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Submission to the Department of Justice, Equality and Law Reform on the Scheme of the Mental Capacity Bill 2008

23 December 2009

Amnesty International Ireland (AI) has a long-term strategic goal of making real in Ireland Article 12 of the International Covenant on Economic, Social and Cultural Rights which states that *"every person has the right to the highest attainable standard of physical and mental health"*. AI is a membership-based campaigning organisation whose mission is to uphold and defend human rights and has been campaigning in the area of mental health in Ireland since 2002. AI strongly welcomes the Government's decision to conduct this long over-due reform of existing legislation and the Government's intention to ratify the International Convention on the Rights of Persons with Disabilities (CRPD). [1]

AI welcomes this opportunity to submit its observations on the Scheme of the Mental Capacity Bill 2008 (the Scheme) to the Department of Justice, Equality and Law Reform. The focus of this submission is on the Scheme as it relates to persons with mental health difficulties. AI's previous submission on the Scheme was sent to the Department on 25 February 2009.

AI has since conducted original, exploratory research with individuals who may be subject to this new legislation by reason of a mental health problem on their views about decision-making capacity. The report on this research is attached in Annex 1 to this submission and its results inform this submission. This research provides an important perspective on the lived experience for this complex issue. This submission was also informed by AI's Experts by Experience Advisory Group.*

AI would welcome the opportunity to meet with the Department to discuss in more detail the issues raised in this submission.

**In October 2008, AI established an advisory group of 'experts by experience' to assist in devising its campaign strategy and to provide policy advice. This group includes individuals who are at the forefront of the mental health movement in Ireland and who have direct experience of a mental health problem.*

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[1] The CRPD and the CRPD Optional Protocol were adopted during the 61st Session of the General Assembly: see GA Res. 61/611, 13 December 2006, A/61/611; 15 IHRR 255.

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Summary of AI Recommendations

- The Bill must address the interplay between its provisions and those of the Mental Health Act 2001. In order to comply with Article 12 CRPD the Mental Health Act 2001 must be amended to ensure that the functional and time-specific approach to capacity and the guiding principles and definition of 'best interests' set out in the Scheme apply equally to persons involuntarily admitted to approved centres under the provisions of the 2001 Act.

- In order to maximise the autonomy of persons with mental health problems, the role of substitute decision-makers such as personal guardians or donees of Enduring Powers of Attorney must be recognised by the Mental Health Act 2001.

- The Bill needs to provide appropriate safeguards for persons who lack capacity and are *de facto* deprived of their liberty in in-patient units or residential care, but do not fall within the scope of the protections provided by Mental Health Act 2001.

- The Bill must restrict the use of informal decision-making provisions to 'minor or routine' matters relating to health or personal welfare and if there is any question as to whether a particular decision is minor or not, such matter should be referred to the relevant Court of Care and Protection or Guardianship Board, as appropriate.

- Codes of Practice on informal decision-making need to be drawn up in consultation with rights holders and they need to be in place before the Bill comes into force.

- The Office of the Public Guardian should be given an express function to oversee the exercise of informal decision-making under the Bill.

- Medical professionals and others involved in care should be provided with training on the limits of informal decision-making powers.

- The role of family members should be clarified.

- The Bill should allow for a multi-disciplinary approach to all assessments of capacity.

- The Bill should require that person(s) making capacity assessments in the context of decisions relating to medical treatment are independent of treating clinicians, while encouraging consultation with those that know the individual well, including the treating clinician.

- Training should be provided to all persons involved in capacity assessments so that the functional approach to capacity is applied in practice in accordance with the guiding principles and best interests principles set out in the Scheme.

- The Bill should provide for regulations or a code of practice on supported decision-making and should ensure that there is consultation with people affected in the preparation of such regulations or code of practice.

- An independent mental capacity advocate service should be established, similar to that provided under the Capacity Act 2005 (England and Wales).

- The provisions on restraint (Head 11(7) and 48(5)) should also apply to informal decision-makers and carers and the word 'or' should be replaced with 'and' at the end of subparagraph (iii) in these provisions. These provisions should also be extended to

expressly state that mechanical restraint may never be used. As regards physical restraint, the Bill should reflect the standards set out in the Mental Health Commission Code of Practice on the Use of Physical Restraint. This should include *inter alia* that physical restraint should only be used for as long as necessary to prevent immediate and serious harm to the person. In addition the Bill should expressly state that physical restraint should only be used where verbal de-escalation has been tried and failed.

- The Bill will need to apply to young persons below the age of 18 years to the extent that they are entitled to make decisions on their own behalf according to the law as amended from time to time.

- The Bill should provide that all wards of court should have their cases automatically reviewed within a reasonable transitional time period. Where appropriate personal guardians should be appointed to manage the property and affairs of wards of court.

- The Bill should strengthen Guiding Principle 1(b) so that where a person is likely to regain capacity no intervention should take place unless it is necessary and cannot be postponed until the person in question is expected to regain capacity.

- Head 1(g) and Head 3(1)(iii) should expressly state that if a person has expressed prior wishes in relation to a form of treatment, such wishes must be respected and in exceptional cases where it is proposed to depart from a person's prior wishes, approval of the Court of Protection (or other appropriate body) is required. This may require regulations and a Code of Practice to be produced.

- Codes of Practice must be drafted as soon as possible and before the Bill is brought into force, in consultation with all relevant stakeholders, including in particular people with direct experience of mental health problems, their representative organisations and other groups most likely to be affected by their provisions.

- The Bill should provide for the establishment of a specialist Guardianship Board as recommended by the Law Reform Commission.

- The Bill should include necessary procedural safeguards in all hearings to adequately protect the rights of persons whose capacity is in question.

- The powers of the Office of the Public Guardian should be extended to include some form of oversight and supervision of the exercise of informal decision-making powers. A specific complaints procedure should also be set out in the Bill and the role of special and general visitors should be clarified.

- The Bill should require periodic reviews of the Act which should cover not only the operation or functioning of the Act but also whether the Act has succeeded in fulfilling the objectives and aims sought to be achieved by its passing into law.

Background: The Convention on the Rights of Persons with Disabilities

International human rights law is constantly evolving and the most recent statement of the rights of persons with disabilities, including persons with mental health problems, is the Convention on the Rights of Persons with Disabilities (CRPD). While Ireland has not yet ratified the CRPD, by signing the Convention it has indicated a clear intention to ratify in the future. The CRPD is seen as marking a 'paradigm shift' in how disability is perceived by moving towards a social model, which recognises that 'disability resides in society, not in the person'.[2] Its provisions on legal capacity are particularly relevant in the current context as the Department acknowledged in its Regulatory Impact Assessment on the Scheme when it stated that '[t]he next step towards ratification of the Convention is to ensure that Ireland complies with obligations under the Convention. The Mental Capacity Bill is one of the significant steps to facilitate the ratification process'.[3]

Article 12(2) of the CRPD expressly states that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'. The Convention then goes on to clarify and expand upon the measures States Parties are required to take to ensure that persons with disabilities may exercise their capacity to the fullest extent possible, while being safeguarded against abuse.

Article 12(3) requires States to put supports in place to assist persons with disabilities in making decisions for themselves, thereby maximising the autonomy of the person and placing substitute decision-making processes such as guardianship to the realm of last resort. In Article 12(4), the Convention calls for safeguards to be put in place to prevent abuse. It recognises that a lack of capacity does not equate with a loss of rights and demands that the rights, will and preferences of the person be respected. It also requires protections against conflicts of interest and undue influence, as well as requiring that any interventions on grounds of incapacity be proportionate, adapted to the individual's needs and applicable for the shortest possible time period, as well as being subject to regular review by a 'competent, independent and impartial authority or judicial body'.

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[2] United Nations *Disabilities – From Exclusion to Equality – Realizing the Rights of Persons with Disabilities* (2007United Nations, New York) 4.

[3] Available at:
http://www.justice.ie/en/JELR/Regulatory%20Impact%20Assessment.doc/Files/Regulatory%20Impact%20Assessment.doc.

Some specific concerns with the Scheme of the Mental Capacity Act 2008

Interplay between the Scheme and the Mental Health Act 2001

The issue of mental capacity is hugely relevant in the context of the Mental Health Act 2001, which deals with the involuntary admission, detention and treatment of persons with mental health difficulties. Firstly, the definition of 'mental disorder' in the 2001 Act includes a reference to impaired judgement of the person concerned. This would appear to be a reference to incapacity. Secondly, Part 4 of the Mental Health Act 2001 (Consent to Treatment) refers to capacity[4] in the definition of 'consent' for the purposes of that section. However, the Scheme is silent on how its provisions will operate vis-à-vis the Mental Health Act 2001.

Empirical studies have demonstrated that a sizeable majority of people with mental health difficulties, including persons diagnosed as having schizophrenia and clinical depression, are no less competent to make decisions regarding medical treatment than the general public.[5] Thus lack of capacity should not be assumed in individuals with a psychiatric diagnosis, even those undergoing inpatient care.[6] This point is reinforced by the CRPD, which requires as a starting point, a presumption of capacity. The recent ECHR case of *Shtukaturov v Russia* also confirmed that the existence of a mental disorder, even a serious one, cannot be the sole reason to justify full incapacitation.[7]

AI welcomes the fact that the Scheme adopts a functional and time specific approach to capacity and contains a presumption of capacity in line with the CRPD. However, AI is concerned that the Scheme does not address the important interplay between its provisions and those of the Mental Health Act 2001.

It is no longer acceptable for the State to allow persons diagnosed with a mental disorder to be treated differently than others, nor to allow their rights to be more readily interfered with. By emphasising the principles of non-discrimination and equality before the law, the CRPD requires the State to justify on objective grounds any interference with the rights of persons with disabilities, including persons with mental health difficulties.

Article 12(2) of the CRPD requires States Parties to recognise "that persons with disabilities [including persons who experience mental health difficulties] enjoy legal capacity *on an equal basis with others in all aspects of life*".[8] Accordingly, if Ireland is to comply with Article 12 of the CRPD, it is crucial that the presumption of capacity, and the time-specific and issue-specific functional approach to capacity and the guiding principles and definition of

[4] It uses the phrase 'capable of consenting' rather than capacity.
[5] T Grisso and P Appelbaum 'The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments' (1995) 19(2) Law and Human Behaviour 149, cited in P Bartlett, O Lewis and O Thorold *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers, Leiden 2007) 152.
[6] See more detailed discussion in capacity research report attached at Annex 1.
[7] Case no. 44009/05 27 March 2008. This case involved a man with a history of mental health problems whose mother had applied for him to be subject to guardianship without his knowing and had then had him admitted to psychiatric institution. The Court confirmed that the existence of a mental disorder, even a serious one, cannot be the sole reason to justify full incapacitation – the 'mental disorder' must be 'of a kind or degree' warranting such a measure. The Court went on to refer to the principles formulated in Recommendation No. R (99)4 of the Committee of Ministers of the Council of Europe, which while they do not have the force of law, define a common European standard in this context. Contrary to these principles, the Russian legislation did not provide for a 'tailor-made response' and as a result the applicant's rights were limited more than strictly necessary.
[8] Emphasis added.

'best interests' set out in the Scheme (which seek to promote the autonomy of the individual to the greatest extent possible) apply equally to all persons, including those involuntarily admitted to approved centres under the provisions of the 2001 Act.

In addition, in order to maximise the autonomy of persons disabled by a mental health problem, the role of substitute decision-makers such as personal guardians or donees of an Enduring Power of Attorney must be recognised by the Mental Health Act 2001. It seems from a review of the mental health laws in civil law jurisdictions in Europe that they give a greater role to substitute decision-makers (usually guardians) in decisions about treatment where a person is found to lack capacity.[9] Respecting the past and present wishes of the person as to who should make important decisions on their behalf where they lack capacity is an important means by which the law can maximise the autonomy of the individual.

RECOMMENDATION: *The Bill must address the interplay between its provisions and those of the Mental Health Act 2001. In order to comply with Article 12 CRPD the Mental Health Act 2001 must be amended to ensure that the functional and time-specific approach to capacity and the guiding principles and definition of 'best interests' set out in the Scheme apply equally to persons involuntarily admitted to approved centres under the provisions of the 2001 Act.*

In order to maximise the autonomy of persons with mental health problems, the role of substitute decision-makers such as personal guardians or donees of Enduring Powers of Attorney must be recognised by the Mental Health Act 2001.

Deprivation of Liberty Provisions

The European Court of Human Rights has stressed that the situation of vulnerability and powerlessness of persons detained in mental health institutions requires special vigilance on the part of the authorities.[10] This requirement for 'special vigilance' applies both to persons detained under the formal provisions of the Mental Health Act 2001 and those 'voluntary' patients who are in fact detained.

It is possible that a substantial number of people who are 'voluntarily' admitted to approved centres (within the meaning of the Mental Health Act 2001) and other in-patient/residential care settings are *de facto* detained, that is deprived of their liberty. The reality for these 'voluntary' patients who lack the capacity to consent to their admission is that if they attempted to leave the hospital or care setting, they would be prevented from doing so. However because, for whatever reason, they are not formally detained under the Mental Health Act 2001, they do not have the benefit of safeguards such as automatic reviews of their detention by Mental Health Tribunals under that Act. It seems that while they do not have the capacity to consent to admission, such persons are often admitted as voluntary patients because they do not object to admission (so called 'Bournewood' cases or compliant incapacitated patients).[11] According to Mary Donnelly, Lecturer in Law at University College Cork, statistics are not available as to how many 'voluntary' patients in approved centres in Ireland lack capacity to consent to admission. Donnelly states that '[I]t is probable that a high

[9] Dawson and Kämpf 'Incapacity Principles in Mental Health Laws in Europe' (2006) 12(3) Psychology, Public Policy and Law 310-331
[10] See *Herczegfalvy v Austria* (1992) 15 E.H.R.R. 437.
[11] See G Richardson 'Coercion and Human Rights: A European Perspective' (2008) 17(3) Journal of Mental Health 245, 247.

proportion of these patients are voluntary only in the sense that they do not object to admission'.[12]

The European Court of Human Rights held in the case of *HL v The United Kingdom*[13] that where a patient who lacked capacity to consent to admission was *de facto* deprived of his or her liberty (as is the case where a compliant incapacitated patient would be prevented from leaving if he/she attempted to do so), the processes under the English common law did not comply with Article 5(1). A more formal process for the detention of such patients was required. This has led to the recent introduction of the Deprivation of Liberty Safeguards in the England and Wales in April of this year.[14] Mary Donnelly has commented that the framework established by the UK Deprivation of Liberty Safeguards is complex and 'arguably … yields little in terms of actual protections, especially in relation to treatment and care decisions for the person once she has been admitted'. Accordingly, she cautions against adopting the same approach in Ireland. Donnelly concludes:

> The important point is that some form of appropriate procedure is required in order to protect the right to liberty of people lacking capacity and, if only to comply with the requirements of Article 5 ECHR, this issue must be addressed in capacity legislation.[15]

Accordingly, it is clear that the Bill needs to provide safeguards for persons who lack capacity, but while they do not fall within the criteria for detention under the Mental Health Act 2001, are *de facto* deprived of their liberty. These provisions must comply with the European Convention on Human Rights[16] (ECHR) and other applicable international human rights law, including in particular the CRPD. Accordingly they must ensure that any such deprivation of liberty is not arbitrary, is proportionate to its legitimate aim, is for the shortest period necessary and is reviewed periodically by an independent body.

RECOMMENDATION*: The Bill needs to provide appropriate safeguards for persons who lack capacity and are de facto deprived of their liberty in in-patient units or residential care, but do not fall within the scope of the protections provided by Mental Health Act 2001.*

Informal decision-making

While AI acknowledges the need for provisions allowing for informal decision-making to reflect the day-to-day reality for carers, AI has serious concerns about the scope of the informal decision-making provisions as currently set out in Head 16 of the Scheme. While the Scheme assigns jurisdiction to the Circuit and High Courts[17] to decide questions of capacity (Head 5), it does not require that the Court assess a person's capacity in all circumstances. Thus it seems that many assessments of capacity and decisions on behalf of persons who lack capacity would fall under the 'informal decision-making' provisions. Under those provisions a person involved in the care and treatment of another person whose decision-making

[12] M Donnelly 'Legislating for Incapacity: Developing a Human Rights-Based Framework' (2008) 30 Dublin University Law Journal 395, 401.
[13] Application No. 45508/99 judgment of the European Court of Human Rights, 5 October 2004.
[14] See section 50 of the Mental Health Act 2007, which inserts additional provisions into the Capacity Act 2005.
[15] See M Donnelly Op Cit (2008) 433.
[16] Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950 CETS 005.
[17] to be known as the Circuit and High Courts of Care and Protection.

capacity is in doubt is effectively tasked with assessing capacity and deciding the best course of action, except in the limited circumstances set out in Head 17 (Heads 16 and 17).[18]

While the Scheme requires informal decision-makers to act in accordance with the Guiding Principles and in the person's best interests (as per Head 3 of the Scheme), it appears that the Scheme leaves it largely to codes of practice to determine the criteria for invoking formal court assessments of capacity and substitute decision-making procedures, including in the context of decisions regarding medical treatment.

Recommendation 99(4) of the Council of Europe foresees informal procedures being used *only* in the case of 'minor or routine' decisions relating to health or personal welfare.[19] If the scope of the informal decision-making provisions of the Bill is not clearly limited to minor or routine matters, there is a real risk that the Bill will not comply with this Council of Europe Recommendation. Furthermore this may lead to an unacceptable situation whereby only decisions relating to property and financial affairs of the incapacitated person will require an independent and thorough hearing as to the person's capacity and who should be tasked with making decisions on their behalf, whereas important decisions regarding such matters as where the person should live or what treatment they should receive would be left to be dealt with under informal mechanisms, which by their nature are less likely to safeguard the rights and interests of the individual.

AI acknowledges that the Bill must seek to strike a balance between the need to protect the rights and interests of persons who lack capacity and the need to avoid over-formalising the capacity process to the extent that it becomes unworkable. However, AI is strongly of the view that some situations, including in particular significant healthcare decisions, require a greater degree of control and supervision than is contemplated by the Scheme.[20]

It is instructive at this juncture to re-iterate the requirements of Article 12(4) CRPD, particularly with reference to protection from abuse, which provides:

> States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective *safeguards* to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity *respect the rights, will and preferences of the person*, *are free of conflict of interest and undue influence*, are *proportional and tailored to the person's circumstances*, apply for the shortest time possible and are *subject to regular review by a competent, independent and impartial authority or judicial body*. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.[21]

It is difficult to see how broad informal decision-making powers could comply with the requirements of Article 12(4). In particular, such informal mechanisms could involve conflicts of interest (where the treating clinician is essentially wearing two hats, that of the

[18] Head 17 provides that an informal decision-maker is not authorised to do any act which (a) would require a court order or (b) would conflict with a decision of a donee of an EPA or a personal guardian. Major healthcare decisions concerning non-therapeutic sterilisation, withdrawal of artificial life-sustaining treatment and organ donation are confined to the jurisdiction of the High Court under Head 21. However, it is not clear to what extent informal capacity assessments and substitute decision-making are otherwise regulated by the Scheme.
[19] Recommendation No. R(99) 4, adopted by the Committee of Ministers on 23 February 1999, Principle 2(8). Emphasis added.
[20] See also M Donnelly Op Cit (2008) 426.
[21] Emphasis added.

treating clinician and that of the substitute decision-maker). While the Office of the Public Guardian could and should be given an express function to oversee the exercise of informal decision-making under the Bill, it is difficult to envisage how broad informal decision-making powers could be subjected to adequate review as required by the CRPD.

It is critical that the Bill restricts the use of informal procedures to ‘minor or routine’ matters relating to health or personal welfare and if there is any question as to whether a particular decision is minor or not, such matter should be referred to the relevant Court of Care and Protection or Guardianship Board, as appropriate.

RECOMMENDATIONS: *The Bill must restrict the use of informal decision-making provisions to ‘minor or routine’ matters relating to health or personal welfare and if there is any question as to whether a particular decision is minor or not, such matter should be referred to the relevant Court of Care and Protection or Guardianship Board, as appropriate.*

Codes of Practice on informal decision-making need to be drawn up in consultation with rights holders and they need to be in place before the Bill comes into force.[22]

The Office of the Public Guardian should be given an express function to oversee the exercise of informal decision-making under the Bill.

Medical professionals and others involved in care should be provided with training on the limits of informal decision-making powers.[23]

The role of family members should be clarified.

Who should assess capacity?

Where an application has been made to the Court of Care and Protection, it will make a declaration as to whether a person lacks capacity to make a specified decision or decisions. In carrying out such assessments of capacity, the Court may ‘request expert reports for the court by such experts as it considers necessary, whether medical (including reports concerning cognitive ability), social and health care (including care in the community) or financial (including reports on valuation of property)’ (Head 13). Thus, where the Court is tasked with assessing capacity, a multidisciplinary approach is provided for.

However, in situations where no application has been made to the Court of Care and Protection, the Scheme does not specify who should be tasked with assessing capacity.

The Research Report shows that participants had a strong preference for a neutral party to conduct capacity assessments. Indeed four participants expressed concern that the power inequality between patients and mental health professionals would impact on the assessment of a person’s capacity.[24]

There is also some acknowledgement in the literature of potential bias by mental health professionals in carrying out capacity assessments. Among a small group of service users and carers, Manthorpe, et al. found that there was concern that professionals would not be able to

[22] Discussed in further detail later.
[23] Discussed in further detail later.
[24] Research Report p 44.

live up to the ideal of a presumption of capacity.[25] In their study of the reliability of the MacArthur Assessment Tool for Competence to Treatment, Cairns, et al. acknowledged that there was probably a bias towards finding that the patient had capacity where the patient agreed with treatment.[26] Okai's systematic review of capacity in inpatients with mental health problems found a higher likelihood that clinicians would find patients have capacity and speculated that this was due to clinicians presuming capacity where the patient agrees with treatment.[27] Significantly, US law generally requires that the capacity assessment must be carried out by someone other than the patient's own doctor.[28] Furthermore, Dawson and Kämpf make the point that the move to the functional approach (and the move away from a status approach that was dependent on the existence of 'mental disorder') potentially means that psychologists as well as psychiatrists will have a role in assessments of capacity.[29]

While the views of those who know the individual concerned well, including the individual's treating clinician, can assist in producing an accurate assessment, there is a need to ensure the independence of the capacity assessment process. The need for such an approach is reinforced by the requirement of Article 12(4) CRPD that measures relating to the exercise of legal capacity be free of conflict of interest.

In order to address these concerns AI would urge the Department to amend the Scheme so as to ensure that the person who carries out the capacity assessment in the context of decisions relating to medical treatment is independent from the treating clinician, while allowing for consultation between the assessor and the treating clinician. This approach should be followed save in emergency circumstances where life-saving treatment is required. This should apply to any informal capacity assessments under the Bill where the decision concerned relates to medical treatment, and to capacity assessments under the Mental Health Act 2001. Also, the multi-disciplinary approach set out in the Scheme in relation to formal assessments of capacity by the Court of Care and Protection should apply to all capacity assessments in relation to medical treatment.

RECOMMENDATION: *The Bill should allow for a multi-disciplinary approach to all assessments of capacity.*

The Bill should require that person(s) making capacity assessments in the context of decisions relating to medical treatment are independent of treating clinicians, while encouraging consultation with those that know the individual well, including the treating clinician.

Training

There is no doubt that assessments of capacity are difficult and require specific skills and training. Grisso and Appelbaum describe capacity assessment as 'one of the most challenging

[25] Manthorpe, JJ Rapaport and N Stanley (2008) 'Expertise and Experience: People with Experiences of Using Services and Carers' Views of the Mental Capacity Act 2005', *British Journal of Social Work* 1-17.
[26] R Cairns, C. Maddock, A. Buchanan, A.S. David, P. Hayward, G. Richardson, G. Szmukler and M. Hotopf (2005) 'Reliability of Mental Capacity Assessments in Psychiatric In-Patients', *British Journal of Psychiatry* 187:372-378.
[27] D Okai, G Owen, H McGuire, S Singh, R Churchill and M Hotopf (2007) 'Mental Capacity in Psychiatric Patients: Systematic Review', *British Journal of Psychiatry* 191:291-7.
[28] M Donnelly 'Treatment for Mental Disorder: The Mental Health Act 2001, Consent and the Role of Rights' (2005) 40 Irish Jurist 220, 233.
[29] Dawson and Kämpf, Op Cit 326.

tasks facing clinicians today'.[30] Without a doubt it requires specific training, in particular to ensure that in practice assessments adopt a functional approach – which is quite a change from the status or outcome approaches often adopted to date.

RECOMMENDATION: *Training should be provided to all persons involved in capacity assessments so that the functional approach to capacity is applied in practice in accordance with the guiding principles and best interests principles set out in the Scheme.*

Supported Decision-Making and Substitute Decision-Making as a Last Resort

AI welcomes the fact that the Government has acknowledged the need for access to supports where required to exercise capacity in its Regulatory Impact Assessment on the Scheme. This is in line with Article 12 of the CRPD, which places an obligation on States Parties to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". However, the Scheme does not fulfil this objective and as proposed, would not adequately meet the requirements in the CRPD to ensure the availability of appropriate supports for decision-making

While the Scheme touches on the concept of supported decision-making under the Guiding Principles and Best Interests Heads, where for example "a person shall not be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success", its main focus is on systems of substitute decision-making. The Scheme does not set out a framework for supported decision-making and accordingly fails to adequately protect the right of the individual to autonomy and self-determination in accordance with Article 12 of the CRPD. A system of supported decision-making would also help to underpin that section of the proposed capacity definition, which refers to a person communicating his or her decision by "any other means" in so far as this could include communicating through the assistance of an advocate or other person. The Bill should be expanded to provide for Regulations or Codes of Practice on supported decision-making.

The appointment of an independent advocate would be one obvious method of providing support in decision-making. Arguably this would prevent or at least minimise subsequent challenges to capacity decisions where these were brought on the grounds that the individual did not have the maximum opportunity to demonstrate that he or she had capacity. It should not be assumed that the advocacy service provided for under the Citizens Information Act 2007, if and when implemented, will necessarily be sufficient for the purposes of the capacity legislation.[31] It would be preferable to insert provisions similar to sections 35-41 of the Capacity Act 2005 (England and Wales), which require that where there is no-one to support the individual in their decision-making (other than someone engaged in providing care or treatment for the person lacking capacity in a professional capacity or for remuneration) and a serious decision has to be made for that person regarding the administration of serious medical treatment or the provision of residential accommodation, an independent mental capacity advocate (IMCA) must be appointed to them. The function of the IMCA is to ensure the fullest possible participation of the person lacking capacity in the decision-making process. This includes obtaining relevant information, ascertaining the person's wishes, beliefs and values, ascertaining alternative courses of action and, if relevant, obtaining further medical opinions regarding treatment.[32] The Bill should make provision for independent

[30] T Grisso and P Appelbaum *Assessing competence to consent to treatment* (Oxford University Press NewYork 1998) v. cited in Dawson and Kämpf 326.
[31] For a discussion of the different approach required in relation to capacity advocates see M Donnelly Op Cit. (2008) 434.
[32] Section 36(2) Mental Capacity Act 2005 (England and Wales).

support persons to be available to assist individuals to make decisions. In the context of the current economic constraints, this could be developed on a gradual basis starting with those individuals who face decisions in relation to their property, financial affairs or medical care and who do not have any individual within their relationship circle to provide such support.

Some persons may prefer a more informal form of support and mechanisms that would allow for this also need to be considered. It is also important that safeguards be included to avoid abuse and that the legal obligations of those providing support be clarified in accordance with Article 12(4) of the CRPD.

It is our understanding that other jurisdictions, in addition to the UK, (and in particular the province of British-Columbia in Canada)[33] are making progress towards incorporating supported decision-making into their laws, policy and practice and AI believes that valuable lessons could be learned from experts in those jurisdictions. The Swedish organisation PO-Skåne provides a 'personal ombudsman' service to support people with mental health problems in decision-making. This service primarily offers supported decision-making for people with severe mental health problems and maintains long term relationships with its clients, based on mutual trust and strict confidentiality.[34] The Irish Government should look into ways in which similar services could be made available in Ireland.

RECOMMENDATION: *The Bill should provide for regulations or a code of practice on supported decision-making and should ensure that there is consultation with people affected in the preparation of such regulations or code of practice.*

An independent mental capacity advocate service should be established, similar to that provided under the Capacity Act 2005 (England and Wales).

Use of force/restraint – the role of rights

While it is undoubtedly positive that Article 12 of the CRPD and accordingly the Scheme has created a focus on the autonomy rights of the individual, it is important that sight is not lost of the importance of the other rights of persons with disabilities, which continue to exist even in cases where they lack the capacity to make certain decisions about their lives.[35]

The rights to dignity, privacy and bodily integrity are central to the CRPD and are reinforced by the provisions of the MI Principles and Council of Europe Recommendation 2004(10).[36] In

[33] See *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities (Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol)* UN/UNOHCHR/IPU Handbook No. 14-2007, page 90, available at http://www.un.org/disabilities/documents/toolaction/ipuhb.pdf accessed on 20 February 2009.

[34] See presentation by Maths Jesperson to the EFC/EDF Symposium on the legal capacity of persons with disabilities in light of the UN Convention on the Rights of Persons with Disabilities, held on 4 June 2009 (available at: http://www.efc.be/ftp/public/Disability/Consortium/lectures%20papers/PO-Sk%C3%A5ne%20and%20supported%20decision-making.doc).

[35] So, for example, the European Court of Human Rights has found that a person does not have to be legally capable to feel degraded within the meaning of Article 3 ECHR (*Herczegfalvy v Austria* (1992) 15 E.H.R.R. 437). Similarly in *Glass v UK* ((2004) 39 EHRR 15), the Court found that the right of physical integrity (Article 8 ECHR) is not restricted to people with capacity.

[36] CRPD: Article 3 (General Principles), Article 15 (prohibition on torture or to inhuman or degrading treatment), Article 17 (respect for physical and mental integrity on an equal basis with others) and Article 22 (right to respect for privacy). MI Principles 1(2), 1(3), 13(1)(b), 14(1)(a), 18(7),. Council of Europe Recommendation 2004(10) Articles 1(1), 11(2)(i), 32(3), 37(3)(1).

the case of *Storck v Germany*[37] the European Court held that Article 8 (right to privacy) was breached by the administration of medication to the applicant against her will while she was detained in a private psychiatric hospital. Whether or not the patient had capacity was not central to the court's decision. Rather its finding made clear that treatment cannot be imposed against a person's will simply because they lack capacity.[38]

Thus, safeguards must be in place to ensure that the person's rights to dignity, privacy and personal integrity are fully protected.

AI welcomes the provision in the Guiding Principles of the Scheme that 'due regard must be given to the need to respect the right of a person to his or her dignity, bodily integrity, privacy and autonomy' and the statement that 'regard must be taken of the views of the person's past and present wishes …'. AI also acknowledges the provisions of Heads 11(7) and 48(5) (applicable to personal guardians and donees of enduring powers of attorney respectively) which place restrictions on the use of restraint. AI notes that where these provisions state that "the act is a proportionate response to the likelihood of the donor suffering harm ***or*** the seriousness of that harm" the word 'or' should be replaced with 'and'. Furthermore these provisions should also be inserted into the restrictions on informal decision-makers, as is the case under section 6 of the Mental Capacity Act 2005 (England and Wales). These provisions should also be extended to expressly state that mechanical restraint may never be used. As regards physical restraint, the Bill should reflect the standards set out in the Mental Health Commission Code of Practice on the Use of Physical Restraint. This should include *inter alia* that physical restraint should only be used *for as long as necessary* to prevent *immediate and serious* harm to the person. In addition the Bill should expressly state that physical restraint should only be used where verbal de-escalation has been tried and failed.

RECOMMENDATION: *The provisions on restraint (Head 11(7) and 48(5)) should also apply to informal decision-makers and carers and the word 'or' should be replaced with 'and' at the end of subparagraph (iii) in these provisions. These provisions should also be extended to expressly state that mechanical restraint may never be used. As regards physical restraint, the Bill should reflect the standards set out in the Mental Health Commission Code of Practice on the Use of Physical Restraint. This should include inter alia that physical restraint should only be used for as long as necessary to prevent immediate and serious harm to the person. In addition the Bill should expressly state that physical restraint should only be used where verbal de-escalation has been tried and failed.*

Children and Young People

As the Department will be aware, the Law Reform Commission has just published a consultation paper entitled Children and the Law: Medical Treatment[39], which makes provisional recommendations to reduce the age of consent to medical treatment below 18 years. To the extent that the age of consent for healthcare decisions is reduced below 18 years, the capacity law will need to reflect this.

RECOMMENDATION: *The Bill will need to apply to young persons below the age of 18 years to the extent that they are entitled to make decisions on their own behalf according to*

[37] European Court of Human Rights Application No 61603/00, judgment 16 June 2005.
[38] See: M Donnelly 'From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights' in B McSherry (Editor) *International Trends in Mental Health Laws* (Law in Context Special Issue, Federation Press, NSW, 2008), 37-57,56. See also M Donnelly Op.Cit. (2008) 421.
[39] Available at http://www.lawreform.ie/.

the law as amended from time to time.

Wards of Court

If the wards of court system is to be effectively abolished and replaced by the guardianship system set out in the Bill, then, in addition to having any detentions of existing wards of court automatically reviewed under the Bill, all existing wards of court should automatically have their capacity reviewed under the Bill and should have personal guardians appointed to manage their property and/or personal affairs, where appropriate.

RECOMMENDATION: *The Bill should provide that all wards of court should have their cases automatically reviewed within a reasonable transitional time period. Where appropriate personal guardians should be appointed to manage the property and affairs of wards of court.*

Other steps to strengthen the Guiding Principles and Best Interests provisions

Where lack of capacity is temporary

A number of participants in the research referred to the often temporary nature of incapacity experienced by persons with mental health problems. As currently drafted Head 1(b) of the Scheme states that 'no intervention is to take place unless it is necessary having regard to the needs and individual circumstances of the person, including whether the person is likely to increase or regain capacity'.

The UN Special Rapporteur on the Right to Health Mr Anand Grover stated in his most recent report that '[i]n the absence of a proxy, if a person is authoritatively judged not to have legal capacity due to a transitory physical or mental state such as unconsciousness, a health-care provider may resort only to a life-saving emergency procedure, and only in the absence of a clear prior or immediate indication of refusal'.[40] This suggests that in order to comply with international law, if a person is likely to regain capacity, treatment should not be administered without consent unless it is necessary and cannot be postponed until the person is expected to regain capacity. Head 1(b) of the Scheme could be strengthened to expressly state that no intervention should take place if it can be postponed until the person in question is expected to regain capacity.

Past and present wishes of the person

AI welcomes the fact that the both the Guiding Principles (Head 1(g)) and the "Best Interests" provisions (Head 3(1)(iii)) of the Scheme require that the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him or her when he or she had capacity) be considered insofar as they are reasonably ascertainable. However, it is our view that this provision does not go far enough to promote the autonomy of the person and the Bill should expressly provide that the person's wishes must be respected and in exceptional cases where it is proposed to depart from a person's prior wishes, approval of the Court of Protection (or other appropriate body) is required.

[40] Report of the Special Rapporteur on the right to the highest attainable standard of physical and mental health UN Doc. A/64/272 (10 August 2009) para 29.

RECOMMENDATIONS: *The Bill should strengthen Guiding Principle 1(b) so that where a person is likely to regain capacity no intervention should take place unless it is necessary and cannot be postponed until the person in question is expected to regain capacity.*

Head 1(g) and Head 3(1)(iii) should expressly state that if a person has expressed prior wishes in relation to a form of treatment, such wishes must be respected and in exceptional cases where it is proposed to depart from a person's prior wishes, approval of the Court of Protection (or other appropriate body) is required. This may require regulations and a Code of Practice to be produced.

Codes of Practice

AI notes that Head 39 of the Scheme provides for the preparation of Codes of Practice by the Public Guardian to provide guidance to relevant persons in applying the provisions of the legislation. Given the importance of such Codes of Practice, it is imperative that they be drafted well in advance of the Bill being brought into force, so that the Codes of Practice can be subject to the necessary scrutiny and discussion by all relevant stakeholders.[41] It is crucial that the Public Guardian consults widely with all relevant stakeholders in preparing such Codes of Practice, including in particular, people with direct experience of mental health problems, their representative organisations and other groups most likely to be affected by their provisions.

RECOMMENDATION: *Codes of Practice must be drafted as soon as possible and before the Bill is brought into force, in consultation with all relevant stakeholders, including in particular people with direct experience of mental health problems, their representative organisations and other groups most likely to be affected by their provisions.*

[41] See M Donnelly Op Cit. (2008) 437.

Other concerns raised in AI's first submission

In addition to the issues discussed above, AI also wishes to reiterate to the Department some of the other concerns with the Scheme which were highlighted in AI's first submission in February 2009.

Guardianship Board/Court

Structure, composition, sitting arrangements and location

Recommendation 99(4) of the Committee of Ministers of the Council of Europe to Member States on Principles concerning the Legal Protection of Incapable Adults requires that there should be "fair and efficient procedures for the taking of measures for the protection of capable adults".[42]

AI strongly urges that the Bill be drafted so as to provide for the establishment of a multi-disciplinary Guardianship Board in accordance with the recommendations of the Law Reform Commission in their report on *Vulnerable Adults and the Law*[43]. The Court system is already overburdened and inaccessible and is an inappropriate setting for decisions in relation to capacity under the legislation. It is our understanding that specialist court systems used in other jurisdictions, such as the Court of Protection system in the UK, are more akin to specialist tribunal systems, which in practice is very different from the ordinary Courts contemplated by the Scheme. The establishment of a multi-disciplinary Guardianship Board would provide the flexibility required to give effect to the time-specific and issue-specific functional approach to capacity adopted by the Scheme; it is difficult to envisage how this will be achieved if the ordinary Courts are given primary jurisdiction under the legislation.

AI notes that the Government has cited additional costs as one of the main reasons for choosing not to establish a specialised tribunal. AI urges the Department to take note of the opinions expressed by the Law Reform Commission and the Law Society of Ireland that the use of the ordinary Courts would lead to greater delay and expenditure in the long run than the establishment of an efficient specialist Guardianship Board.

AI also echoes the recommendation of the Law Society of Ireland that the Bill should provide that the specialist court or tribunal may sit at any place, on any day and at any time.[44] Such flexibility is essential if a functional approach to capacity is to become a reality.

RECOMMENDATION: *The Bill should provide for the establishment of a specialist Guardianship Board as recommended by the Law Reform Commission.*

Procedural Safeguards

Recommendation 99(4) of the Committee of Ministers on Principles concerning the Legal Protection of incapable Adults calls for "adequate procedural safeguards to protect the human rights of the persons concerned and to prevent possible abuses".[45]

[42] Principle 7(1).
[43] Law Reform Commission *Report: Vulnerable Adults and the Law* LRC 83-2006, 8.51.
[44] Submission by the Law Society of Ireland to the Department of Justice, Equality and Law Reform on the Scheme of the Mental Capacity Bill 2008, available at http://www.lawsociety.ie/documents/committees/lawreform/Submission_Mental_Capacity_Bill_260109.pdf, accessed on 20 February 2009.

As has been highlighted in a number of other submissions already made to the Department, some of the provisions of the Scheme relating to procedures for hearings are a cause of concern.[46] In particular, AI calls on the Department to amend Head 9(5), 9(6) and Head 13 to provide for the following in the Bill: -

- All persons whose capacity is contested should be given an express right to legal representation, both at the initial proceedings where the presence or absence of capacity is determined and at all subsequent applications, including applications for review of capacity decisions. This is necessary to comply with the requirements of Article 6(1) ECHR and Principle 1(6) of the MI Principles.
- The person whose capacity is in question should be entitled to attend the hearing save in the most exceptional circumstances, which should be clearly stated in the Bill. Moreover, the specialist court/tribunal should not be empowered to dispense with a full hearing save in limited circumstances to be specified in the Bill. These protections are essential safeguards required by the jurisprudence of the European Court of Human Rights and other international human rights law and standards, including Principle 13 of the Principles of the Committee of Ministers of the Council of Europe Concerning the Legal Protection of Incapable Adults[47].
- The person whose capacity is in question should also be given the opportunity to challenge any expert reports or other evidence brought before the hearing and to present their own evidence whether medical or otherwise.

RECOMMENDATION: *The Bill should include necessary procedural safeguards in all hearings to adequately protect the rights of persons whose capacity is in question.*

Office of the Public Guardian

AI welcomes the establishment of the Office of the Public Guardian whose main functions shall include the supervision of personal guardians and donees of enduring powers of attorney. The powers of the Public Guardian should be extended to include some form of oversight and supervision of the exercise of informal decision-making powers. In our view, the Office of the Public Guardian should also be given a similar function in respect of persons providing support in decision-making. AI queries whether the reporting obligations which apply to Personal Guardians and Donees of Enduring Powers of Attorney under the Scheme are adequate and would ask the Department to clarify these obligations and to consider whether more detailed regulations are required in this regard.

A specific procedure for complaints to be made to the Public Guardian concerning the exercise of substitute or supported decision-making roles should also be established under the Bill.

Furthermore, the Scheme is quite unclear as to the role of special and general visitors, which needs to be clearly defined in the Bill.

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[45] Recommendation No. R(99) 4, adopted by the Committee of Ministers on 23 February 1999, Principle 7(2).
[46] See: Irish Human Rights Commission Observations on the Scheme of the Mental Capacity Bill 2008, November 2008, available at http://www.ihrc.ie/documents/article.asp?NID=272&NCID=6&T=N&Print, accessed on 23 February 2009 and Submission by the Law Society of Ireland referred to at note 15 above.
[47] Recommendation No. R(99) 4, adopted by the Committee of Ministers on 23 February 1999.

RECOMMENDATION: *The powers of the Office of the Public Guardian should be extended to include some form of oversight and supervision of the exercise of informal decision-making powers. A specific complaints procedure should also be set out in the Bill and the role of special and general visitors should be clarified.*

Exclusion of Certain Areas such as Marriage, Sexual Relations etc

AI notes that certain areas where consent is required are excluded from the Scheme pursuant to Head 20. AI acknowledges that certain aspects of the Scheme relating to substitute decision-making should not apply to such areas but queries whether the existing law will be sufficient to comply with the CRPD. What steps are being taken to ensure that the existing law is appropriately amended to comply with the CRPD? In particular AI would ask the Department to clarify what steps are being taken to ensure that the necessary changes will be made to section 5 of the Criminal Law (Sexual Offences) Act 1993 in order to bring Irish law into compliance with Article 23 of the CRPD.

Review of the Act

The Bill should include a provision requiring periodic reviews of the Act including not only the operation or functioning of the Act but also a broader review of whether the Act has succeeded in fulfilling the objectives and aims sought to be achieved by its passing into law.

RECOMMENDATION: *The Bill should require periodic reviews of the Act which should cover not only the operation or functioning of the Act but also whether the Act has succeeded in fulfilling the objectives and aims sought to be achieved by its passing into law.*

Conclusion

While AI welcomes the publication of the Scheme of the Mental Capacity Act 2008 AI has a number of serious concerns about how its provisions fulfil Ireland's obligations under international human rights law, as set out in detail above. We are eager to meet with relevant members of the staff of the Department to discuss in more detail our comments and the results of our research. AI looks forward to the publication of the Bill and hope that it will take on board our suggestions, thereby allowing Ireland to move a step closer to the effective protection and realisation of the equal rights of persons who experience mental health difficulties in accordance with international human rights laws and best practice.

ENDS//

For further information, please contact Mary Forde, Legal Officer (Mental Health), Amnesty International Ireland, First Floor, Ballast House, Westmoreland Street, Dublin 2 (tel: 01 – 863 8313; email: mforde@amnesty.ie).

Annex 1
Capacity Research Report