

National **Safeguarding** Committee

Promoting the rights of adults who may be vulnerable



March 2018

The National Safeguarding Committee (NSC) is a multi-agency and inter-sectoral body established in December 2015. It was established in recognition of the fact that safeguarding vulnerable people from abuse is a matter that cannot be addressed by any one agency working in isolation, but rather by a number of agencies and individuals working collaboratively with a common goal.

In December 2017 the NSC published its first Strategic Plan 2017- 2021 and sets out the core objectives of the Committee. These are:

- To raise public understanding of attitudes, behaviours, circumstances and systems that create vulnerability that may result in abuse, and that may require a safeguarding response
- To promote the protection and rights of people who may be vulnerable, by encouraging organisations and services to recognise, prevent and deal with exploitation and abuse effectively
- To inform and influence Government policy and legislation to safeguard the rights of people who may be vulnerable
- The Committee dedicates itself to optimise its collective capacity and available external resources to achieve its aims and objectives

Given its remit the NSC is particular pleased to make this submission on the proposed legislative framework with regard to the right to liberty. The NSC makes this submission in response to the publication of the **Preliminary Draft Heads of Bill on Part 13 of the Assisted Decision-Making (Capacity) Act 2015** and the **Consultation Paper**.

Part 1 – General Comments

1 Introduction

The Assisted Decision-Making (Capacity) Act 2015 (the 2015 Act) took several years from inception to final enactment and went through a detailed legislative scrutiny process to ensure that it would comply, in particular, with the UNCRPD. The overall objective of the 2015 Act is to have a rights based approach to decision-making capacity to comply with human rights obligations contained in the Constitution of Ireland, the European Convention on Human Rights (ECHR), the UNCRPD and also to ensure that Ireland adheres to its international human rights

obligations generally. Any addition to the 2015 Act must therefore critically meet the human rights standards required of the State. Members of the NSC are only too aware of ongoing and continuing breaches of human rights particularly with regard to the right to liberty and therefore welcomes this opportunity to make a submission on this important right.

The Consultation Paper at paragraph 8 states that the approach taken in the Draft Heads builds on the decision-making procedures, supports and safeguards already provided by the 2015 Act and also includes some additional safeguards specific to deprivation of liberty. However, while the Guiding Principles are mentioned in a number of the Heads they are not embedded in the proposed detailed provisions, particularly the initial presumption of capacity, and generally the Draft Heads do not, meet the standards required and fail to adhere to the philosophy and principles contained in the 2015 Act.

Before answering the questions posed in the Consultation Paper a number of general comments are necessary. (It should be noted that the use of the terminology in the comments as used in the Draft Heads are not intended to endorse that terminology but are used for convenience of referencing).

2 Due regard to the need to respect the right of the relevant person to dignity

2.1 The 2015 Act provides at Section 8(6) (b) that any intervention in respect of a relevant person shall have due regard to the need to respect the right of the relevant person to dignity.

2.2 Principle 1 of the Council of Europe's Recommendation on Principles concerning the Legal Protection of Incapable Adults (Rec. No R (99)4) provides that *[I]n relation to the protection of incapable adults the fundamental principle, underlying all the other principles, is respect for the dignity of each person as a human being.*

2.3 The terminology and definitions used in the Heads (and ultimately in the legislation) should comply with the requirement to respect the dignity of the person. Term such as 'relevant facility,' which refers to a person's place of residence, should not be used. It is demeaning of the person and demeaning of their proposed place of residence. Similarly, the definition of an 'admission decision' is defined in terms to deprive a person of his or her liberty rather it should refer to the safeguarding of liberty. The NSC submits that any terms which do not fully respect the right of a person to dignity should be avoided.

2.4 The Drafts Heads (legislation) should be putting the rights and needs of the service user first. They should not primarily be for organizational or staff needs but should consider how professional staff and organisations are expected to respond to respect rights where any deprivation of liberty is being considered.

3 Right to liberty and security of person

3.1 Both the ECHR and the UNCRPD refer to the right to liberty. The NSC suggests that the appropriate heading to Part 13 of the 2015 should read:

SAFEGUARDING THE RIGHT TO LIBERTY OF A RELEVANT PERSON.

3.2 Article 14 of the UNCRPD provides that:

1 State Parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2 State Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

3.3 The essential first step before any intervention (admission) is contemplated is the requirement to assess the needs of and risks to the person. The purpose of such assessment is to assess care needs, treatment requirements or other needs issues. Any such assessment must necessarily establish whether or not the person's needs are being met given the person's current circumstances. If the person's needs are not being met it is necessary to objectively ascertain what are the choices and options for that person to include home and social living circumstances/independent living capacity. The choices and options must be communicated to the person and their will and preferences ascertained in the context of those options. (This raises policy issues generally for the State but must be addressed in order to comply with the UNCRPD). This first step must presume that the person has the capacity to participate unless the contrary is indicated in accordance with the provisions of the 2015 Act.

3.4 If it is decided that a person's needs can only be met by admission to a 'relevant facility' it must be explained to a person why the intervention (admission) is necessary, why their needs or quality of life can only be met or improved by admission to a 'relevant facility,' what benefit the person may expect from such admission and whether a less restrictive or less intrusive alternative decision is available which would be as effective and as beneficial to the relevant person.

The NSC submits that the legislation must provide that a preliminary 'needs assessment' be undertaken before there is any determination that an 'admission decision' is required.

3.5 The NSC suggests that further consideration be given (in light of the developments in case law of the European Court of Human Rights) to the use of the terms 'admission decision' and 'under continuous supervision and control and is not free to leave.'

The Draft Heads are very much focussed on admission to a place and the controls while there

and not addressing the important issue of a person not wishing to be there and/or not agreeing with aspects of their care.

3.6 The NSC notes that in order to comply with the equal treatment provision of the UNCRPD it is necessary to ensure that the existence of a disability shall in no case justify a deprivation of liberty. It is proposed that Part 13 of the 2015 Act will apply to a person who having followed the Guiding Principles of the Act becomes a ‘relevant person’ – a person who is not in a position to make an ‘admission decision.’ The key test for the purposes of the 2015 Act is whether a person has the capacity to make a decision and not whether that person is old, has a disability or has a mental illness. The statement therefore in paragraph 14.2 of the Consultation Paper that: *[T]he draft Heads apply to older people, persons with disabilities and people with a mental illness or should those with mental health illness be treated differently* is not appropriate. The fact that a person has a disability should not be a determining factor as to whether they should be admitted to a ‘relevant facility.’ It should of course also be stated that the fact that a person has a mental illness does not mean the he or she lacks decision-making capacity.

- 4 (i) Right to autonomy and self determination**
- (ii) Fundamental Principle of Presumption of Capacity and Lack of Capacity does not mean a person has no understanding of what is going on in their lives**

4.1 The 2015 Act specifically provides that any intervention in respect of a relevant person shall have due regard to the need to respect the right of the relevant person to autonomy.

4.2 The 2015 Act provides that a person over the age of 18 years is presumed to have capacity to make decision about their own lives unless the contrary is shown in accordance with the provisions of the Act. It also recognises that where a person’s capacity may be at issue or a person may lack capacity to make a decision, does not mean that a person should not be fully involved in any decision. A lack of capacity does not mean that a person has no understanding of what is going on in their lives.

4.3 A number of the Heads as currently drafted **do not** indicate the ongoing requirement to have the relevant person participate in so far as possible in the decision to deprive him or her of liberty. Where a person, no matter how frail or ill, endeavours to (even if they require support to do so) expresses their wish by words or actions to admission to a ‘relevant facility’ which may include restrictions on their liberty, then in keeping with the provisions of the UNCRPD, this express wish, should be considered as giving a valid consent for the purposes of Article 5 of the ECHR and should not require the intervention of the court.

4.4 Where a person voluntarily entered and lived in a ‘relevant facility’ but subsequently lacks capacity to make a decision to remain (Head 7(4) refers), should not be subject to a court application. Such intervention, does not respect the presumption that the person had the

capacity to make the initial decision, is not in compliance with the Guiding Principle that there shall be no intervention unless it is necessary to do so having regard to the individual circumstance and is not respecting the person's right to make such a decision. Obviously, if, following loss of capacity, there are changes in the circumstances of the person's care or the conditions in which the person is now residing, then an application to court may be necessary.

4.5 It would be important that the legislation does provide for a distinction between situations where a person seeks to express their decision (even if support is required to do so) which must be respected and situations where there is coercion and undue influence.

4.6 Equally important is the situation outlined in Head 7(9) where a person who previously lacked capacity may have regained capacity and decides to live in the 'relevant facility.' The decision of such person must be fully respected and the requirement to make an application to court in these circumstances is excessive. What may be required is that the Director of the Decision Support Service be notified and she, if she believes it is in order to do so, may either consult with any person as indicated in Section 95(5) of the 2015 Act or direct a Special Visitor to visit the person and notify the court of the outcome of such consultation or visit.

5 Support must be given to a person to maximise their decision-making capacity

5.1 The 2015 Act states that a person shall not be considered as unable to make a decision in respect of the matter concerned unless all practical steps have been taken, without success, to help him or her to do so. It sets out a number of Guiding Principles that must be followed. There is an emphasis on the need to focus on the right of a relevant person to make a decision and the obligation on any intervener to support a person to maximise his or her decision-making and full effect to be given to the past and present will and preferences of the relevant person. The 2015 further requires that no assessment of the relevant person's capacity should be carried out before he or she is supported in so far as practical to make his or her own decision.

5.2 While it is acknowledged that some few of the Heads do refer to the Guiding Principles there is a gap in providing for the support that may be required. Even where there are arrangements or orders in place giving authority for such admission decisions or where there are no such arrangements in place, for the purposes of the 2015 Act there is still a requirement to involve the person and if necessary give them access to the support to personally make the decision and ascertain their will and preferences. There is no point in having legislation that is informed by human rights principles if the same piece of legislation does not provide for mechanisms to ensure that those principles can be operationalised.

5.3 If there is an acceptance that the concept of autonomy and self-determination demands that the person be placed at the centre of all decisions affecting him/her, then in order to ensure that the voice of the person is heard, support by way of access to advocacy is essential.

In order, therefore, to reflect the underlying principles of a rights-based approach contained in the 2015 Act, a statutory provision for an Independent Advocate is required in Part 13 of the Act. Indeed, the Oireachtas Joint Committee on Health and Children's *Report on the Role of Advocacy in Health and Social Care Services in Ireland* (January 2016) commented that the lack of statutory powers for advocacy acts as a barrier of access to advocates by vulnerable people.

5.4 The NSC recognises the requirements of the UNCRPD that people with disabilities have equal legal capacity with all others in all aspects of life and must be enabled to participate fully in all aspects of civil society and where possible to play an active role in the social, cultural and political life of the State. However, the reality is that some people, due to circumstances, age, isolation or disability render them less able to defend their rights and interests, they may not be aware of the abuse to their rights and may not know or have access to a means of dealing with violations to their human rights. In addition, in many cases where abuse or violation of rights occur, such people are under the control of the perpetrator of the abuse or violation and fear retaliation. In other cases, there are higher levels of abuse where people do not have the capacity to voice their concerns. Members of the NSC are acutely aware of important role advocates can and do play in safeguarding vulnerable members of society. Many of the organisations represented on the NSC work in collaboration with the HSE Safeguarding teams and the available advocacy services but at times are frustrated in assisting vulnerable persons because of the lack of a statutory framework in the recognition of advocates who are independent.

5.5 Recognising that advocacy needs to be put on a statutory footing and given that the right to liberty is a convention right for the purposes of both the ECHR and the UNCRPD, the legislation must include the following safeguards:

- Access to an Independent Advocate is an essential safeguard where a decision is being taken to admit a relevant person to a 'relevant facility'.
- The legislation should provide that where an Independent Advocate has given support to a relevant person, the Independent Advocate should report back to the Director of the Decision Support Service who may then direct a Special Visitor to visit the relevant person.
- The legislation should provide that where a co-decision-maker, attorney or decision making representative who has authority to do so and has made an 'admission decision' shall give notification to the Director.

The proposed amendments to Section 44 (decision making representative) and 62 (attorney) are noted but amendment is also required to Section 17 for co-decision-makers.

5.6 The NSC notes that the 2015 Act already recognises the concept of advocates (Section 103(2) (x)) but as stated above it is necessary to put a formal mechanism in place for Independent Advocates particularly where a convention rights requires formal processes.

The legislation should provide as follows:

- (i) Section 101 of the 2015 Act be amended by the addition of (e) Independent Advocates
- (ii) By the addition of:

Appointment of Independent Advocates

- (1) If the relevant person does not have a decision-making representative, a co-decision-maker or attorney with the relevant authority to make a decision for the provision of residential accommodation, an advocate will be made available to the relevant person. The advocate may be chosen by the relevant person themselves. If a relevant person is not in a position to appoint an advocate, the healthcare professional or a member of the team of healthcare professionals who has an interest in the welfare of the relevant person will request that the Director of the Decision Support Service shall within 3 days appoint an Independent Advocate for the relevant person from a panel of appropriately trained advocates.*
- (2) In requesting access to an Independent Advocate, the healthcare professional shall have regard to the principle that a person to whom a proposed intervention relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the intervention.*
- (3) For the purpose of enabling an Independent Advocate carry out his functions, he or she –*
 - a. may interview in private the person whom he or she has been instructed to support, and*
 - b. may, at all reasonable times, examine and take copies of any health or other record which the person holding the record considers may be relevant to the Independent Advocate.*

Functions of Independent Advocates

- (1) The Minister may make Regulations as to the appointment and functions of Independent Advocates.*
- (2) The Regulations may, in particular, make provision requiring an Independent Advocate to take such steps as may be prescribed for the purpose of –*

- a. *Providing support to the relevant person so that the relevant person may participate as fully as possible in any relevant decision*
- b. *Obtaining and evaluating relevant information*
- c. *Ascertain what the will and preferences of the relevant person would be likely to be, and the beliefs and values that would be likely to influence the relevant person if he or she had decision-making capacity*
- d. *Ascertaining what alternative course of action are available in relation to the relevant person and*
- e. *Obtaining a further medical opinion where medical treatment is proposed and the Independent Advocate thinks that one should be obtained.*

(3) *The Regulations may also make provision as to the circumstances in which the Independent Advocate may challenge, or provide assistance for the purpose of challenging any relevant decision.*

6 Any intervention must be for the benefit of the relevant person

6.1 The Guiding Principles provide that an intervention in respect of a relevant person shall be made in a manner that minimises the restriction of the relevant person’s rights and the restriction of the relevant person’s freedom of action; must be proportionate to the significance and urgency of the matter the subject of the intervention and any intervention must be **for the benefit** of the relevant person. It is clear that any intervention (action or decision being made) to a relevant person can only made when the benefit cannot be achieved without such intervention.

6.2 Following the comments at 3.4 above it is essential that any decision to admit a relevant person to a ‘relevant facility’ must indicate the benefit of such admission for the relevant person. This will also be required by the court. (See paragraph 9 below. See also replies to Questions on Head 3 below).

7 Decision-Making Capacity is a legal test not a medical diagnosis

7.1 The 2015 Act set out the criteria to determine if a person lacks the capacity to make a decision if he or she is unable –

- to understand the information relevant to the decision
- to retain that information long enough to make a voluntary choice
- to use or weight that information as part of the process of making the decision or
- to communicate his or her decision

Depending on the particular decision to be made, the appropriate person to assist the person to make a relevant decision and to give relevant information will vary depending on the subject matter.

7.2 It is clear that some Heads are drafted on the basis that a lack of decision-making capacity is equated with ‘unsound mind’ for the purposes of Article 5(1) (e) of the ECHR.

This is not correct either for the purposes of the UNCRPD nor does it equate with the definition of capacity in the 2015 Act and indeed it is not correct for the purposes of the ECHR (See paragraphs 7.3 and 7.4 below).

7.3 Generally, there appears to be confusion in the Heads (particularly in Head 6) by conflating decision-making capacity with mental illness/mental disorder. Issues with regard to decision-making capacity are governed by the legal test set out in the ADMC Act 2015 and confirmed by the High Court in a number of cases. (FK [2008] IEHC and SCR [2015] IEHC) Matters determining whether a person has a mental illness/mental disorder requires a medical diagnosis and are matters to be determined by medical professionals. What Part 13 aims to do is to put in place a procedures whereby a decision may be made to admit a relevant person to a residential centre where that person lacks the capacity to make such a decision personally.

7.4 The Explanatory Notes on Head 1 paragraph 6 state that:
The case law of the European Convention on Human Rights (ECHR) requires medical evidence to justify a decision to deprive a person of their liberty under Article 5(1) (e).

The case law requiring medical evidence refers to cases mainly involving people who are mentally ill and who would in the Irish context be involuntarily detained under the provisions of the Mental Health Act 2001. A diagnostic test is required to establish if a person has a mental illness and for involuntary detention must establish that a person has a 'mental disorder'. This assessment is normally done by a psychiatrist ('medical expert'). This is very different from the functional legal test required to establish whether or not a person has decision-making capacity for the purposes of the ADMC Act 2015 which is a legal test.

7.5 In considering the English legislation and proposals, it is also important to remember that the Mental Capacity Act 2005 for England and Wales provides for an initial diagnostic test for the assessment of 'mental capacity' which is not in compliance with the UNCRPD and is scheduled for amendment. (See Essex Autonomy Report 2016 Chapter 5).

7.6 The use of the term 'medical expert' is therefore inappropriate in the context of the ADMC Act 2015. The new Part 13 needs to be consistent with other parts of the Act which for some specific purposes provide that a registered medical practitioner will assess capacity in addition to another healthcare professional. See both Section 21(4) (f) for a co-decision-making agreement and Section 60 (1) (c) + (d) for an enduring power of attorney, both of which provide for a registered medical practitioner and another healthcare professional.

7.7 The Heads as currently drafted do not give clarity whether it is intended that Part 13 applies to a 'relevant person' who is also a person with a 'mental disorder' who is involuntarily detained under the provisions of the Mental Health Act 2001. In this regard particular consideration should be given to the Guidelines of the Committee on the Rights of Persons with Disability on Article 14 of the UNCRPD (September 2015) which state:

There are still practices in which States parties allow for the deprivation of liberty on the grounds of actual or perceived impairment. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment. However, legislation of several States parties, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty.

8 Invoking the jurisdiction of the Court

8.1 The 2015 Act states that the court and the High Court are interveners for the purposes the Act and that an intervention includes an order of the court or High Court. Further, the 2015 provides that any application to the court must state **the benefit to the relevant person** sought to be achieved by the application and the reason why the application is being made, in particular –

- the reason why the benefit to the relevant person sought to be achieved has failed to be achieved in any other appropriate, practicable and less intrusive manner taken prior to the making of the application and
- the reason why, in the opinion of the applicant, no other appropriate, practicable and less intrusive manner to achieve that benefit remains to be taken prior to the making of the application

It is therefore important that before an application to the court is triggered that consideration is given to these important issues.

8.2 Further, the 2015 Act provides that Rules of court must make provision as to the manner and form in which proceedings are to be commenced and as to what may be received as evidence in such proceedings and the manner in which it is to be presented. For the purposes of Part 13 it will be necessary for the rules to ensure that the preliminary steps as set out above in paragraph 3.3 (assessment of need) and paragraph 5.3 (access to an Independent Advocate) have been complied with.

9 Equal recognition before the law – no disability tag

9.1 In compliance with the UNCRPD that persons with disabilities have the right to recognition everywhere as persons before the law and that persons with disabilities enjoy legal capacity on an equal basis with others in all aspect of life it is essential that the rights of all persons are respected and that there are no exclusions.

9.2 The rights of Wards of Court, who also have a ‘mental disorder,’ have already been compromised in that they were not brought within the provisions of the Mental Health Act 2001 but remain within the jurisdiction of the wardship court under the provisions of the Mental Treatment Act 1945. Such wards are therefore not entitled to the review procedures provided in the Mental Health Act 2001 nor are they entitled to any legal representation as of right. It is only since 2014 that the High Court commenced a review of their detention some 7 years after the commencement of the Mental Health Act 2001.

9.3 It is understood that there will be a review of the capacity of all Wards of Court on the commencement of Part 6 of the ADMC Act 2015 but on the commencement of this Part (Part 13) if any ward has not been discharged from wardship they are entitled to the same procedural safeguards in relation to their place of residence as all others. The NSC submits that excluding wards from the proposed safeguards in relation to their right to liberty would not be in compliance with either the ECHR or the UNCRPD and therefore must not be excluded from Part 13 of the 2015 Act.

The Department is referred to the recent review of wardship commissioned by the NSC and attaches a copy to this submission.

Part 2 – Answers to questions posed in Consultation Paper

Head 1 – Definitions

Questions on Head 1:

1.1 Do you have any views on the definitions currently included in this draft Head?

The definition of ‘admission decision’ needs to be reviewed in the light of developments in jurisprudence of the European Court of Human Rights. (See paragraph 2 and 3 of General Comments).

The terminology used ‘relevant facility’ is inappropriate. Any term used should be meaningful to the person to whom it applies and should be respectful of his or her situation. Suggest the term to be used be a ‘place of residence’. (See paragraph 3 of General Comments).

The definition of a ‘relevant facility’ includes:

- at (b) for **an approved centre** as defined in section 2(1) of the Mental Health Act. However, in Clause 5 of the Consultation Paper it states that: *It is intended that these safeguards will also apply to mental health facilities in instances in which such persons have mental-health issues but are not suffering from a mental disorder and therefore cannot be involuntarily detained under the Mental Health Act 2001.* If this is what is intended, then it should be made clear in the legislation that persons in an approved centre for the purposes of Part 13 of the Assisted Decision-Making (Capacity) Act 2015 (ADMC Act 2015) do not include those who are subject to an admission order under Section 14 of the Mental Health Act 2001. (See paragraph 7 of General Comments).

- at (c) includes residential services as provided by the HSE and other ‘institutions’ that receive funding under the Health Act but it does not appear to include community based housing or group homes. It is necessary that all such residence be included so that the consent of each person to reside in such residence is freely obtained. Some funding provisions may not be confined to provision being made under the Health Acts but may include for example provision being made under the Housing Acts and the definition needs to reflect this fact.
- The definition at (c) (ii) excludes person being cared for in acute hospitals. Many older persons are de facto detained in acute settings for extended periods. The legislation should provide a cut off period, suggest a period of 6 weeks at which time then the consent of the person or his or her legal representative is required for further detention in an acute setting.

1.2 In particular, do you have any views as to the types of healthcare professionals that should be included within the definition of “other medical expert”?

The use of the term ‘medical expert’ is not appropriate in the context of the 2015 Act and should not be used. (See paragraph 7 of General Comments).

1.3 Do you have any other views specific to Head 1?

Head 1 should contain a definition of an Independent Advocate. An Independent Advocate is an essential support for a relevant person.

Suggest: An Independent Advocate is a person who is on the panel established by the Director of the Decision Support Service and appointed for the purpose of supporting a relevant person to make a relevant decision or decisions. (See paragraph 5 of General Comments).

Head 2 - Application and Purpose of this Part

Questions on Head 2:

2.1 Do you have any views specific to Head 2?

Head 2(2) provides that this Part does not apply to Wards of Court. This is not in compliance with either the ECHR or the UNCRPD. (See paragraph 9 of General Comments).

Head 3 – Person’s Capacity to Make a Decision to Live in a Relevant Facility in Advance of an Application to enter the Relevant Facility

Questions on Head 3:

3.1 Do you have any views specific to Head 3?

As indicated at paragraph 3.3 of General Comments, this Head should specify that a social enquiry report and assessment of need is carried out by a registered healthcare professional. This report would look at home and social living circumstances/independent living capacity and consider issues such as frailty and social isolation. It would also contain evidence that any proposals on loss of liberty are the least restrictive option.

It is suggested that Head 3(1) be recast to provide

Before a healthcare professional determines that a relevant person requires admission to a 'place of residence' he or she must act in accordance with the Guiding Principles and must state the following:

- *The benefit to the relevant person sought to be achieved by admission to a 'place of residence'*
- *The reason why the benefit to the relevant person sought to be achieved has failed to be achieved in any other appropriate, practicable and less intrusive manner*
- *That every effort was made to permit, encourage and facilitate, in so far as practicable, the relevant person to participate, or to improve his or her ability to participate, as fully as possible in the decision as to where the relevant person should live*
- *Effect was given, in so far as is practicable, to the past and present will and preferences of the relevant person as to where he or she should live.*

Head 3(1)(a) *Subject to the Guiding Principles being followed and a statement as set out above being complied with and where a healthcare professional determines that a relevant person requires admission.....*

Head 3(2) Where a healthcare professional, following enquiries, believes that there is no admission decision in place then he or she should request the Director to nominate an Independent Advocate from the panel established under Section 101.

Head 3(2) as currently drafted is not appropriate for a number of reasons:

If there is no person (either appointed by the relevant person or by the court) with authority to make an admission decision, then in compliance with the Guiding Principles, it must be established if the relevant person can either make the relevant decision (admission decision) or has the capacity to appoint a co-decision-maker to jointly make the decision with him or her or has the capacity to appoint an attorney under an enduring power of attorney and give such attorney authority to make an admission decision.

3(2) as drafted is at variance with the provisions of the Guiding Principles of the AMDC Act 2015. It provides that if the healthcare professional believes there is no admission decision in place but there is a co-decision-maker, a decision-making representative or an attorney, he or she may notify such of them for the purpose of affording them the opportunity to make an application to court under Part 5. Apart from the decision-making representative who can revert to the court at any time, neither the co-decision-maker nor the attorney has any such authority to do so under the instrument appointing them. While there is such provision under Section 36(4) for a co-decision-maker and an attorney to make an application to court, the Head as drafted does not provide that account must be taken of the will and preference of the person in the particular circumstance. A live example might best illustrates the point, where a person has given an attorney authority to deal with his or her property and affairs but has stated 'over my

dead body will I give him authority to put me into a nursing home.’ The right of a person **not to give** authority for specific decisions must be fully respected and not simply be overridden when the person lacks capacity.

The Independent Advocate, in interacting with the relevant person, where the relevant person does not have the capacity to enter into a co-decision-making agreement nor to appoint an attorney for the purposes of giving authority to consent to admission, but having applied the Guiding Principles and taking account of the views of persons listed in Section 8(8) would be best placed to indicate who may be the person best suited to make the application to the court. This may include the Independent Advocate him/herself. Part 13 then needs to provide for this. Regulations should also provide for the Independent Advocate to notify the Director of the Decision Support Service of the need, if there is one, for an application to be made to the court.

For the reasons stated above the distinction between 3(2) and 3(3) is not tenable except perhaps in the case of a decision-making representative who has been appointed by the court and can revert to the court at any time.

Head 4 – Procedure for Routine Admission of a Relevant Person to a Relevant Facility

Questions on Head 4:

4.1 Do you think the term “under continuous supervision and control” should be defined? If so, what should this definition include?

The definition of ‘under continuous supervision and control and not free to leave’ needs to be reconsidered following recent decisions of the European Court of Human Rights. (See paragraph 3 of General Comments).

4.2 When the person in charge has reason to believe that a relevant person may lack capacity to decide to live in a relevant facility, who should be notified with a view to affording them the opportunity to make an application to Court under Part 5 of the Act? This issue also arises in Heads 3(3), 7(4) and 8(1).

As suggested in answers to Head 3 above, access to an Independent Advocate by the relevant person will enable an advocate who following the Guiding Principles, ascertain, first if the relevant person can be supported to make the relevant decision and then to suggest who might be an appropriate person to notify from the relevant person’s perspective. If there is no such person, then the Independent Advocate may the appropriate person to make the application to court and will be in a position to assist and attend with the relevant person in court or, if the relevant person is not attending the hearing concerned, promote the interests and will and preferences of the relevant person in court.

As already stated it is not appropriate to notify persons who may have been given authority for some decisions but not given specific authority to consent to make an admission decision in respect of a relevant person.

4.3 Do you have any other views specific to Head 4?

It is necessary to query the use of the term 'routine admission'. No admission which consists of an intention to deprive a person of his or her liberty can be termed 'routine'. The word 'routine' should be deleted from this heading.

This Head must also be subject to the provisions of a revised Head 3 which provides for a statement as set out at 3(1) above. An admission decision shall only be made if such a statement has been provided and if the relevant person has had the support of an Independent Advocate to ascertain whether the relevant person can make the decision him or herself or has capacity to appoint a co-decision-maker to make the admission decision jointly with him or her or has the capacity to appoint an attorney to make an enduring power of attorney and give such attorney the authority to make an admission decision.

Head 5 – Procedure for Admission of a Relevant Person to a Relevant Facility in Urgent Circumstances

Questions on Head 5:

5.1 In subhead (1), what are your views on the proposed circumstances in which an urgent admission can be made?

On what basis does a healthcare professional have reason to believe that an immediate admission is necessary? The legislation should set out the criteria for 'urgent circumstances'. If this is not included, then in practice where a person has not given authority to another to make an admission decision or there is no court order in place, this section will be used for such admissions without the necessary safeguards. It would be preferable if the term 'emergency admission' was used instead of 'urgent circumstances.' It is suggested that, the HIQA definition of Emergency Admission as used in its standards for residential services for people with disabilities and the standards for older people, be adopted. HIQA definition: *an admission to a residential service that is unplanned, unprepared or not consented to in advance.*

A number of comments are necessary in relation to the wording of Head 5(1) (a) (i) and (ii).

If (i) and (ii) are to remain the following needs to be added as (iii):

Admission is a proportionate response to the likelihood of harm and the seriousness of the harm.

Is there confusion in 5(1) (a) as to the criteria that may arise for involuntary detention for the purposes of the Mental Health Act 2001? Is it intended that this includes a person who has a 'mental disorder' as defined in the Mental Health Act 2001?

In many case where older persons are concerned, the need for admission to a residential centre may be simply that they have nowhere else to live or are isolated and living in fear. Similarly a person with an intellectual disability, they may have no family or no home. Many of these situations arise in emergency situations where a family member dies. This of course raises the wider policy issue of the need for assisted living accommodation or other types of accommodation. However, the current factual situation is that many, older people in

particular, are living in designated centres as there is no suitable alternate residence for them. In many of these situations the risk of harm does not arise. If existing residents of such centres are to come within the provision of Part 13 then this Head needs to be recast.

5.2 In subhead 2(b), should a health professional other than a registered medical practitioner be able to provide medical evidence? If so, what type of healthcare professional? This issue also arises in Head 6(2).

Before answering on subhead 2(b), it is necessary to comment on subhead 2(a).

The requirement to have medical evidence is suggesting the ongoing conflation with mental illness.

Hence the query as to how subhead 1(a) is drafted.

As already stated under Head 1(2) above there should be consistency with other parts of the ADMC Act 2015 and provision should be made in subhead 2(b) for a registered medical practitioner and another healthcare professional. Another healthcare professional, for example, a social worker or a public health nurse would be the more appropriate persons to ascertain the living accommodation needs of a relevant person.

In Head 5(3) and (4) - Any notification being given to the relevant person and any other person or persons that may have been specified by the relevant person in writing under the provision of this subhead should also be notified to the Director of the Decision Support Service.

If there is a registered co-decision-making agreement or a registered enduring power of attorney in place the Director will have details of the authority that such a person has and will have contact details of such persons. (Indeed, the Registers will be available to such persons who need access to such information).

In Head 5 generally - it is not sufficient to simply have authority in relation to personal welfare matters, there must be specific reference in the authority for the making of an admission decision. This has been confirmed in the Explanatory Notes to Head 6 but must be the same for the purposes of each section within Part 13.

5.3 In subhead (7), who should make the application to Court if no one else does so? Do you have a view on the proposed role of the Director of the Decision Support Service? This issue also arises in Heads 7(6), 7(11) and 8(3).

As suggest in reply to Head 3.2 above the appropriate person in such circumstances may be the Independent Advocate who will be responsible for notifying the Director of the need for such application to court. Before such application is made the Director may, if she considers it necessary to do so, and in carrying out her functions, can either *consult with any person who has any function in relation to the care and treatment of a relevant person* under Section 95(5) or direct a Special Visitor to visit the relevant person under Section 99(5).

5.4 Do you have any other views specific to Head 5?

This Head needs to be reworked to take account of access to an Independent Advocate by a

relevant person where an emergency admission is required.

The timelines set out in this section will then have to be reconsidered in the light of more appropriate safeguards being available. (See paragraph 7 of General Comments).

Head 6 – Procedure for making an Admission Decision

Questions on Head 6:

6.1 Is the evidence of one medical expert sufficient?

Paragraph 1 of the Explanatory Note to Head 6 is incorrect in stating that the ECHR requires an admission decision to be based on medical evidence.

As already indicated and for the reasons stated above, a report of a ‘medical expert’ is not required.

Head 6(1) as currently drafted providing for a medical expert is not consistent with the provisions of Parts 1 and 2 of the ADMC Act 2015 nor in compliance with the UNCRPD.

6.2 Do you have any other views specific to Head 6?

It is suggested that this Head Procedures for making an Admission Decision comes after Head 2 Application and Purpose of this Part.

There is a poor attempt in this draft Head 6 to set out that such a decision is necessary and there is no other appropriate, practicable and less intrusive manner. However, these important principles, need to be more fully developed, to include an initial assessment of needs and risks, giving effect to the presumption of capacity and evidence of support given to the relevant person to make an admission decision before any action is taken or intervention made. (See reply to 3.1 above and paragraphs 3 and 5 of General Comments).

The use of the word ‘harm’ is not defined. The word ‘harm’ usually connotes injury. This wording appears to be borrowed from the Mental Health Act 2001. Does this mean that the relevant person must be provided with care elsewhere if there is no ‘harm’? There may be situations where there is no alternative accommodation for a relevant person and they lack capacity to make any decision. Part 13 must provide for this also. (See reply to Head 5(1) above).

Head 7 – Persons Living in a Relevant Facility

Questions on Head 7:

7.1 In subhead (2), do you have views on how the issue of fluctuating capacity should be addressed?

Regard must be had to Section 3 of the 2015 Act which provides for a functional construction of capacity.

The need for assistance and support of an Independent Advocate is particularly necessary when a person’s capacity may fluctuate. An Independent Advocate following the Guiding Principles may be able to ascertain the will and preference of the person. However, it is suggested that

this matter is best dealt with by detailed Code of Practice. When a review of the implementation of the Act takes place this matter can be revisited as to whether there should be legislative provision based on best practice experience.

7.2 In subhead (2), do you have a view on the length of time that would be considered a “short period”? This issue also arises in Heads 7(8), 7(12) and 8(5)

See reply above.

7.3 Do you have any other views specific to Head 7?

Person who is living in a relevant facility either before or after commencement of this Part and wishes to leave it

Subhead 1 provides for procedures to be followed where a relevant person who is living in a ‘relevant facility’ wishes to leave and the person in charge or a healthcare professional has reason to believe that in accordance with the Guiding Principles, the relevant person lacks the capacity to make the decision to leave, in such circumstances it is necessary that the relevant person has access to an Independent Advocate.

Person Who After Commencement of this Part Had Capacity to Decide to Live in a Relevant Facility and May Now Lack Capacity

Subhead 4 provides for an intervention where a person who voluntarily entered and lived in a ‘relevant facility’ no longer has capacity and affording them the opportunity to apply to court.

This is an intervention that is totally unnecessary. What is necessary, is to give effect to the provisions of the 2015 Act:

- (i) The ADMC Act 2015 applies the presumption of capacity unless the contrary is shown. If a relevant person voluntarily entered and lived in a residence, on what basis is the person’s capacity to make that decision now being questioned?
- (ii) The Guiding Principles provide for the least interventionist approach, an application to court, in the light of a decision which was made voluntarily, is not respecting the right of the autonomy of the relevant person.
- (iii) The court in considering an application to it, must seek the reason the application is being made and reason why the benefit to the relevant person sought to be achieved has failed to be achieved by the relevant person’s own expressed will and preference. The court will also be obliged to enquire as to the will and preference of the relevant person.

(See paragraph 4.4 of General Comments).

Person Who Previously Lacked Capacity and May Have Regained it

Subhead 9 provides that where a person has regained capacity in respect of a person where the court had made an order pursuant to Section 37(1) (b) that the person lacked capacity then an application under Section 49 for a review of that order is necessary. This again is excessive. A

notification to the Director and the court by the relevant person should be sufficient. (See paragraph 4.6 of General Comments).

Head 8 – Transitional Arrangements for Existing Residents on Commencement of this Part

Questions on Head 8:

8.1 Do you have any views specific to Head 8?

As already replied to under Head 2 above, Part 13 and particularly Head 8 must apply to a Ward of Court.

Head 8 as drafted needs to be clear that what is intended is that before a view is formed that a person lacks capacity to make an admission decision and trigger an application to court that every effort must be made to maximise the person's capacity to make this particular decision. This Head also illustrates the needs for a person, if they do not have persons close to them to give this support that access to an Independent Advocate is necessary. If there is a reasonable belief that a person lacks capacity then the Independent Advocate will notify the Director of the Decision Support Service. (See replies to Heads 3.2 and 5.3 above. See also paragraph 5 of General Comments).

Head 9 – Review of Admission Decisions

Questions on Head 9:

9.1 Do you have any views specific to Head 9?

It is repeated that the ECHR does not require medical evidence unless the person being deprived of his or her liberty has 'mental disorder' and is being involuntarily detained.

Medical evidence may not be the most appropriate evidence with regard to an admission decision.

This draft Head also provides evidence of conflation with decision-making capacity and mental disorder.

The association of admission 'in order to protect the relevant person from significant harm' is questioned. If Part 13 is intended to include relevant persons who are being involuntarily detained for the purposes of the Mental Health Act 2001 then this needs to be made clear. However, if it is not intended to include persons who have a 'mental disorder' (as stated in paragraph 5 of the Consultation Paper) then amendment to the criteria for an admission decision is necessary. (See paragraph 7.7 of General Comments).

The ADMC Act 2015 provides that a relevant person may apply to the court him or herself. This should be reflected in this Head providing for a review of an admission decision. It should not be necessary in such circumstances for a court to hear 'medical evidence' or evidence from a third party where the person is able to attend in court and give whatever direct evidence the court may require.

Head 10 - Chemical Restraint and Restraint Practices

Questions on Head 10:

10.1 Do you have any views specific to Head 10?

The NSC very much welcomes the banning of chemical restraint, the aim of which is to prevent the administration of medication which is not necessary for a medically identified condition but is used with the intention of controlling or modifying the relevant person's behaviour. It is important however, that oversight of the administration of medication be undertaken in accordance with Regulations prescribed by the Minister under Head 12.

Head 11 – Records to be Kept

Questions on Head 11:

11.1 Do you have a view on the types of records that must be kept under this Head?

Records should be kept of the assistance and supports given to a relevant person to enable them to make an admission decision. This may be required by the court.

Records should be kept of when and in what circumstances access to an Independent Advocate was sought. This will be required under Regulations. (See paragraph 5.4 of General Comments).

Records relating to the reasons for the administration of medication to ensure compliance with the requirements of Head 10 (1) and (2)

Records relating to the exceptional practices that gave rise to the use of restraint of a relevant person.

11.2 Do you have any other views specific to Head 11?

Subhead 3 – It is agreed that Regulations should specify to whom records should be made available for inspection. It is also necessary to provide that access to such records are available to the Director of the Decision Support Service to enable her to carry out her function with regard to investigations.

Head 12 – Regulations

Questions on Head 12:

12.1 In subhead (1), do you think that the Minister should be empowered to make regulations on any other aspect of the Heads?

As already suggested in answer to 10.1 and 11.1 above, Regulations are required with regard to the recording the reasons for the administration of medication to a relevant person in a residential setting and to provide that the Director of the Decision Support Service may send out a Special Visitor to carry out audits if required.

Regulations should provide for the appointment and functions of an Independent Advocate. (See paragraph 5.4 of General Comments).

12.2 In subhead (2), do you have a view on any other policy and procedure that should be included in this subhead?

Question arises as to whether the provisions of Part 13 apply to step down/respice/assisted-living facilities where there may be de facto detention.

12.3 Do you have any other views specific to Head 12?

No

Head 13 – Offences

Questions on Head 13:

13.1 Do you have a view on the proposed offences set out in this Head?

It should be an offense for a person who uses coercion or undue influence to force another person to agree to admission to a ‘relevant facility.’

It should be an offence if any person debars a relevant person access to an Independent Advocate.

13.2 Do you have any other views specific to Head 13?

No

14 - General Questions

A number of the Heads - 5(2) (b), 5(3), 5(4), 5(7), 5(8), 7(6), 7(9), 7(11), (8(1) and 8(3) - set down timeframes within which certain actions must be taken. Do you have a view on any of these proposed timeframes?

Timeframes need to be further considered when the legislative framework is further developed to comply with human rights standards and obligations.

14.2 The draft Heads apply to older people, persons with disabilities and people with a mental health illness. In terms of timeframes and in light of the existing provisions of the Mental Health Act 2001, should those with mental health illness be treated differently to others?

Part 13 should apply to any person who is detained against their wish and do not come with the excluded provision of the ECHR. The class of persons mentioned here do not come within those exclusions. Persons with mental health illness have the same rights as others. Question that arises is, is it intended that a person who has a ‘mental disorder’ and can now be involuntarily detained be included or excluded from the provisions of Part 13. For clarity, a person with a mental illness is not necessarily a person with a ‘mental disorder’. There appears to be confusion on this issue in the Draft Heads.

14.3 Do you have any other views on the draft provisions?

Part 13 as drafted appears to apply the ‘disability tag’ to some of the provisions set out and on the other hand where the relevant person may need support and assistance does not appear to comply with human rights standards. It is necessary that there is a clear understanding of the need for a rights based approach to comply with the UNCRPD.