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NO LONGER 'ANOMALOUS, CONFUSING AND UNJUST': THE MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016

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I. INTRODUCTION

Northern Ireland is a distinct legal jurisdiction which is one of the four countries of the United Kingdom (Dickson, 2013). It is a small jurisdiction in the north east corner of the island of Ireland. In 2015 its population was estimated to be 1,851,600, which is about 30% of the island's total population and about 3% of the UK's population (Office of National Statistics, 2016). Since 2002 there has been a broad and extensive process to develop new legislation relating to mental health and mental capacity which is of interest as it represents a new departure in terms of such legislation. The Mental Capacity Act (Northern Ireland) 2016¹ legislates a fusion approach to mental capacity/mental health law (Dawson & Szmukler, 2006; McCallion & O'Hare, 2010). The provisions of the Act apply in general to people who are aged 16 and over and it goes beyond a proposed 'model law' of the fusion type in that it incorporates criminal justice provisions (Szmukler, Daw & Dawson, 2010).

This article provides an overview of the process of development of the Mental Capacity Act (Northern Ireland) 2016. The Act has its origins in the Recommendations of the Bamford Review of Mental Health and Learning Disability which are considered first. The publication of these recommendations was followed by an extended policy development process which is discussed next. Following an overview of the contents of the Act, key issues which emerged during the policy development and legislative processes are outlined.

II. THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY

The Bamford Review of Mental Health and Learning Disability was established in 2002 to look at the law, policy and provisions which affect people with mental health needs or a learning disability in Northern Ireland.² The inclusiveness of the Bamford Review has helped ensure that the voices of the most important drivers for reform were given priority—the voices of users of services and their carers. The review completed its task in 2007 with the publication of its report on legislative reform.³ Its call was for 'a holistic person-centred approach, which is respectful of the individual and delivered in a way that avoids stigma; services should be 'Recovery'

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¹ The Act and its Explanatory Memorandum are available at: <http://www.legislation.gov.uk/nia/2016/18/contents/enacted>

² Information about the work of the Bamford Review, who was involved and copies of its Reports are available at: <http://www.dhsspsni.gov.uk/bamford.htm/>

³ Bamford Review of Mental Health and Learning Disability (2007). A Comprehensive Legislative Framework. This is available (along with an Executive Summary and an Easy Read Summary) at: <http://www.dhsspsni.gov.uk/index/bamford/published-reports/cl-framework.htm>

focused...to empower people to achieve their potential and lead a fulfilling life.’ (Bamford Review, 2007: 8).

The proposed ‘Comprehensive legislative framework’ for mental health and learning disability provided a vision for reform of mental health legislation which indicated clear directions such reform should take. In Northern Ireland the current mental health legislation is the Mental Health (Northern Ireland) Order 1986.⁴ The Order is essentially traditional mental health legislation with provisions for detention and compulsory treatment in hospital and for guardianship.⁵ Entry to its powers is through ‘mental disorder’ and risk of harm criteria. ‘Mental disorder’ is defined at Article 3(1) as ‘mental illness, mental handicap and any other disorder or disability of mind’. There are certain exclusions from the definition of ‘mental disorder’ at 3(2): ‘personality, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.’ The ‘mental disorder’ also has to be ‘of a nature or degree which warrants his [sic] detention in a hospital for assessment (or for assessment followed by medical treatment)’ (Article 4(2)(a)). The risk criterion is set out in 4(2)(b) and is that ‘failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons.’ There is a short Code of Practice for the Order.⁶ The Review saw shortcomings in the Mental Health (Northern Ireland) Order 1986 and recommended a new approach (Bamford Review, 2007). Northern Ireland has not had mental capacity legislation in place alongside the Mental Health Order, with capacity law remaining at common law. The Bamford Review saw an opportunity for both service modernisation and law reform in a comprehensive manner and these two reform processes were seen as intrinsically linked (Bamford Review, 2007).

Taking a social model approach to mental disabilities, the Review recognised that people with mental health difficulties or a learning/intellectual disability ‘experience a range of barriers which prevent them from exercising their rights’ (Bamford Review, 2006: 11). One of the barriers identified relates to presumed lack of capacity:

Assumptions are often made by others about the capacity of people with mental health difficulties or a learning disability to participate in or contribute to the life of their community, or to make decisions. These assumptions are often due to ignorance and prejudice, arising from a lack of information and understanding about mental health or learning disability. (Bamford Review, 2006: 1)

Rather than recommending new mental health legislation with separate mental capacity legislation, as was the approach taken in England and Wales⁷ and in Scotland⁸, the Review sought a comprehensive approach which avoided the complexity of multiple legal options in addressing similar situations:

⁴ Mental Health (Northern Ireland) Order 1986. Available at: <http://www.legislation.gov.uk/nisi/1986/595>

⁵ For an overview of the Mental Health (Northern Ireland) Order see White (2004) Chapter 11.

⁶ Code of Practice available at: http://www.gain-ni.org/flowcharts/downloads/mental_health_order_1986_code_of_practice.pdf

⁷ Mental Health Act 1983 (as amended) <http://www.legislation.gov.uk/ukpga/1983/20/contents>; Mental Capacity Act 2005 <http://www.legislation.gov.uk/ukpga/2005/9/contents>

⁸ Mental Health (Care and Treatment) (Scotland) Act 2003 <http://www.legislation.gov.uk/asp/2003/13/contents>; Adults with Incapacity (Scotland) Act 2000 <http://www.legislation.gov.uk/asp/2000/4/contents>

The key proposal for statutory reform is that Government should adopt a coherent and co-ordinated approach to legislative provision. This should be through the introduction of comprehensive provisions for all people who require substitute-decision-making. A single legislative Framework is proposed for interventions in *all* aspects of the needs of people requiring substitute decision-making, including mental health, physical health, welfare or financial needs. (Bamford Review, 2007: 53)

The Bamford Review focused firmly on human rights and equality concerns (Bamford, 2006):

A rights-based approach is proposed as the guiding principle for reform of legislation which should respect the decisions of all who are assumed to have capacity to make their own decisions. Grounds for interfering with a person's autonomy should be based primarily on impaired decision-making capacity. New legislative solutions are, therefore, required for issues posed by the effects of disorder of the brain or mind on an individual's decision-making capacity and which affects his/her own personal health, the need for care and treatment, safety and the welfare or the safety of others. (Bamford Review, 2007: 26)

The Review understood the foundation for such an approach as being well-established principles of human rights and equality which had not previously been fully applied to people with mental disorder or a learning disability. 'Justice', one of the foundational principles articulated in the Review, required non-discrimination:

persons with a mental disorder or a learning disability should retain the same rights and entitlements as other members of society. (Bamford, 2007: 37)

Central to the Bamford proposals for legislative reform is the repeal of separate and discriminating mental health legislation. The Review concluded that 'having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust' and so '...the Review considers that Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory.' (Bamford, 2007: 36).

The proposals of the Bamford Review were thus for a form of 'fusion' legislation (Dawson & Szmukler, 2006) which combines respect for decision-making capacity where it exists, regardless of whether an individual has a physical or mental health issue. The basic principle of respect for decision-making autonomy should equally apply for decisions relating to mental health care and treatment. This principle of non-discrimination, or of equal respect for the dignity and rights of an individual, should also extend to decisions to deprive someone of their liberty. The Review envisaged legislation which did not create a 'double-standard' for people with mental health issues or a learning disability.

III. THE DEVELOPMENT OF THE MENTAL CAPACITY (NORTHERN IRELAND) ACT 2016

Following the conclusion and recommendations of the Bamford Review, an extensive process of detailed policy formation followed. The Review had recommended that the proposed legislative framework be applicable to all people in society, including those subject to the criminal justice system (Bamford, 2007). The

policy formation process thus involved the Department of Health, Social Services and Public Safety (DHSSPS)⁹ and the Department of Justice (DoJ)¹⁰.

Considerable time was been taken in the development of the new legislative framework. Building on the inclusive approach taken in the Bamford Review, the development of the Act has benefited from extensive engagement with a wide range of civil society actors and this is a key reason for the length of time taken.

The Northern Ireland government generally accepted the recommendations of the Review, but a further period of policy development was necessary before it was generally accepted that the specific legislative proposals delivered on the Bamford vision. The initial response of the Northern Ireland Executive to the recommendations of the Bamford Review was a proposal for two separate pieces of legislation dealing with mental health and mental capacity respectively, along the lines adopted in other UK jurisdictions (DHSSPS, 2008). The proposal was to amend the Mental Health (Northern Ireland) Order 1986 and to introduce new capacity legislation. This 'parallel' approach was that recommended in the DHSSPS public consultation on policy proposals in 2009 (DHSSPS, 2009a). In the light of responses to the consultation, which overwhelmingly supported the Bamford Review's recommendation for a single Bill approach, the Minister for Health, Social Services and Public Safety committed to the development of a single Bill (DHSSPS, 2009b: 27).

Following on from the Good Friday Agreement, the devolution of justice powers from Westminster to Northern Ireland was only carried out in 2010 which meant that work on the criminal justice policy provisions got underway at a later date than those within the remit of DHSSPS. Following consultation (DoJ, 2012) and equality screening (DoJ, 2013), the Department of Justice decided to include those subject to the criminal justice system within the scope of the proposed new framework. In May 2014, a public consultation was launched on draft civil provisions (along with an updated Equality Impact Assessment) and on policy proposals on the criminal justice aspects of the Bill.¹¹

In addition to formal public consultation, both DHSSPS and DoJ ran Legislative Reform Reference Groups to engage with key stakeholders throughout the policy development process. The DHSSPS 'Mental Health and Mental Capacity Reference Group' ran over 16 meetings in the policy development phase from October 2009 until drafting work on the Department's policy positions started to take precedence over the development of policy positions. The Department of Justice conducted a similar engagement exercise once it started its work on the Bill. The DoJ 'Mental Capacity Legislation and Criminal Justice System Project Reference Group' met five times between January 2012 and January 2014.

⁹ See DHSSPS website at <http://www.dhsspsni.gov.uk/>

¹⁰ See DoJ website at <https://www.dojni.gov.uk/>

¹¹ The Consultation Document, Annex A with the Draft Mental Capacity Bill (Civil Provisions) and the Summary of Responses received are all available at: <http://www.dhsspsni.gov.uk/showconsultations?txtid=68523>. The full set of consultation responses received are available at: <http://www.dhsspsni.gov.uk/index/consultations/mental-capacity-bill-responses-2014.htm>

The Mental Capacity Bill entered the Northern Ireland Assembly on 8 June 2015. The text of the Bill as introduced to the Assembly¹² and the accompanying Explanatory Memorandum¹³ are available on the Assembly Website. The Second Stage plenary debate of the general principles of the Bill took place on 16 June 2015.¹⁴ An Ad Hoc Joint Committee to Consider the Mental Capacity Bill was established on 15 May 2015 to consider the Bill.¹⁵ The Ad Hoc Committee received written submissions over the summer of 2015¹⁶ and through September and October 2015 took oral evidence on the Bill from a wide range of groups¹⁷. The Ad Hoc Committee agreed its Final Report¹⁸ on the legislation on the 25th of January 2016 with the Bill then returning to the Assembly. It completed its Final Stage on 15 March 2016¹⁹ and received Royal Assent on 9 May 2016.

Throughout the policy development process a series of key issues attracted substantial debate. Such issues were often initially formulated within the Departmental Reference Groups and then expanded upon in written and oral evidence to the Ad Hoc Committee. Key issues included:

- The recurring use of mental disorder (as out of keeping with the fusion approach);
- The possible separation of processes by type of decision (e.g. having separate authorisation processes for mental health and physical health);
- Professional roles (whether health professionals beyond doctors and social workers should be able to fill key roles within the Bill);
- Independent advocacy (what constitutes effective independence and whether an independent advocate should be involved in forming best interests decisions);
- Inclusion of clauses on advance decisions in the Bill (including the implications of providing a statutory basis for binding advance decisions with respect to mental health treatment);

¹² See <http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity---as-introduced.pdf>

¹³ <http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity-bill---efm---as-introduced.pdf>

¹⁴ The Official Report of this debate is available at: <http://aims.niassembly.gov.uk/officialreport/report.aspx?&eveDate=2015/06/16&docID=238200>

¹⁵ The archived material relating to the work of the Ad Hoc Committee is available at: <http://www.niassembly.gov.uk/assembly-business/committees/archive/ad-hoc-joint-committee-to-consider-the-mental-capacity-bill/>. It was a joint Committee made up of members of the Committee for Health, Social Services and Public Safety and the Committee for Justice.

¹⁶ The written submissions are available at: <http://www.niassembly.gov.uk/assembly-business/committees/archive/ad-hoc-joint-committee-to-consider-the-mental-capacity-bill/written-submissions/>

¹⁷ The Minutes of Evidence are yet to become available.

¹⁸ The Report of the Ad Hoc Committee raised five key issues: the lack of codification of advance decisions within the Bill; the complete replacement of Enduring Powers of Attorney by Lasting Powers of Attorney; the conditions for detention under a Public Protection Order; the extent to which the Department was granted power to make further provision by secondary legislation; and the lack of certainty that resources will be made available to meet implementation costs. The Report is available at: <http://www.niassembly.gov.uk/globalassets/documents/ad-hoc-mental-capacity-bill/report-on-the-mental-capacity-bill.pdf>

¹⁹ See Report on the Final Stage at: <http://aims.niassembly.gov.uk/officialreport/report.aspx?&eveDate=2016/03/15&docID=263222#2103963>

- The application to the criminal justice system (particularly whether a capacity-based approach can sufficiently protect public safety);
- The lack of engagement by key stakeholders (whether the Bill has been sufficiently formed by the perspectives of physical health professionals);
- The compliance of the Bill with the UN Convention on the Rights of Persons with Disabilities; and
- The inclusion of children under 16 within the provisions of the Bill.

IV. OVERVIEW OF THE CONTENT OF THE ACT

The Mental Capacity Act (Northern Ireland) 2016 is one of the largest and most complex pieces of legislation to have been passed by the NI Assembly. The Act has 15 Parts consisting of 308 sections and 11 Schedules. The Act contains around 100 enabling powers for either the DHSSPS or the DoJ, to introduce subordinate legislation. It is clear that extensive secondary legislation is required, although this is still in development and it is not yet entirely clear yet what form this will take.

Part 1 of the Act sets out the key principles which must be complied with where a determination has to be made as to whether a person lacks capacity (sections 1(2)-(5) and also the principle that where a substitute decision is being made, that it must be in the best interests of the person who lacks capacity (sections 2 and 7). There is also a definition of the meaning of lack of capacity. Lacking capacity as defined in clauses 3 and 4 is, in general, the only gateway into the provisions of the Act.²⁰ These principles and definition largely match those of the England and Wales Mental Capacity Act 2005, as was proposed by the Bamford Review (Bamford, 2007). Clause 1(4) requires that a person is not to be treated as lacking capacity ‘unless all practicable help and support to enable the person to make a decision about the matter have been given without success’. This is then amplified by section 5, ‘Supporting person to make decision’, which specifies the steps which must be taken

²⁰ The exception is when the Court makes a ‘Public Protection Order’ (Sections 167 to 173) which is a Court power (which does not require a lack of capacity to be present) to detain people who are not culpable for their actions, but cannot be released because they pose a danger to others. This Court power only exists where a person is convicted of an offence punishable by imprisonment. Such an Order requires that the person convicted of the offence be admitted to and detained in an appropriate establishment, which is a hospital or care home. The core requirements that must be met for a Public Protection Order as laid out in Section 168(2) are:

- “(a) that there is an impairment of, or a disturbance in the functioning of, the offender’s mind or brain;
- (b) that appropriate care or treatment is available for the offender in the establishment;
- (c) that dealing with the offender in any way not involving his or her detention would create a risk, linked to the impairment or disturbance, of serious physical or psychological harm to other persons; and
- (d) that detaining the offender in the establishment in circumstances amounting to a deprivation of liberty would be a proportionate response to—
 - (i) the likelihood of the harm concerned; and
 - (ii) the seriousness of that harm.”

Decision-making with respect to health and welfare for those subject to a Public Protection Order remain subject to the core provisions of the Act. Such an Order does not in itself serve a health interest, but rather seeks to serve a public protection interest. Thus, in Northern Ireland it has indeed proven the case that a measure primarily aimed at reducing harm was necessary as ‘a basis for society to take action’ even within a fusion law. (Gledhill, 2010). However, such circumstances are extremely limited and there is not universal agreement on the need for the Public Protection Order in practice nor on its acceptability in principle

for the purposes of section 4(1). This section thus provides detail on the face of the Act of the support which must be provided before a finding of a lack of capacity can be made. The 'support principle' has the potential to be a central and progressive aspect of the new legislative framework and provides the opportunity for the evidence based for the range of possible supports to be further explored (Davidson et al., 2015). The Act both accepts a necessary connection between mental capacity and legal capacity and requires support for decision-making capacity to ensure that legal capacity is not unduly restricted. It does not simply adopt a substitute decision-making approach over a supported decision making approach, but rather sees support for decision-making as being necessary precisely because a person may lack the mental capacity to make a particular decision.

Part 2 of the Act lays out the core of the legislation which is the availability of a possible protection from civil and criminal liability for an intervention or substitute decision if certain conditions are met. Unlike the Mental Health (Northern Ireland) Order 1986 which conferred powers on substitute decision makers, the Act does not in general do so. Acts have the potential to be lawful through the availability of a defence; they are not lawful because they involve the exercise of a legal power. The Act puts the common law doctrine of necessity into the statute. For certain **kinds of intervention**, or in certain **circumstances**, one or more of a set of additional safeguards must also be in place for the defence to be available. The 'additional safeguard provisions' of Part 2 relate to:

- Conditions for any act of restraint (section 12);
- Formal assessment of capacity (sections 13 & 14);
- Consultation with nominated person (section 15);
- Second medical opinion required for certain treatment (section 16-18);
- Independent advocate must be in place (section 35-36);
- Authorisation by a Health and Social Care Trust of certain interventions (section 19-23); and
- Right to review of such an authorisation by a Tribunal (section 45-51).

The basic approach of the Act seeks to legislate for a 'hierarchy' of interventions where the more serious the intervention, the more significant the safeguards which must be in place to protect the rights and interests of the person who lacks capacity. In practice this means the more serious the intervention, the more onerous the obligations on a substitute decision maker should they wish to have available the possible protection from liability enacted in clause 9. The key distinction with respect to the **kind** of intervention is whether the intervention is a 'serious intervention'. The Act defines this pivotal concept of a 'serious intervention' in section 60(1) and (2) as follows:

- 63.—(1) In this Part "serious intervention" means an intervention in connection with the care, treatment or personal welfare of P which (or any part of which)—
- (a) consists of or involves major surgery;
 - (b) causes P serious pain, serious distress, or serious side-effects;
 - (c) affects seriously the options that will be available to P in the future, or has a serious impact on P's day-to-day life; or
 - (d) in any other way has serious consequences for P, whether physical or non-physical.
- For all serious interventions the required safeguards are: a formal assessment of capacity; the involvement of the nominated person; and, for certain interventions, a second opinion.

There are also specific serious interventions which require the additional safeguard of authorisation by a panel. These include where the 'nominated person' is objecting to the intervention; any deprivation of liberty; and the imposition of an attendance or community residence requirement.

Part 3 makes further provisions relating to the role and appointment of nominated persons and Tribunal powers with respect to nominated persons. This role replaces the role of nearest relative who, under the current Mental Health (Northern Ireland) Order 1986, was identified through a set order of relatives, and was able to act as applicant for compulsory admission. The previous role created concerns about: nearest relatives' knowledge and understanding of the law; the implications for the future relationship between the applicant and the service user; and the potential additional distress for those involved. The new role does not involve acting as applicant for compulsory admission and allows the person to nominate the person they would like to be involved although how this will be done in practice has yet to be detailed. If a nominated person is not in place then the default will still be the nearest relative.

Part 4 lays out when an independent advocate must be in place, procedures for their instruction and obligations on Health and Social Care Trusts to make provision for such advocates. It had been hoped that Northern Ireland might follow Scotland and create a duty to provide independent advocacy for all using services but the statutory duty in this Act is restricted to those subject to interventions that require authorisation.

Currently in Northern Ireland there is a system of Enduring Power of Attorney which relates to decisions about finances.²¹ Part 5 provides for a Lasting Power of Attorney which will include decisions on health and welfare matters in addition to financial decisions.

Part 6 of the Bill covers the powers of the High Court to make decisions and to appoint deputies as substitute decision makers. Part 7 makes provision for the creation of a Public Guardian to maintain registers of Lasting Powers of Attorney and Court appointed Deputies and to supervise Deputies. Part 8 makes provisions relating to research involving people who lack capacity to consent to participate in it. It clarifies what general safeguards from the Bill must be in place and provides for specific safeguards in research situations.

Part 9 retains powers for police officers to remove a person from a public place to a 'place of safety' where the person appears to be in immediate need of care or control. The conditions for the police powers are now that the person is unable to make the relevant decision about going to a place of safety, it would be in their best interests, failure to do so would create a risk of serious harm and removal is a proportionate response. The purpose of the police powers are to enable examination by a medical practitioner and interview by an Approved Social Worker. The maximum period of detention has been reduced from 48 to 24 hours.

²¹ Enduring Power of Attorney (NI) Order 1987. Available at: <http://www.legislation.gov.uk/nisi/1987/1627/contents>

Part 10 of the Act creates court disposals to send persons on remand and convicted offenders to healthcare facilities for medical treatment. The general approach of the Act in terms of respecting decision-making capacity with respect to healthcare decision-making will continue to apply even in the circumstances of these court disposals.

Part 11 covers transfer of persons who are deprived of their liberty in a hospital between UK jurisdictions and a power to create regulations for transfers, including to and from jurisdictions outside the UK. Part 12 Provides for additional safeguards for children subject to the Act and the Mental Health (Northern Ireland) Order 1986 which is being retained and amended for children under 16. (See section 5 below.) Part 13 sets out offences specific to the Act. Part 14 sets out miscellaneous provisions, including giving effect in Northern Ireland to the Hague Convention on the International Protection of Adults. Finally, Part 15 makes provisions relating to codes of practice and other matters.

The Act also has 11 Schedules which provide some more detail about implementation. These include Schedule 2 which sets out the process for authorisation for short-term (up to 28 days, which is an extension of the current 14 days) detention in hospital.

V. KEY ISSUES ARISING IN THE DEVELOPMENT OF THE ACT

There was an extended and somewhat diffuse process over 14 years (from the commencement of the Bamford Review), involving sustained work on the part of many stakeholders, in getting to the point where legislation was actually introduced to the NI Assembly. In contrast, the available legislative timetable of nine months proved to be a challenging one, especially given the ongoing specific political challenges faced by Northern Ireland as a post-conflict society. In particular, there were two key contentious issues which emerged in the policy development process which also posed challenges for the enactment of the Bill.

A. Human Rights

The initial discussions around the reform of the Mental Health (Northern Ireland) Order 1986 took place very much in a context of concern for human rights and the need for new legislation to not only comply with human rights standards, but to promote them and be a model of best practice. (Davidson et al., 2003; Bamford, 2006). In 2008 the United Nations Convention on the Rights of Persons with Disabilities came into force and the United Kingdom ratified the Convention in 2009. As Bartlett (2009) has highlighted, a major implication of the UNCRPD, as set out in Article 14, is that disability, including mental disability, should no longer be a criterion for detention as it is in most mental health laws including the current Mental Health (Northern Ireland) Order 1986. One of the drivers for the new Act was to develop a law which no longer discriminated against those with any form of mental health problems and/or intellectual disabilities. The implications of the Convention were discussed extensively in the DHSSPS Reference Group, initially with a focus on the requirement for support for decision-making capacity. With the publication by the Committee on the Rights of Persons with Disabilities of its General Comment No. 1

on article 12 of the Convention on Equal Recognition before the Law (2014)²², the debate shifted with increasing questioning of the substantive compatibility of the Bill with the approach of the Convention and thus with human rights standards. However, the literature also contains cogent arguments which see great difficulties in the interpretation of the Convention being put forward by the Committee and suggestions that a more realistic approach is needed (Freeman et al., 2015; Dawson, 2015).

There is not space in this general article to engage with these issues in the depth they require²³, but several comments can be made about the proper context for any such assessment:

- To date, debate about the human rights implications of the Northern Ireland law reform process have focused almost exclusively on the UNCRPD (McSherry, 2015). However, the NI Act does not just apply to persons with disabilities and thus assessment of its compliance with international human rights law requires that it be viewed in the context of the human rights system as a whole, including the European Convention on Human Rights as the relevant regional instrument. Fennell and Khalqi (2011) have highlighted some of the potential conflicts between the UNCRPD and the European Convention on Human Rights although these have yet to be tested.
- The focus of debate has also been narrow in a further respect in terms of being conducted almost exclusively with respect to article 12 of the UNCRPD. (Flynn, 2013) However, the correct interpretation of article 12 can only be established in the context of that broader set of human rights treaties and the jurisprudence they have generated.
- Article 12 has been presented as containing a new paradigm which wholly rejects substitute decision making. However, the text of the article itself is clear that it envisages no such shift. This is clearly seen in the use of 'reaffirm' and 'recognise' in articles 12(1) and 12(2) respectively.²⁴ An interpretation of article 12 which sees it as requiring a 'paradigm shift' continues to be consistently rejected by the State Parties to the UNCRPD.²⁵

It is only on the basis of a debatable interpretation of the UNCRPD, and in particular of its article 12, that the Northern Ireland Act seems incompatible. With the United Kingdom now expected to be examined by the UN Committee on the Rights of Persons with Disabilities in 2017, it is likely that the compatibility of the Act with human rights standards will continue to be a matter of deep dispute.

²² Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>

²³ See Colin M Harper, "The Mental Capacity Act (Northern Ireland) 2016 and the human rights of people with intellectual disabilities". *Advances in Mental Health and Intellectual Disabilities* (Forthcoming, 2017).

²⁴ Art. 12/ 1. "States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law."

Art. 12/2. "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."

²⁵ See the reservations and interpretative declarations entered by State Parties to the UNCRPD available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=en. Most recently, that entered by the Netherlands on its ratification on 14 June 2016: "Article 12. The Kingdom of the Netherlands recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Furthermore, the Kingdom of the Netherlands declares its understanding that the Convention allows for supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law. The Kingdom of the Netherlands interprets Article 12 as restricting substitute decision-making arrangements to cases where such measures are necessary, as a last resort and subject to safeguards."

B. Children under 16 years old

Concerns about the impact of the reform of mental health law on children and young people in Northern Ireland were expressed at an early stage, mainly with respect to insufficient attention being given to the requirements of the UN Convention on the Rights of the Child and to the need for appropriate services (Niwa, 2007). Whilst this early commentary was supportive of the fusion approach, the Act as passed does not in general apply to children under 16. The Bamford Review had suggested that consideration might be given to a rebuttable presumption of capacity between 12 and 16 (Bamford Review, 2007). However, the lobby from the children's sector was focused on the full inclusion of children under 16 in the Bill, rather than calling for the more limited Bamford proposal. In the absence of substantive legal reform for under 16s, the Mental Health (Northern Ireland) Order 1986 is being retained and proposed amendments to this are contained in Part 12 and Schedule 12 of the Act. It is clear that the concerns about the discriminatory nature of the Mental Health Order expressed by the Bamford Review have not yet been addressed by the law reform process. In many ways the legal situation of younger children has not yet received the attention it deserves in discussions of the fusion approach to mental health law.

VI. CONCLUSION

The Mental Capacity (Northern Ireland) Act 2016 legislates one potential approach to fusing mental health and mental capacity legislation. The process of its development has been inclusive and the small size of the jurisdiction has meant that it has perhaps been easier to establish and maintain good working relationships amongst key stakeholders over a sustained period through the Bamford Review, the Mental Health and Learning Disability Alliance and the Departmental Reference Groups. There is no doubt that taking about 12 years to get a full draft of the legislation to the Assembly has helped ensure continuing broad support for the majority of policy positions taken. Northern Ireland has also benefited from very substantial investment from the Atlantic Philanthropies Foundation in policy work in the areas of mental health and the human rights of people with disabilities which has undoubtedly helped to build expertise and sustain engagement over the period of development of the Act. With policy development coming a sufficiently long time after legislation had been enacted in England and Wales and in Scotland has meant that Northern Ireland has been able to learn from the experience of these jurisdictions. The coming into force of the UN Convention on the Rights of Persons with Disabilities has reinforced a proper focus on the need for legislation to be progressive in human rights terms and in particular has drawn attention to the need to legislate for support for decision-making and to seek to ensure proportionate respect for the wishes of a person who has been found to lack capacity.

One of the conclusions of the recent House of Lords post-legislative scrutiny of the England and Wales Mental Capacity Act 2005 was:

We acknowledge the wide-spread support which the Act enjoys among stakeholders. It is described in unusually enthusiastic language. It is disappointing therefore that the implementation of the Act has yet to receive the same acclaim. (House of Lords, 2014: 50)

Challenges to full and effective implementation of the Northern Ireland Act remain, the more so in that it represents the first attempt at implementing a fusion approach. The NI Assembly Research Service has published a series of reports which seek to critically analyse estimates of the cost of implementing the Bill, with particular consideration given to the likely costs of training staff across the criminal justice and health and social care sectors and the costs of implementing the safeguards the Act requires for deprivations of liberty.²⁶ Concern about the cost of implementing the Act has also been expressed by the Ad Hoc Committee. It is not yet clear what implications cost considerations will have for the implementation of the Act. Whether the Committee will seek to amend the legislation to make it less costly to implement and whether this can be done in a manner which does not undermine the principles of the legislation or the effectiveness of its safeguards remains to be seen.

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