrangements proposed in the Bill.

## 7. Assessment of Capacity – a different approach?

While the intention of the Bill is to assist people to make their own decisions as far as possible, there will nevertheless be situations in which capacity will need to be assessed by an independent assessor having regard to section 3 of the Bill. This will be particularly so with respect to co-decision making and decision-making representatives. In such cases, the process begins with an application under section 14 of the Bill resulting in a declaration as to capacity being made by the Circuit Court pursuant to section 15. Section

[13] *"Subsections (5) to (7) shall not be construed to prejudice the generality of section 69 of the Mental Health Act 2001 or of rules made under that section"*

[14] ADM (Capacity) Bill 2013 ss 20, 24 and 40

30 provides that in making such a declaration the Circuit Court *"shall have all such powers as are necessary to assist it"* including directing the preparation of expert reports. Section 31 provides for a notification to the Public Guardian of any declarations or orders made under Part 4.

While there appears to be no difficulty in principle with this approach, the Commission would have some concerns about how it may work in practice when compared to the experience of Mental Health Tribunals.

For example, the Commission would be particularly concerned in relation to access to the Circuit Court across the country. The Commission has some relevant experience in this regard. Under section 19 of the MHA 2001, a patient may appeal the decision of a Mental Health Tribunal to affirm an admission order (or renewal order) to the Circuit Court on the grounds that the patient is not suffering from a mental disorder. This appeal must be brought within 14 days.[15] In order to be of benefit to the patient, this application must be afforded a hearing date within a short period of time. While every effort is made by the Courts Service to schedule early hearings, the Commission is aware that there is a disparity in the court lists to fix hearing dates depending on the part of the country in which the appeal has been filed. The Commission suggests that this might also prove to be the case with respect to applications brought under section 14 of the Bill.

Furthermore, and notwithstanding the terms of section 14 (10), the Commission would be concerned about whether it is appropriate to bring applications of this nature, on behalf of vulnerable persons, before a court in the first instance. There may also be considerable costs associated with these applications and the Commission notes that while legal aid is available under section 35, it will be subject to a financial qualification.

By way of comparison, the MHA 2001 provides for the patients' right to an automatic independent review of an involuntary admission. Within 21 days of an admission (or renewal) order, a three person mental health panel consisting of a lawyer as chair, a consultant psychiatrist and another person review the admission (or renewal order). Prior to the independent review, a legal representative is appointed by the Commission for each person admitted involuntarily (unless s/he proposed to engage one privately) and an independent medical examination by a consultant psychiatrist, appointed by the Commission, will have been completed.

In the view of the Commission, a system somewhat akin to the Mental Health Tribunal system may be more appropriate and might have a number of advantages over the Circuit Court. However, it would require some modifications. The Commission would respectfully suggest something along the following lines:

- Mental capacity review boards operating on the basis of contracts for service with the Office of Public Guardian. As per sections 48 and 49 of the MHA 2001, these boards would be independent of the Public Guardian and would have all necessary powers including the power to direct the preparation of expert reports and hear evidence;

[15] MHA 2001, s.19(2)

- They could be administered effectively by the Office of Public Guardian from a central base and without recourse to Circuit Court Offices/Registrars etc. around the country and they would be more cost effective as the board members would not be employees of the State and would be paid set fees which would be closely monitored by the Office of Public Guardian, the Department of Justice and Equality and the Department of Public Expenditure;
- They would afford equal access to applicants irrespective of their geographic location and they would be informal and inquisitorial and could take place in a cost neutral venue suitable to the applicant's needs.

It would still be possible for certain matters to be reserved for the Circuit Court or the High Court as is already contemplated in section 4(2) of the Bill.

In making the above suggestions, the Commission is cognisant of some of the recommendations made by the Richardson Committee in the UK[16] and the Law Reform Commission[17]. For example, the Richardson Committee stated:

> *" Following Who Decides? and Bournewood, it is most likely than an independent body will eventually be required to approve certain decisions in relation to long-term incapacitated adults. In considering the precise form of such a body we strongly recommend that early thought be given to the creation of a single 'tribunal' with sufficient expertise and flexibility to operate in relation to both mental disorder and long-term incapacity. There would be great advantage in concentrating expertise and administration in one body and, therefore, we recommend that if any new tribunal is established, this wider context be born in mind".* [18]

Similarly, the Law Reform Commission (LRC) examined a number of different decision-making body models in Ireland including Mental Health Tribunals and the Garda Síochána Ombudsman Commission and stated "*the Commission considers that either of these two models could provide the multi-disciplinary approach favoured by the Commission. Furthermore, both models provide an informal, non-intimidating approach to decision-making whilst maintaining procedural safeguards"*. Ultimately, the LRC recommended the establishment of "*a Guardianship Board composed of 3 full time members along the lines of the Garda Síochána Ombudsman Commission"* on the basis that "*such a body has the potential for greater speed in hearing cases and making determinations whilst maintaining the flexibility of sitting at different locations around the country*."[19]

The Commission submits that the model suggested above might prove more effective in satisfying the important criteria of expertise, flexibility, informality and speed emphasised by the Richardson Committee and the LRC.

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[16] Department of Health Report of the Expert Committee: Review of the Mental Health Act 1983 (1999)

[17] LRC83-2006 Report: Vulnerable Adults and the Law

[18] Department of Health Report of the Expert Committee: Review of the Mental Health Act 1983 (1999), para 5.73

[19] LRC83-2006 Report: Vulnerable Adults and the Law, para 6.39

## 8. Other issues

The Bill is a complex piece of legislation containing a large amount of cross-referencing between sections. It introduces terms such as appointer, relevant person, relevant decision, intervener, decision-making assistant agreement, co-decision making agreement and decision making representative. These terms are defined in the Bill. However, in many cases, these definitions are complicated and inter-dependent. The Commission believes these definitions may require considerable judicial scrutiny at Superior Court level before a clear understanding of them emerges.

The Bill may perhaps be overly prescriptive in parts. For example, sections 14, 15, 17 and 23 include detailed provisions for applications before the Circuit Court. Arguably, these provisions stray into territory which may be more appropriately dealt with in regulations. It is submitted that these provisions are unnecessary in primary legislation and may result in applicants having to grapple with form over substance.

The Bill seeks to cater for a broad spectrum of cases by providing for six separate categories of assistance. This is commendable. However, it may be unwieldy in practice. For example, under the Bill[20], it appears that a person may enter into a decision making assistance agreement in respect of one category of decisions and yet they may also have separate and distinct relationships with a co-decision maker, decision making representative and an attorney as long as the relevant decisions fall into separate categories and all of which will be overseen by the Public Guardian.

The Commission is of the view that every capacity case is unique and will have to be judged on its own facts. The Commission would argue for enabling provisions within the Bill which provided for fewer categories of assistance but a greater degree of flexibility within those categories and which would result in similar outcomes.

## 9. Conclusion

The Commission has endeavoured to be as forthright as possible having regard to its own knowledge and experience and is available to discuss any of these issues in further detail should that be of assistance.

10 February 2014

[20] ADM (Capacity) Bill 2013, ss 10(5) and 10(6)