NORTHERN IRELAND HUMAN RIGHTS COMMISSION

Response to DHSSPS consultation on the Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland

1. The Northern Ireland Human Rights Commission (the Commission) is a statutory body created by the Northern Ireland Act 1998. It has a range of functions including reviewing the adequacy and effectiveness of Northern Ireland law and practice relating to the protection of human rights,[1] advising on legislative and other measures which ought to be taken to protect human rights,[2] advising on whether a Bill is compatible with human rights[3] and promoting understanding and awareness of the importance of human rights in Northern Ireland.[4] In all of that work the Commission bases its positions on the full range of internationally accepted human rights standards, including the European Convention on Human Rights and Fundamental Freedoms (ECHR), other treaty obligations in the Council of Europe and United Nations systems, and the non-binding 'soft law' standards developed by human rights bodies.

2. The Commission welcomes the opportunity to comment on the proposed Legislative Framework for Mental Health in Northern Ireland. The revision of mental health legislation should assist in safeguarding the human rights of persons with mental disorders and subsequent services should be organised so that these rights can be fully protected. The Commission concurs with the construction of the legislation around the Bamford Review's principles of autonomy, justice, benefit and least harm.

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[1] Northern Ireland Act 1998, s.69(1).
[2] *Ibid.*, s.69(3).
[3] *Ibid.*, s.69(4).
[4] *Ibid.*, s.69(6).

3. The present consultation envisages separate legislation relating to mental health and mental capacity, with the aim of simultaneous enactment by April 2011. It is not apparent to the Commission that there is any advantage in proceeding along this 'twin-track' approach, with significant overlap in the content of the two Bills, rather than producing one comprehensive piece of legislation for mental health and capacity.[5] The Department has a unique opportunity to learn from the problems experienced in England, Wales and Scotland in harmonising the implementation of separate Acts.

4. The Commission notes the intention that the new legislation should apply, in respect of capacity, to those aged 16 and over (paragraph 4.2). It is not clear why this particular age has been chosen as a starting point. The UN Convention on the Rights of the Child, as the most comprehensive and almost universally accepted standard on children's rights, defines childhood as applying to those up to the age of 18. It is noted that the document refers at 5.6 to the Convention on the International Protection of Adults, an instrument developed by the Hague Conference on Private International Law which is applicable to adults from 18 years. On the other hand, domestic law has accepted the Gillick principle in relation to the capacity of children under 18 to consent to treatment, and that could presumably extend to such matters as power of attorney (para 5.1) or a 'nominated person' (para 9.1). The consultation document does not offer a rationale for selecting 16 years of age as a more meaningful boundary than either the age of majority, or Gillick competence, and the Commission would wish to be satisfied that the rights of persons were equally protected at all ages.

6. At paragraph 4.3, addressing mental capacity, the consultation document indicates that the legislation will contain a definition of 'impaired decision-making', and further at paras. 8.5-6, addressing mental health, the document refers to 'significantly impaired decision-making ability' as one of the criteria for authorised assessment and for intervention for medical treatment. Of course, any involuntary admission to hospital, or other measures depriving a person of liberty, must satisfy Article 5 of the European Convention on Human Rights (ECHR). Along with a clearly stated definition of 'impaired decision-making', detailed guidance will be needed as to how the criteria

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[5] The replacement of the 1986 Order with a single piece of legislation appeared to be the consensus of experts attending a seminar organised at the end of February 2009 by Law Centre NI.

for both assessment and intervention will be established as warranting detention.

7. At para 5.1, the proposed lasting power of attorney to cover not only financial but welfare concerns, and provision for a High Court-appointed deputy, are useful additional safeguards for the interests of persons lacking capacity. Also at 5.1, the reference to 'statutory recognition of the views of carers' raises issues as to how, where the 'nominated person' referred to at 9.1 is different from the carer, any conflict between the different parties is to be resolved.

9. The references at 5.1 to legal protection for those providing care for someone who lacks capacity provide the example 'restraint' being used on the basis that the person 'reasonably believes it is necessary'. Very precise guidance will be required to ensure that such provisions do not undermine the rights and dignity of the person who lacks capacity, and do not provide encouragement or cover for the violation of rights.

10. The document proposes at 5.4 the creation of an offence of ill-treatment or neglect of those who lack capacity, and indicates at 9.2 that the similar offence in respect of mental disorder, contained in the 1986 Mental Health (NI) Order, is to be reviewed. This is one instance where the benefit of a single provision in one Act, rather than two, is apparent. To the extent that 'neglect' as opposed to active maltreatment may arise from lack of resources, services and support in the community, it will be for the State to ensure that carers are genuinely enabled to provide the requisite standard of care to avoid liability for this offence.

11. The Commission welcomes the proposal at 5.2 for provision of 'enhanced advocacy services for those who lack capacity', and that at 9.1 in respect of mental health service users. These services need to be properly funded, organised and overseen, to ensure adequate, appropriately skilled and equitable provision across the region.

12. The Commission looks forward to the development of a new definition of 'mental disorder' as proposed at 8.1, so that those people suffering from personality disorder will receive the safeguards and protection of the new legislation. However it is noted that one rationale given for the new definition is to aid the transfer of service users to other jurisdictions 'if required'. For the progressive realisation of the right to the highest attainable standard of mental health, the Department should be

looking to the future development of specialist mental health services in Northern Ireland, and only transfer service users to other jurisdictions as a last resort.

14. With regard to the proposal at 8.3 to extend the authority for compulsory admission for assessment from 14 days to 28 days, with a review after 14 days by the Mental Health Review Tribunal, the Tribunal will need to be resourced to review cases expeditiously so as to ensure compliance with Article 5 ECHR. The Scottish Mental Health Tribunal, for example, provides a valuable service in the context of a 28-day assessment period, but has reportedly experienced considerable problems with workload, time delays and limited resources. The Tribunal will provide such an important function in safeguarding the rights of persons with a mental disorder that substantial resources will need to be allocated to this facility, and to advocacy services, for the legislation to work.

15. At para 8.7 the wider interpretation of medical treatment better reflects modern practice, and this complies with international human rights standards on mental health. However, the wider scope of activities related to medical treatment also has the potential to impact on the success of community-based care if mental health services become over-reliant on compulsory Community Treatment Orders (CTOs). The main focus should be on "making services in the community acceptable to people with mental disorders and investing effort and resources in engaging them in the services".[6] In order for CTOs to be effective, resources will be required to ensure that intensive community-based treatments are available for the small group of people that need them.

16. As Government addresses the implementation of the Bamford recommendations there has been a steady shift evident in several recent consultations from statutory provision of services to the 'independent' or private sector. In principle the Commission is in favour of more integrated community services, particularly in relation to mental health. However, the move from statutory to non-statutory provision raises concerns about the availability of the specific protection that, in statutory settings, is provided by the Human Rights Act 1998; and more generally in terms of human rights law, it complicates the accountability of the Department for its responsibility to respect, protect and fulfil human rights in Northern Ireland. The Commission would welcome the Department's views on

[6] World Health Organisation (2003), *Mental Health Legislation and Human Rights*, Geneva: WHO.

how the human rights obligations of the State can best be observed in the context of increased external commissioning of health services. To assist in that, the Commission now wishes to outline the international human rights standards that are especially relevant in the drafting of the legislation and should be reflected in the content of the Bill.

International human rights standards

17. As the primary duty-bearer the State is obliged to respect, protect and fulfil the rights enshrined in international human rights conventions and these should be taken into account when drafting mental health legislation. Relevant standards include the ECHR, and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), which provides a comprehensive statement (in Article 12) on the right to physical and mental health in international human rights law. The ICESCR was followed up by the UN Committee on Economic and Social Rights' General Comment No. 14 'On the right to the highest attainable standard of health' (2000), the most authoritative guide for States on the implementation of ICESCR.

18. The right to health is also recognised in other international and regional instruments,[7] and the UN Convention on the Rights of Persons with Disabilities is soon to be ratified by the UK Government. International human rights standards which reflect good practice in the field of mental health should also be considered, for example the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles), the Standard Rules for Equalisation of Opportunities for Persons with Disabilities (the Standard Rules), the Declaration of Caracas, the Declaration of Madrid and other standards, e.g. WHO's Mental health care law: ten basic principles, can usefully inform the content of mental health legislation"[8]. It should also be noted that the MI Principles specifically address the health care for prisoners under Principle 20, and also of note is the UN Body of

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[7] The right to health is also recognised, *inter alia*, in Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (1965), in Arts. 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979) and in Art. 24 of the Convention on the Rights of the Child (1989). Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (Art. 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Art. 10).

[8] WHO (2003).

Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by General Assembly resolution 43/173 of 9 December 1988. In Northern Ireland, the principle of equivalence of care for prisoners has not been properly observed.

18. The Commission looks forward to further opportunities to comment on the proposals for draft legislation in this field.

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