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## Legal Capacity in a Mental Health Context in Ireland A Critical Review and a Case for Reform

Andrew Guy

*Technological University Dublin, [andrew.guy@tudublin.ie](mailto:andrew.guy@tudublin.ie)*

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**Legal Capacity in a Mental Health Context in Ireland  
A Critical Review and a Case for Reform**

**By**

**Andrew Guy**

**B.A. (Hons) National College of Ireland  
PgDip in Legal Studies, Dublin Institute of Technology**

**A thesis submitted in part-fulfilment of the requirements of the  
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**Under the supervision of  
Dr. Stephen Carruthers**

## **Abstract**

This thesis examines the issue of legal capacity in the context of existing and proposed mental health legislation in Ireland from a human rights perspective. Its primary focus is to assess whether certain recent proposed reforms to Ireland's existing mental health legislation will meet the relevant prevailing international human rights standards, namely the United Nations Convention on the Rights of Persons with Disabilities (the "**CRPD**").

In particular, it includes a critical review of the proposed legislative reforms in the area of legal capacity in a mental health context. In summary, the main reforms are contained within the Scheme of Mental Capacity Bill which was published in 2008 (hereinafter referred to as the "**2008 Scheme**") and the recently published Advanced Healthcare Decisions Bill 2010 (hereinafter referred to as the "**2010 Bill**") which specifically focuses on the contentious area of advanced decisions (also known as advance directives or advance care directives). Following on from this review, the thesis highlights comments on some of the potential human rights violations that could arise if the aforementioned 2008 Scheme and 2010 Bill were implemented into Irish law without making consequential amendments to the main existing legislation in Ireland governing capacity in a mental health context, namely the Mental Health Act, 2001.

Finally, this thesis seeks to identify and consolidate the implications these issues will have for the Irish Government with respect to its obligations under the CRPD. It also considers the implications the enactment of the aforementioned proposed legislation may have on the most vulnerable people in our society.

## **Declaration**

I certify that this thesis which I now submit for examination for the award of M.A. in Law, is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

This thesis was prepared according to the regulations for postgraduate study by research of the Dublin Institute of Technology and has not been submitted in whole or in part for an award in any other Institute or University.

The work reported on in this thesis conforms to the principles and requirements of the Institute's guidelines for ethics in research.

**Signature:** \_\_\_\_\_

# Acknowledgements

I would like to thank my family for all their help and support;

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## **Chapter 1. Literature Review.**

This section details the primary sources used in this thesis. These are:

- The Mental Health Act 2001
- The United Nations Convention on the Rights of Persons with Disabilities 2006
- The Scheme of Mental Capacity Bill 2008
- The Advance Healthcare Decisions Bill 2010

These sources will be briefly discussed below as they relate to this thesis. They will be examined in further detail in later chapters. In addition, there are numerous submissions and reports on the proposed reform of mental capacity law that were used in preparing this thesis from agencies such as the Law Reform Commission, the Irish Council for Bioethics, Inclusion Ireland, the Irish Human Rights Commission and the Mental Health Commission.

The secondary sources used in this thesis are namely legal articles and opinions from legal journals such as the Medico-legal Journal of Ireland, The Irish Jurist and the Dublin University Law Journal. Submissions by lobbying groups such as Amnesty International also offer good insights to some of the proposed legislation from a human rights perspective. These sources are discussed briefly below.

This section also briefly describes how some of the main sources generally relate to the thesis topic. These sources are discussed in further detail in later chapters.

### **1.1. Primary Sources:**

#### **The United Nations Convention on the Rights of Persons with Disabilities 2006:**

International human rights law is constantly evolving and the most recent statement on the rights of persons with disabilities, including persons with mental health problems, is

the Convention on the Rights of Persons with Disabilities (CRPD).

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities. The CRPD does not create any new rights but clarifies the steps to be taken by States to ensure rights of persons with disabilities are respected, protected and fulfilled.

One of the foundation stones of the CRPD is that there is equal recognition before the law for all persons with disabilities. Therefore if Ireland is to ratify this convention a reform of our mental health laws will be needed so that persons with disabilities being treated under mental legislation are not discriminated on the basis of their disability. As will be seen many provisions in the Mental Health Act would be deemed discriminatory to persons with disabilities contrary to the convention.

### **Proposed Legislation:**

#### **The Scheme of Mental Capacity Bill 2008:**

The Scheme is part of Ireland's reform of mental capacity law. The Scheme broadly follows the structure set out by the Law Reform Commission (LRC) in their report.<sup>1</sup> The Scheme will be discussed in greater detail in chapter 3. Its main purpose is to introduce a modern statutory framework governing decision making for people who lack capacity. The Scheme contains a presumption of capacity and a definition of capacity.

The Regulatory Impact Assessment (RIA) of the Scheme states that the Scheme marks a significant step to the ratification process of the CRPD. However, the Scheme is silent on how its provisions will interplay with those of the Mental Health Act. It is important for Ireland's international obligations in complying with the CRPD that the positive aspects of the Scheme apply equally to persons being treated under the Mental Health Act.

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<sup>1</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006).

## **The Advance Healthcare Decisions Bill 2010:**

This thesis will consider if certain provisions in the Bill, would comply with the relevant international human rights standards namely the CRPD. Specifically the focus will be on how the Bill will interact with the provisions of the Mental Health Act. The Bill basically provides a mechanism to allow a person to formally record their wishes at a time when they have capacity in relation to future healthcare decisions that may arise at a time when the person lacks capacity.

In an Irish Times article Senator Liam Twomey, who initiated the Bill in the Seanad, said the initiative aimed to provide for a patient's dignity, bodily integrity, privacy and autonomy during the later stages of life: "There is a dearth of legislation in this area. Ireland lags behind when it comes to providing an opportunity to legally set out an individual's preferred end-of-life treatment, in the event of an incurable or terminal illness."<sup>2</sup>

### **Existing Legislation:**

#### **Powers of Attorney Act 1996:**

A power of attorney is an authority given by one person (the donor) to another (the donee) to perform certain acts which the former has power to perform. They may be general, enabling the donee to perform all the acts the donor could perform or specific, limited to a particular act or acts. The 1996 Act also provides for an "enduring" power, to be effective during any subsequent mental incapacity of the donor. At present, decisions about the giving or refusing of healthcare are not in the scope of the Powers of Attorney Act. The Advance Healthcare Decisions Bill proposes to amend the Powers of Attorney Act 1996 so that certain healthcare decisions can be designated to a donee.

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<sup>2</sup> Fine Gael to publish Bill on 'living wills' - The Irish Times, 27 May 2010.

## **The Mental Health Act 2001:**

The issue of mental capacity is hugely relevant in the context of the Mental Health Act which deals with involuntary admission, detention and treatment of persons with mental health difficulties. However the Mental Health Act does not contain a definition of capacity, rather this is implied in its definition of consent. Legal capacity is at the centre of this thesis and the provisions relating to consent to treatment in the Mental Health Act raise further issues for patient autonomy.

Section 59 of the Mental Health Act deals with the administration of Electro-convulsive Therapy (ECT). Section 59(1) (b), deals with the administration of ECT to a patient without consent. The wording of the section, which will be discussed later, implies that ECT can be administered to a capable patient who is “unable or unwilling” to receive it.

This wording is very important, as it would clearly seem to undermine patient autonomy, and has been the topic of much debate. A Bill has recently been passed in the Seanad<sup>3</sup> to amend section 59. However, pending reform, the Section still stands and, as this thesis will argue, have serious implications for Ireland’s international obligations relating to human rights law.

## **1.2. Secondary Sources:**

### **Law Reform Commission Reports:**

The Law Reform Commission (the LRC) have carried out extensive research in the area of mental capacity law and their reports form the basis of Ireland’s proposed reform of mental capacity law.

The LRC Report on Vulnerable Adults and the Law forms the basis for the reform of mental capacity law in Ireland and the proposed Scheme keeps within its

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<sup>3</sup> On the 24<sup>th</sup> of March 2011 the Mental Health (Involuntary Procedures) (Amendment) Bill 2008 was passed by the Seanad.<sup>3</sup> This Bill, if passed, will amend section 59 of the MH Act to delete the term “or unwilling”.

recommendations. The Report brings together related issues dealt with in two previous Consultation Papers, LRC Consultation Paper on Law and the Elderly<sup>4</sup> and the LRC Consultation Paper on Vulnerable Adults and the Law: Capacity.<sup>5</sup>

The focus of the first Consultation Paper was to make recommendations concerning older people with decision-making disabilities. The LRC concluded that a lot of these issues were relevant to other adults with decision-making disabilities and this formed the basis of the second Consultation Paper<sup>6</sup> which provisionally recommended the enactment of new capacity legislation in order to create clear rules on legal capacity which would apply to a wide range of decisions, including making contracts buying groceries at a shop, transferring ownership in land, entering into a personal relationship and making healthcare decisions.

In 2008 the LRC published its Consultation Paper on Advance Care Directives<sup>7</sup>. The LRC in its previous Report and Consultation Papers addressed the topic of advance directives. However, noting that there was no legislation specifically dealing with the efficacy of advance directives, they concluded that this topic was one which may “merit further consideration in the context of the establishment of a coherent legal framework for capacity and substitute decision-making.”<sup>8</sup>

In 2009 the LRC published its Report on Advance Care Directives and this Report sets out the LRCs final recommendations on advance directives, together with a draft Mental Capacity (Advance Care Directives) Bill intended to implement those recommendations.<sup>9</sup>

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<sup>4</sup> Law Reform Commission *Consultation Paper on Law and the Elderly* (LRC CP 23 -2003).

<sup>5</sup> Law Reform Commission *Consultation Paper on Vulnerable Adults and the Law: Capacity* (LRC CP 37-2005).

<sup>6</sup> *Ibid.*

<sup>7</sup> Law Reform Commission Consultation Paper, *Bioethics: Advance Care Directives* (LRC CP 51-2008)

<sup>8</sup> Consultation Paper on *Vulnerable Adults and the Law: Capacity* (LRC CP 37-2005) para 7.64.

<sup>9</sup> Law Reform Commission Report, *Bioethics: Advance Care Directives* (LRC 94-2009)

### **1.3. Legal opinions:**

#### **Irish Council for Bioethics:**

In addition to the LRCs extensive work on the topic, the Irish Council for Bioethics (ICB) had previously conducted research and public consultation on the legal and ethical issues surrounding advance care directives and published its opinion, *Is It Time for Advance Healthcare Directives?* in February 2007.<sup>10</sup>

Similar to the LRC Report the ICB opinion is focused on advance directives dealing with end of life treatment and care. Unfortunately, the ICB has ceased to operate due to discontinuation of government funding.

#### **Amnesty International (Ireland):**

Amnesty International Ireland has done extensive work on the area of mental health law from a human rights perspective. They have carried out exploratory research in the area of decision making capacity with people who have had impaired capacity. Furthermore they have made a submission together with recommendations to the Government on the proposed Scheme in the context of how it will affect people with disabilities and how it will relate to the Mental Health Act.

In addition Amnesty has recently made a submission to the government on the proposed amendment to section 59 of the Mental Health Act. The submission looks at the proposed Bill in the Seanad that proposes to amend s. 59. This Bill is called the Mental Health (Amendment) Bill 2008 and is at its final stages in the Seanad.<sup>11</sup> The Bill was initiated in the Seanad so will have to be sent to the Dail before it is enacted into law. As it has taken two years and many debates to get to this stage, it is likely in the current climate that it will be a long time before the Bill will be passed.

Many other agencies and bodies have made submissions on the proposed reform of

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<sup>10</sup> Available at [www.bioethics.ie](http://www.bioethics.ie).

<sup>11</sup> Mental Health (Amendment) Bill 2008, Report and Final Stages, 24/03/2011

mental capacity law in Ireland (the Scheme). Some of these include, Inclusion Ireland<sup>12</sup> and the Irish Human Rights Commission.<sup>13</sup> I have reviewed these for the purposes of this thesis.

### **Miscellaneous:**

Academic opinions offer great insight into some the issues that arise in the area of mental capacity and the Mental Health Act. Mary Donnelly, a senior lecturer from University College Cork, has done extensive research in the area of mental capacity and patient autonomy in the context of the Mental Health Act<sup>14</sup>. She has published a number of informative articles in the leading journals on these issues which I have reviewed.

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<sup>12</sup> Available at, [http://www.inclusionireland.ie/topics\\_capacity.asp](http://www.inclusionireland.ie/topics_capacity.asp)

<sup>13</sup> Available at, <http://www.ihrc.ie/newsevents/press/2010/02/15/ihrc-calls-for-mental-capacity-legislation-and-rev/>

<sup>14</sup> Mary Donnelly, profile available at, <http://www.ucc.ie/en/lawsite/staff/mdonnelly/>

## **Chapter 2. Legal Provisions Governing Capacity.**

### **Overview:**

This chapter will identify some of the key legal issues relating to a person's decision making capacity in Ireland. In particular it highlights the issues relating to capacity for people who have a mental disorder and are being treated under the Mental Health Act. These issues are an important part of the overall topic relating to decision making capacity in Ireland and are relevant in the context of the proposed reform of mental capacity law in Ireland via the Scheme of Mental Capacity Bill 2008<sup>15</sup> and the Advance Healthcare Decisions Bill 2010.<sup>16</sup> Certain issues relating to capacity in general will also be discussed. The wards of court system, which is the current system governing capacity, will be discussed.

In highlighting these issues relating to capacity this chapter will then identify the international standards for assessing capacity contained in the UN Convention on the Rights of Persons with Disabilities (CRPD).<sup>17</sup> In brief, the CRPD is seen as making a “paradigm shift” in how disability is perceived by adopting a social model where disability resides in society not in the individual.

Advance Directives will be discussed briefly in this chapter as these will be given more detailed analysis in chapters 3 and 4. For the purpose of this chapter their potential benefits for treatment options relating to people who lack capacity will be highlighted.

### **2.1 Capacity:**

In summary, legal capacity consists of two integral components: the capacity to hold a right and the capacity to act and exercise the right. Both these elements are integral to the

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<sup>15</sup> Department of Justice, Equality and Law Reform, Scheme of Mental Capacity Bill 2008.

<sup>16</sup> Advance Healthcare Decisions Bill 2010 [Seanad] [PMB], [www.oireachtas.ie](http://www.oireachtas.ie)

<sup>17</sup> Convention on the Rights of Persons with Disabilities, available at <http://www2.ohchr.org>

concept of legal capacity. Therefore, recognition of the legal capacity of any group or individual mandates recognition of both these integral elements.

### **Conceptual issues concerning capacity:**

At present in Ireland there is no specific definition of capacity at common law or in statute. Irish law begins with a presumption of capacity. However, this may be rebutted if there is evidence establishing a lack of capacity, for instance, the presence of a mental disorder. The LRC have identified three approaches when assessing capacity: the ‘status’ approach, the ‘outcome’ approach and the ‘functional’ approach.<sup>18</sup>

### **Status approach:**

Under the status approach, the determination of incapacity is based on the characteristics of the individual, for example their medical or psychiatric diagnosis. The status approach makes an “across-the-board” or “all-or-nothing” assessment of capacity or incapacity, rather than an assessment based on a particular decision at a particular time. The LRC noted that “[a] status approach to capacity has particular potential to operate inequitably in relation to persons whose capacity fluctuates.”<sup>19</sup> The ‘status’ approach for determining capacity is evident in the current wards of court system operated in Ireland. This is discussed in further detail at 2.2 below.

The ‘status’ approach for assessing capacity raises particular difficulties. For example, many patients who would be diagnosed as having a mental disorder or intellectual disability could still be able to make some decisions. However, the use of a status approach means that the patient could be given a range of treatments, even if they might have capacity to refuse one or more of these treatments as they would be deemed not to have sufficient capacity.

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<sup>18</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006).

<sup>19</sup> *Ibid.*, para 1.65

### **Outcome approach:**

Under the ‘outcome’ approach, capacity is determined based on an assessment of the consequences of an individual’s decision. The result of the decision is taken as an indicator of the individual’s capacity. This could mean that “[a] decision which does not conform to normal societal values (or the values of the assessor) might be deemed to be evidence of incapacity.”<sup>20</sup>

### **Functional approach:**

The third approach in assessing capacity recognised by the LRC is the ‘functional’ approach. A functional definition of capacity focuses on a person’s cognitive ability to understand the nature and consequences of a decision in the context of his or her available choices.

The functional approach involves an “issue-specific and time-specific assessment of a person’s decision-making ability”.<sup>21</sup> This means that the capacity of an individual is determined on the basis of a particular decision at a particular point in time. A ‘functional’ approach would also recognise that a person may be capable of making some decisions while incapable of making others. In addition, under the functional approach to capacity, a new assessment of capacity is required for each new decision or task.

### **Assessing Capacity under Irish Law:**

As noted above, in Ireland, there is a presumption of capacity at law albeit there is no definition of capacity in statute. The common law approach to capacity is a functional one but problems seem to arise when persons are diagnosed with a mental disorder. In these instances, such individuals may be made a ward of court or detained under the Mental Health Act. If this occurs, it would seem that their capacity is assessed under the provisions of the relevant legislation which would amount to a de facto status approach to

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<sup>20</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006) para 1.63

<sup>21</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006) p 46.

capacity as opposed to a functional approach.

The appropriateness of the functional test for capacity is widely accepted and is favoured by the LRC.<sup>22</sup> However, until there is a meaningful reform of mental capacity law that incorporates and a functional approach together with a definition of capacity laid down in statute, there is still a risk that vulnerable people will be assessed as lacking capacity solely on the grounds of them having a particular mental disorder.

The proposed new capacity legislation contained in the Scheme of Mental Capacity Bill 2008<sup>23</sup> adopts a time-specific and issue-specific functional approach towards capacity. Nonetheless, pending this reform, questions may still be raised regarding the current status of the functional test in Irish law in two circumstances. As noted above these are, first where a person has been made a ward of court and secondly where they have been involuntarily admitted under the Mental Health Act.

## **2.2. Wards of Court:**

The wards of court system is the existing mechanism for managing the affairs of persons who lack decision making capacity in Ireland. The wards of court system encompasses a ‘status’ based approach to capacity. In summary, an individual who becomes a ward of court comes under the care of the High Court.

The wards of court procedure is primarily used when a person is of “unsound mind” and incapable of managing their affairs and significant decisions need to be made concerning their property. However, it can be used in cases where the welfare, rather than the property, of the person requires protection.

The main legislation governing this area is the Lunacy Regulation (Ireland) Act 1871. Therefore, the wards of court procedure and language contains terminology and concepts which are arguably inappropriate and out of date today and ill-adapted to the modern

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<sup>22</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006)

<sup>23</sup> Department of Justice, Equality and Law Reform, Scheme of Mental Capacity Bill 2008.

understanding of mental illness and legal capacity.

### **The Wardship Procedure:**

In order for an adult to be admitted to wardship under the 1871 Act, a person must be both of “unsound mind” and incapable of managing their affairs. The wardship procedure is commenced in the High Court by petition to the Office of the Registrar of Wards of Court. The petition must be supported by the affidavits of two medical practitioners. If the President of the High Court is satisfied with the medical evidence, he will direct an inquiry into the capacity of the individual prior to determining whether the individual should be taken under the protection of the court. This “inquiry order” requires that a medical visitor (usually a consultant psychiatrist) examines the person and reports to the President.

If no objections are then filed, the petition is listed before the President of the High Court whereby a “Declaration Order” may be made declaring the individual to be of “unsound mind” and incapable of managing his/her affairs whereby the individual will be taken into wardship.

There is no definition of “unsound mind”; this would seem to be left to the discretion of the medical practitioners and ultimately the President of the High Court.

### **The Effects of being made a Ward of Court:**

Once a person is made a ward of court, they effectively lose the right to make most decisions about their person and property. In relation to treatment of a ward of court, the LRC states that the High Court would seem to have exclusive jurisdiction to grant or withhold consent to treatment. However, in the case of an emergency, a doctor is entitled to take necessary urgent action to preserve the life and health of a patient.<sup>24</sup>

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<sup>24</sup> Law Reform Commission, Consultation Paper on Law and the Elderly, (LRC CP23-2003), para. 4.50.

The LRC identifies that for procedures that are considered “non-controversial”, for example, treatment of fractures, the Registrar of Wards of Court is authorised by the President of the High Court to issue consent to the carrying out of these procedures.

Other procedures are considered as “controversial” or “non-routine”, and these are considered personally by the President of the High Court.<sup>25</sup>

It is interesting to note that this category of “controversial” procedures also includes procedures where the ward was capable of consenting, but did not consent. “The second category also includes procedures to which the ward, if capable of indicating agreement, did not agree; or to which the next-of-kin did not agree, if the ward was personally incapable of indicating agreement. In such cases the President of the High Court seeks the advice of one of the members of his panel of Medical Visitors as to whether it would be appropriate to give consent of the Court to the treatment.”<sup>26</sup>

This would seem to further illustrate the limitations of a status approach to capacity as it indicates that a ward could be found capable of making a healthcare decision but could be denied making that decision if the Court deems it inappropriate. Donnelly argues that if following a separate assessment of capacity to make healthcare decisions, the ward is found to be capable; their right to make their own decision in this respect should subsist and should not be determined by the fact that they are a ward.<sup>27</sup> Furthermore, the wardship order is of indefinite duration and is not subject to automatic periodic review. There are some provisions for review in the legislation, but these are limited and tend to arise only if a complaint is made.<sup>28</sup>

Ireland’s legislation concerning wards of court is outdated. In addition, it would appear that it could be in violation of international human rights law which advocates equal recognition before the law for all persons with disabilities.

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<sup>25</sup> *Ibid*, para. 4.50.

<sup>26</sup> *Ibid*, para. 4.50.

<sup>27</sup> Mary Donnelly, “Assessing Legal Capacity: Process and the Operation of the Functional Test” (2007) 2 *Judicial Studies Institute Journal* 141 at 151.

<sup>28</sup> Law Reform Commission, Consultation Paper on Vulnerable Adults and the Law: Capacity (LRC CP 37-2005), para. 4.25-6

This status approach towards capacity raises serious equality issues for people who are deemed to be a ward of court or persons diagnosed with a mental disorder. A person cannot be seen to be treated as equal if there is someone else making their decisions. In instances where that person is deemed incapable of making decisions, appropriate support must be supplied to include the person as much as possible in any decision made for them. It is widely acknowledged that the current ward of court system is woefully outdated and in need of reform.

### **2.3. The Mental Health Act 2001.**

The Mental Health Act raises some serious concerns in relation to capacity issues which will need to be addressed if there is to be a meaningful reform in this area. As previously noted, there is no specific legal definition of capacity in Ireland. In the Mental Health Act, capacity is referred to as consent to treatment. As a general principal of law, treatment cannot be given without consent. This principal is underpinned by the constitutional rights to autonomy and bodily integrity.<sup>29</sup> However if the patient lacks the capacity to consent to treatment, such treatment may be administered if it is in their “best interests”. There are specific rules in the Mental Health Act concerning treatment of involuntary detained patients.

#### **Mental Disorder:**

The Mental Health Act sets out the legal framework for the compulsory admission and the treatment of patients with a mental disorder. In order to be compulsory admitted to a psychiatric facility, a patient must be shown to suffer from a mental disorder.

A mental disorder is defined in section s.3 of the Mental Health Act as:

“**3.**—(1) In this Act “mental disorder” means mental illness, severe

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<sup>29</sup> Mary Donnelly, “The Right of Autonomy in Irish Law” (2008) 14(2) *Medico-Legal Journal of Ireland* 34

dementia or significant intellectual disability”<sup>30</sup>

These terms are defined in more detail in section 3(2). In addition they must fulfill one of the two conditions set out in section 3(1). These are that:

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

(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission”.<sup>31</sup>

There is no definition of what impaired judgment is and this could raise questions as to how this is assessed. It would seem that this would be left up to the responsible consultant psychiatrist (RCP).

### **Consent:**

Part 4 of the Mental Health Act deals with the issue of capacity. In the Act capacity is referred to as consent to treatment. At first sight, this part of the act affords a prominent role to the requirement of consent and would seem to follow a functional approach. Consent is defined in s.56 of the Mental Health Act as meaning:

“**56.**—In this Part “consent”, in relation to a patient, means consent obtained freely without threats or inducements, where—

(a) the consultant psychiatrist responsible for the care and treatment of the patient

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<sup>30</sup> Mental Health Act 2001, s.3.

<sup>31</sup> *Ibid.*

is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

(b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.”<sup>32</sup>

This definition of consent contains, by implication, a definition of capacity. Section 56 defines consent as arising where the patient is “capable of understanding the nature, purpose and likely effects of the proposed treatment.” Donnelly contrasts this standard of capacity with the common law standard adopted by the English Courts where, in order to be capable, a patient must be able to understand and retain information and to use and weigh that information in reaching a decision.<sup>33</sup>

This common law standard would seem to be a higher standard for assessing capacity as it requires the person not just to understand the purpose and likely effects of the treatment, but to be able to retain and weigh that information in reaching their decision. Arguably, setting a lower standard for capacity for people with a mental disorder (people being treated under the Mental Health Act) to that which is applied to patients in other contexts is inequitable and unjustifiable.

Another noteworthy aspect of the definition of consent under section 56 concerns the role of the Responsible Consultant Psychiatrist (RCP). It is the RCP who decides if the patient is capable of “understanding...the treatment”. There does not seem to be any mechanism under the Mental Health Act for a review of this decision by the RCP or any other faculty to challenge the decision. Donnelly notes that there is a real risk that a patient who rejects treatment proposed by their RCP will be assessed as incapable by the RCP who proposed the treatment in the first place.<sup>34</sup> Clearly, this is a real practical difficulty.

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<sup>32</sup> Mental Health Act 2001, part 4 s56

<sup>33</sup> Mary Donnelly, “Treatment For A Mental Disorder: The Mental Health Act 2001, Consent And The Role Of Rights” *Irish Jurist* 220: (2005) 40(1)

<sup>34</sup> Mary Donnelly, “Treatment For A Mental Disorder: The Mental Health Act 2001, Consent And The Role Of Rights” *Irish Jurist* 220: (2005) 40(1)

### **Circumstances where consent is required:**

Notwithstanding some of these issues regarding the definition of consent in the Mental Health Act, there would seem to be comprehensive procedures in section 57 whereby consent to treatment is required. This section states that,

“ The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.”<sup>35</sup>

This would seem to mean that ‘capable’ adult patients have the right to refuse treatment even if that treatment is considered necessary to safeguard the patient’s life or restore their health. Arguably, this elevates patient autonomy above values such as patient welfare or even the protection of patient life. However, as noted in section 57, whether a patient is capable or not is reliant on the opinion of the RCP and what type of mental disorder the patient is suffering from. Moreover, as noted above a person who is involuntary detained under the Mental Health Act will be regarded as having ‘impaired judgment’. While this term is not defined under the Mental Health Act, it would be difficult to imagine many situations in which a patient has impaired judgment at admission stage but would be capable of refusing prescribed treatment. Donnelly argues that most involuntary patients who seek to refuse treatment are likely to be found incapable by their RCP and will be administered treatment.<sup>36</sup>

In summary it would seem that section 57 does provide some safeguards for capable patients who wish to refuse treatment. However, as seen above, on closer inspection it would seem to be all too easy for the RCP to ignore a patient’s refusal to treatment on

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<sup>35</sup> Mental Health Act 2001, Part 4 S57

<sup>36</sup> Mary Donnelly, “Treatment For A Mental Disorder: The Mental Health Act 2001, Consent And The Role Of Rights” *Irish Jurist* 220: (2005) 40(1)

grounds of their mental disorder.

**Exceptions to consent requirements:**

Notwithstanding these loopholes, the requirement for patients consent under section 57 is further restricted by a number of key exceptions. These exceptions are contained in sections 58, 59 and 60.

Section 58 deals with psychosurgery, section 59 deals with electro-convulsive therapy (ECT) and section 60 deals with the administration of medicine. These sections limit a capable involuntary patient's right to refuse treatment. The wording in section 59 and section 60 refer to a patient being "unable or unwilling" to give consent. Section 59 is discussed in more detail below.

Section 59 of the Mental Health Act provides as follows:

**“59.—(1)** A programme of electro-convulsive therapy shall not be administered to a patient unless either—

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, **or**

**(b) where the patient is unable or unwilling to give such consent—**

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist. (2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in

accordance with such rules.”<sup>37</sup>

This wording means that treatment may be imposed on a capable, unwilling patient on the basis of the authorisation of a second consultant psychiatrist chosen by the patient’s own psychiatrist. In summary, the effect of section 59 (1) is to allow ECT to be given regardless of patient objections provided that the procedural steps outlined above set out are taken. However, Donnelly notes that these steps provide a very limited degree of review.<sup>38</sup> For instance, the authorisation by a second consultant psychiatrist: “There is nothing on the face of the Act to prevent a consultant psychiatrist from referring the matter to a second consultant whom he or she knows will agree with the treatment decision made.”<sup>39</sup>

While the Mental Health Act leaves the details regarding the form of approval and authorisation to be adopted to be specified by the Mental Health Commission (MHC),<sup>40</sup> the statute itself clearly limits the extent to which this approval procedure can be truly independent. This can be seen in the authorisation form drawn up by the MHC, Form 16. Both consultant psychiatrists must complete a Form 16, confirming that they have examined the patient and that they are of the opinion that the administration of ECT would be “of benefit” to the patient and give reasons for their opinion.<sup>41</sup> This further illustrates that the decision is in reality with the RCP.

### **Proposed Amendment to section 59:**

There has been much debate about abolishing section 59 of the Mental Health Act as on a pure literal interpretation it clearly infringes on the right to autonomy of the patient. The Department of Health and Children published a review of the Mental Health Act in 2007.

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<sup>37</sup> Mental Health Act 2001, Part 4 S59

<sup>38</sup> Mary Donnelly, “Treatment For A Mental Disorder: The Mental Health Act 2001, Consent And The Role Of Rights” *Irish Jurist* 220: (2005) 40(1)

<sup>39</sup> Mary Donnelly, “Treatment For A Mental Disorder: The Mental Health Act 2001, Consent And The Role Of Rights” *Irish Jurist* 220: (2005) 40(1)

<sup>40</sup> The Mental Health Commission is an independent statutory body established under the Mental Health Act to promote high standards in the delivery of mental health services and ensures the interests of those involuntarily admitted to Approved Centres are protected.

<sup>41</sup> Form 16, Treatment without consent Electroconvulsive Therapy Involuntary Patient (Adult), available at, <http://www.mhcirl.ie/documents/statutory/9179%20FORM%2016.pdf>.

The review suggests very few changes to the Act but the Minister accepts in principle that the references to “unwilling” in sections 59 and 60 should be removed.<sup>42</sup>

On the 4 March 2010, Amnesty International (Ireland) made a submission to the Department of Health and Children in relation to the proposed amendment of section 59 of the Mental Health Act.<sup>43</sup> This submission follows the initiation of a Private Members Bill in the Seanad, the Mental Health (Involuntary Procedures) (Amendment) Bill 2008.<sup>44</sup> The Bill will delete the term “or unwilling”

Despite the minister acknowledging that the term “unwilling” be removed and the initiation of the Private Members Bill to amend s.59, there still has been nothing done about it. It would seem that on a purposive interpretation of s.59, taking into account all the above that it would be quite unjustified to administer ECT to a capable, unwilling patient. However as seen above, if it is the RCPs opinion that it will benefit the patient the RCP would still, after following the procedures, be able to administer ECT to an “unwilling” patient.

The Activity Report of the Administration of Electro-convulsive Therapy in Approved Centres<sup>45</sup> in 2009 record that 44 patients were administered ECT without consent and 9 of these were determined as “unwilling” by both consultant psychiatrists.<sup>46</sup>

This clearly seems to undermine the autonomy of a patient being treated under the Mental Health Act. It would appear that the Mental Health Act does not respect the right of a competent patient to refuse treatment. Instead it allows such treatment to be imposed against such a person’s will, regardless of their decision-making capacity.

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<sup>42</sup> Review of the Operation of the Mental Health Act 2001 p 27, available at: [www.dohc.ie](http://www.dohc.ie)

<sup>43</sup> Amnesty International, Submission to the Department of Health and Children in relation to the proposed amendment of section 59 of the Mental Health Act 2001 and related matters.

<sup>44</sup> Mental Health (Involuntary Procedures) (Amendment) Bill 2008.

<sup>45</sup> The Administration of Electro-convulsive Therapy in Approved Centres: Activity Report 2009, Mental Health Commission.

<sup>46</sup> *ibid.*, at page 21, Table 5: Patient unable or unwilling to give consent. Number and percentage of Form 16s returned to the Commission in 2009.

## **Interaction between Mental Health Act and the Scheme of Mental Capacity Bill 2008:**

The issues highlighted above are highly relevant to the proposed reform of mental capacity law in Ireland. The Scheme of Mental Capacity Bill 2008 is to introduce a modern statutory framework governing decision making for people who lack capacity. The Scheme adopts a functional and time specific approach to capacity and contains a presumption of capacity. The Scheme will be discussed in greater detail in the following chapter.

As seen above, the issue of mental capacity is also relevant in the context of the Mental Health Act. Firstly, the definition of “mental disorder” includes a reference to impaired judgment, which would appear to be a reference to incapacity. Secondly, as seen above, Part 4 of the Mental Health Act refers to capacity (consent to treatment).

While the Scheme is a much needed and welcome piece of legislation it falls short on how its provisions will operate vis-à-vis the Mental Health Act. If the provisions in the Scheme will not apply or be subject to treatment that is lawful under the Mental Health Act, people who may have capacity to refuse treatment will still be denied their right to autonomy.

For the Scheme to benefit those who are most vulnerable the Mental Health Act must be amended to ensure that a functional and time-specific approach to capacity and the guiding principles and definition of “best interests” set out in the Scheme apply equally to persons involuntarily admitted to approved centres under the provisions of the Mental Health Act.

## **Interaction between the Mental Health Act and the Advance Healthcare Decisions Bill 2010:**

Another piece of proposed legislation which is relevant in the context of mental capacity

is the Advance Healthcare Decisions Bill 2010. This Bill will be discussed in detail in chapter 4. However, in the context of the above issues relating to consent to treatment under the Mental Health Act it has considerable relevance.

The potential benefits of having a legal mechanism that record patients treatment wishes at a time when they have capacity are significant. Winick lists a number of therapeutic benefits including the facilitation of preventative care, patient empowerment, the prevention of future incapacity, the reduction of stress and anxiety, enhanced self-esteem and decision-making capacity.<sup>47</sup> However the proposed Bill would appear to be more geared towards decisions regarding end-of-life care. Furthermore its provisions will not apply to treatment that is lawful under the Mental Health Act.

### **Conclusion:**

In short, for the reform of mental capacity reform to be of real benefit to the most vulnerable people in our society, namely people with disabilities being treated under the Mental Health Act, the Mental Health Act will need to be amended, specifically section 59 so that a functional approach to capacity is applied to any references to capacity, impaired decision-making or ability to consent under the Act. As it stands the current legislation dealing with capacity (ward of court) is outdated, furthermore the law relating to the assessment of capacity and consent to treatment for patients under the Mental Health Act needs to be amended as it is in breach of Human Rights laws as discussed in further detail at 2.4 below.

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<sup>47</sup> Winick, "Advance Directive Instruments for those with Mental Illness" (1996) 51 *University of Miami Law Review* 57.

## **2.4. The UN Convention on the Rights of Persons with Disabilities (CRPD).**

### **Background:**

International human rights law is constantly evolving and the most recent statement of the rights of persons with disabilities, including persons with mental health problems, is the Convention on the Rights of Persons with Disabilities (CRPD). Ireland has signed the Convention but has yet to ratify it.

### **Social Model of Disability:**

The CRPD is seen as marking a ‘paradigm shift’ in how disability is perceived by moving towards a social model, which recognises that “disability resides in society, not in the person.”<sup>48</sup>

The social model identifies systemic barriers, negative attitudes and exclusion by society that mean society itself is the main contributory factor in disabling people. One of the fundamental aspects of the social model concerns equality. Equal rights give empowerment and the ability to make decisions and the opportunity to live life to the fullest. The social model implies that attempts to change, “fix” or “cure” individuals, especially when against the wishes of the patient, can be discriminatory and prejudiced.

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.<sup>49</sup> The CRPD encompasses a range of rights that affect the everyday lives of persons with disabilities, such as, equality and non-discrimination (Article 5), accessibility (Article 9), personal mobility (Article 20), education (Article 24), health (Article 25), work and employment (Article 27), participation in political and public life (Article 29).

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<sup>48</sup> United Nations *Disabilities – From Exclusion to Equality – Realizing the Rights of Persons with Disabilities* (2007) United Nations, New York) 4.

<sup>49</sup> Convention on the Rights of Persons with Disabilities. Article 1.

It is important to note that the CRPD does not create any new rights but clarifies the steps to be taken by countries to ensure rights of persons with disabilities are respected, protected and fulfilled.

### **Current status of the CRPD:**

On the 23<sup>rd</sup> of December 2010, the European Union (EU) ratified the CRPD. Following its ratification, the CRPD became legally binding for the EU on the 23 of January 2011.<sup>50</sup> This was a historic moment in that it was the first time that the EU has signed and ratified a human rights convention.<sup>51</sup>

Countries that have ratified the CRPD should take action to check that all policies, legislation and programmes comply with the CRPD provisions. Ratifying countries will need to make sure that people with disabilities fully enjoy their rights on a non discriminatory basis. Under Article 4 of the CRPD signatory states must “take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities”.<sup>52</sup>

Countries should take action in the following areas: access to education, employment, transport, infrastructures and buildings open to the public, granting the right to vote, improving political participation and ensuring full legal capacity of all persons with disabilities.

### **Capacity and the CRPD:**

As Ireland has signed the CRPD with the intention of ratifying it as soon as possible it is important to look at how the Convention assesses capacity. This is important because the proposed capacity legislation which Ireland is to bring in must conform to the standards

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<sup>50</sup> IDDC, International Disability and Development Consortium, available at, [www.iddcconsortium.net](http://www.iddcconsortium.net)

<sup>51</sup> As of the 5 January 2011 the CRPD has been signed by all 27 member states and ratified by 16 of these.

<sup>52</sup> Convention on the Rights of Persons with Disabilities. Article 4.

and provisions in the CRPD.

**Article 12: Equal recognition before the law:**

The provisions on capacity in the CRPD are set out in Article 12, which is titled “Equal recognition before the law.”<sup>53</sup> The provisions are as follows:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

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<sup>53</sup> Convention on the Rights of Persons with Disabilities. Article 12.

The CRPD's provisions on legal capacity are particularly relevant in the context of this thesis. Article 12(2) expressly states that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life".

The CRPD model of capacity represents the current legal trend toward a functional approach to persons with disabilities, which supports their involvement in their decision-making and discourages substitute decision-making. This is in stark contrast to an "all-or-nothing" approach adopted by many States and Ireland via its current ward of court system. In addition, under the functional approach capacity is both time-specific and decision-specific. Therefore, a person may be found to lack capacity only during a particular time, and not permanently, and in relation to a particular matter, not all matters.

Under paragraph (1) of Article 12 State Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law. This paragraph of Article 12 addresses the identity requirement of legal capacity and recognises the personhood of persons with disabilities. Paragraph 2 of Article 12 provides that "States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." This paragraph of Article 12 fulfils the agency requirement of legal capacity.

The agency requirement of legal capacity is further borne out by the remaining paragraphs of Article 12. Paragraph 3 of Article 12 requires State Parties to "take appropriate measure to provide access by persons with disabilities to the support they may require in exercising their legal capacity". Paragraph 4 concerns itself with the need to guard against the abuse of such support and does so by making provision for appropriate and effective safeguards. Paragraph 5 explicitly mentions that persons with disabilities should be able to inherit, manage financial affairs and own property. Thus both on a purposive and a textual interpretation of Article 12 it can be concluded that legal capacity in the CRPD has been constructed to include both the capacity for rights and the capacity to act.

It is important to note that a definition of disability has not been incorporated in Article 2, the definitions section of the CRPD. However an inclusive definition finds place in Article 1, which states:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.<sup>54</sup>

As can be seen from the above, it is clear that individuals suffering with mental health issues would be regarded as having a disability for the purposes of the CRPD.

### **Ireland and the CRPD:**

As mentioned above, Ireland has signed the CRPD but has not yet ratified it. In the new Programme for Government they have committed to review the Mental Health Act 2001 in consultation with service users, carers and stakeholders, informed by human rights standards, and introduce a Mental Capacity Bill that is in line with the CRPD.

However as seen above the current status of Ireland's framework regarding capacity is outdated and archaic and would seem to be seriously infringing on the human rights of some of the most vulnerable in our society. Ireland, like many other countries that have to review their capacity legislation has an opportunity to reform its laws relating to capacity and mental health to benefit vulnerable people in our society. It is important for Ireland to make meaningful changes that will have real effect. For instance, the Advance Healthcare Decisions Bill 2010 has the potential to offer a myriad of benefits to people who are in in-patient care and are receiving on-going treatment.

However the main purpose of the Bill is described as facilitating advance refusals i.e. decisions which deal with refusing treatment at the end of life. It would seem that by

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<sup>54</sup> Convention on the Rights of Persons with Disabilities. Article 1.

limiting the scope of the Bill to these decisions, there is an implicit exclusion of advance decisions generally relating to treatment for people with mental or psychiatric difficulties in circumstances that are other than end of life. On the face of it, this would seem to be a clear infringement on the human rights of persons with disabilities under the CRPD.

## **Chapter 3. The Reform of Mental Capacity Law in Ireland.**

### **Introduction.**

This chapter will look at some of the reforms proposed by the Scheme of Mental Capacity Bill 2008 (the Scheme). It will firstly highlight certain relevant background issues surrounding the creation of mental capacity legislation in Ireland, including the adoption of the CRPD and how the CRPD assesses capacity.

The LRC have proposed various reforms in relation to mental capacity and the Scheme encompasses many of these recommendations. In addition, the reform of mental capacity law has become topical in other jurisdictions in recent years. In England and Wales the Mental Capacity Act was introduced in 2005. The Bamford review in Northern Ireland has also proposed change in mental capacity.<sup>55</sup> This chapter touches on these developments.

The relationship between the Mental Health Act and the proposed Scheme will be discussed as this will have significant impact on the overall reform of mental capacity law. In particular, the Scheme will be discussed in the context of how it will relate to people with disabilities particularly people being treated under the Mental Health Act. Observations will be made on the Scheme in relation to how it will protect patient autonomy. In particular, the use of advance directives will be discussed in relation to the Scheme and to what extent the Scheme will permit these.

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<sup>55</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007.

### **3.1 Background.**

#### **Ireland and the CRPD:**

As noted in chapter 2, Ireland has signed the CRPD but has not yet ratified it. The recently elected Government have indicated a clear intention to ratify it in the future. In their Programme for Government for 2011 they have committed to review the Mental Health Act 2001 in consultation with service users, carers and stakeholders, informed by human rights standards, and introduce a Mental Capacity Bill that is in line with the CRPD.<sup>56</sup>

However, the current status of Ireland's framework regarding capacity is outdated and archaic and would seem to be seriously infringing on the human rights of some of the most vulnerable in our society. There is already, however, proposed capacity legislation that was introduced under the former Government which will now be looked at to see if it will bring Ireland in line with its international human rights obligations. The former government stated in the Report of the Disability High Level Group on the UN Convention that this legislation the Scheme): "... will give effect to the Convention in so far as it applies to the legal capacity issues in Article 12 of the Convention."<sup>57</sup> As noted in chapter 2, Article 12 guarantees persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

#### **Scheme of Mental Capacity Bill 2008:**

The main purpose of the Scheme is to introduce a modern statutory framework governing decision making for people who lack capacity in Ireland. It will replace the wards of court system and the Lunacy Regulation (Ireland) Act 1871. The wards of court system is the existing mechanism for managing the affairs of persons who lack decision making capacity.

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<sup>56</sup> Department of the Taoiseach, Programme for Government for 2011.

<sup>57</sup> "Second Disability High Level Group Report on Implementation of the UN Convention on the Rights of Persons with Disabilities" (June 2009) at page 96. Available at: <http://ec.europa.eu/social/main.jsp?catId=431&langId=en>.

## **Background issues to the creation of the Scheme.**

The Regulatory Impact Assessment (RIA) of the Scheme notes some of the current problems with the existing legal framework for the protection of persons who lack capacity including the current wards of court system. Some of the problems regarding this system have been highlighted in chapter 2. The wards of court procedure and language is particularly subject to criticism as the terminology and concepts used in the existing legislation of 1871 are inappropriate to the modern understanding of mental illness and legal capacity. Furthermore, the RIA notes that the current system is incapable of coping with the existing demographic of people who lack capacity. Moreover this demographic is projected to grow as the Irish population continues to expand.

As this thesis argues, the biggest problem with the existing legal framework on mental capacity is that it would seem to be in violation of Irish citizens constitutional and human rights. Ireland has signed the UN CRPD. The next step towards ratification of the CRPD is for Ireland to reform its current legal framework on mental capacity. The Scheme is Ireland's attempt to facilitate this ratification process.

## **The Law Reform Commission (The "LRC")**

The LRC's consideration of issues of mental capacity began with its Consultation Paper on Law and the Elderly in 2003.<sup>58</sup> While the LRC reviewed a lot of the issues concerning capacity, for example, capacity to make a will, enduring powers of attorney, wards of court and protection against abuse, its focus was primarily on older adults.

The LRC issued a second Consultation Paper on Vulnerable Adults and the Law in 2005.<sup>59</sup> These Consultation Papers were followed by a report on Vulnerable Adults and the Law in 2006.<sup>60</sup> These papers considered legal capacity issues relevant to all adults with limited decision making. In addition it included a draft Scheme of a Mental Capacity

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<sup>58</sup> Law Reform Commission, Consultation Paper on Law and the Elderly (CP23, 2003).

<sup>59</sup> Law Reform Commission, Consultation Paper on Vulnerable Adults and the Law: Capacity (CP37, 2005).

<sup>60</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006).

and Guardianship Bill as an Appendix.

### 3.2 Overview of the Scheme.

The Scheme is in draft format and is divided into four parts. The four parts are as follows:

- Part 1 (Capacity, formal and informal decision-making)
- Part 2 (The Office of the Public Guardian)
- Part 3 (Enduring Powers of Attorney)
- Part 4 (Private International Law)

Head 1 of the Scheme contains a set of guiding principles. These include a presumption of capacity, the least restrictive principle<sup>61</sup> and the need to take account of a person's past and present wishes, where ascertainable.<sup>62</sup> Head 1 (i) states that acts and decisions made on behalf of a person who lacks capacity must be done in the person's best interests. In determining best interests regard must be had to the provisions in Head 3 which is titled "Best Interests". This section gives a non-exhaustive list of matters to be taken into account when considering what is in a person's best interests. This list suggests an approach to best interests which seeks to maximize the autonomy of the individual, as well as respecting the individual's right to dignity, privacy and bodily integrity.

A definition of capacity is provided in Head 2. It defines the capacity to make a decision as the "ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made."<sup>63</sup> It then establishes that a person lacks capacity if they are unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or to communicate their decision.<sup>64</sup> This indicates that the Scheme does adopt a functional and time specific approach and contains a presumption of capacity that

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<sup>61</sup> This means that any act done or decision made is done or made in the way which is least restrictive of the person's rights.

<sup>62</sup> This provision would seem to support the use of advance decisions.

<sup>63</sup> Department of Justice, Equality and Law Reform, Scheme of Mental Capacity Bill 2008. Head 2 (1).

<sup>64</sup> *Ibid*, Head 2 (2).

would seem to be in line with the CRPD. In particular, the definition of capacity contains an additional component related to memory ('retaining' the information) and excludes an appreciation component. However, notwithstanding this it would seem that there are still certain issues which the Scheme fails to address appropriately and whereby Ireland would still be in breach of its international obligations.

These issues are discussed in further detail below and include questions on: who should assess capacity; supported decision making and substitute decision making; advance decisions and the relationship between the Scheme and the Mental Health Act.

### **Who assesses capacity?**

Head 1 of the Scheme lists the guiding principles of the proposed Act on mental capacity. The very first thing that is mentioned is that it shall be presumed, unless the contrary is established, that a person has capacity. However, if the contrary is established it is essentially the High Court who will assess the person's capacity. The High Court is known as the Court of Care and Protection under the Scheme.<sup>65</sup>

Where an application has been made to the Court of Care and Protection, it will make a declaration as to whether the person lacks capacity to make a specified decision or decisions. The Court may 'request expert reports for the Court by such experts as it considers necessary, whether medical (including reports concerning cognitive ability), social and health care (including care in the community) or financial (including reports on valuation of property)'.<sup>66</sup> Therefore, where the Court is tasked with assessing capacity a multidisciplinary approach is provided for.

However, where no application is made to the Court of Care and Protection the Scheme does not specify who should be tasked with assessing capacity. It is likely that this decision will be left up to the treating clinician. This raises the question of how independent this process actually is in reality. As noted earlier with section 59 of the

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<sup>65</sup> Department of Justice, Equality and Law Reform, Scheme of Mental Capacity Bill 2008. Head 4 (5)

<sup>66</sup> *Ibid*, Head 13.

Mental Health Act, the responsible consultant psychiatrist has to consult a second consultant psychiatrist, but it does not specify that the second consultant psychiatrist be independent.

Okai's systematic review of capacity in inpatients with mental health problems found a higher likelihood that clinicians would find patients have capacity and speculated that this was due to clinicians presuming capacity where the patient agrees with treatment.<sup>67</sup>

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

### **Supported Decision Making and Substitute Decision Making.**

The process of supported decision-making is important when considering incapacity from the perspective of a social model of disability. In brief, supported decision-making in this context refers to providing all the practical steps necessary to help someone make a decision rather than make the decision on their behalf. Tina Minkowitz says that in order to fulfill the CRPD supported decision making must be understood as an essential component of capacity. She argues that "the construction of capacity as being dependant on any cognitive, perceptual, physical, communication and relational capabilities discriminates based on disability," while the support paradigm constructs legal capacity without reference to evaluation of capabilities.<sup>68</sup> Therefore assessments of cognitive function must take into account the effects that having appropriate support may have on an individual's ability to demonstrate capacity. In the RIA on the Scheme, it acknowledged the need for access to supports, where required, to exercise capacity. This is in line with Article 12 of the CRPD which places an obligation on State Parties to "take

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<sup>67</sup> D Okai, G Owen, H McGuire, S Singh, R Churchill and M Hotopf (2007) 'Mental Capacity in Psychiatric Patients: Systematic Review', *British Journal of Psychiatry* 191:291-7.

<sup>68</sup> Minkowitz, T. (undated) 'The Paradigm of Supported Decision-Making', unpublished, available for download at [www.barcsi.hu/letolteseke/.../Minkowitz\\_presentation.pdf](http://www.barcsi.hu/letolteseke/.../Minkowitz_presentation.pdf)

appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”.<sup>69</sup>

However, the Scheme only touches on the concept of supported decision-making under the Guiding Principles where it states that “a person shall not be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success”.<sup>70</sup> The Scheme does not set out a framework for supported decision-making. Instead the emphasis is on procedures for substitute decision-making such as informal decision-making, Court appointed personal guardians and enduring powers of attorney. Given the importance of how supported decision-making is to the social model of disability adopted by the CRPD, it would be a missed opportunity not to incorporate a framework for supported decision-making in the proposed Scheme.

Indeed, as noted earlier, some interpretations of Article 12 of the CRPD leaves no room for substitute decision-making. For instance Canada has entered interpretive declarations and reservations in relation to Article 12. The government of Canada would seem to be sufficiently concerned that Article 12 did not allow any room for substitute decision making.

“Canada declares its understanding that Article 12 permits supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law.

To the extent Article 12 may be interpreted as requiring the elimination of all substitute decision-making arrangements, Canada reserves the right to continue their use in appropriate and effective safeguards.”<sup>71</sup>

In reality this would seem to be the stance that many State Parties would take. However this approach, which may be a last resort, is flawed. The decisions of the substitute

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<sup>69</sup> Convention on the Rights of Persons with Disabilities. Article 12 (3).

<sup>70</sup> Department of Justice, Equality and Law Reform, Scheme of Mental Capacity Bill 2008. Head 1, c.

<sup>71</sup> Declarations and Reservations on the CRPD, available at, [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-15&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en)

decision-maker may not reflect the views of the individual. This illustrates the potential benefits of having a mechanism of advance decision-making for patients to express their views.

### **Advance Decisions.**

Advance Decisions are a mechanism to allow a person to formally record their wishes at a time when they have capacity in relation to future healthcare decisions that may arise at a time when the person lacks capacity.

At present there is no Irish legislation which deals with the validity of advance decisions regarding medical treatment and there is no certainty on the law in this area, in particular in the area of advance decisions in a mental health context. The LRC did not deal with the area of advance decisions in its Report<sup>72</sup> on the Scheme and while it subsequently published a report on Advance Directives,<sup>73</sup> it expressly excluded psychiatric advance care directives from its scope.<sup>74</sup> The LRC acknowledged the benefits that advance decisions could have in a mental health context.<sup>75</sup> For instance, in the context of a recurring illness, or the use of effective medication during previous psychiatric episodes and how this could improve the person's adherence to a treatment plan, with consequent benefits in terms of quality of life and reduced need for hospitalisation.<sup>76</sup>

While the Scheme seeks to update the existing law relating to Enduring Powers of Attorney (EPAs) (whereby a person can appoint someone to make decisions on their behalf including certain healthcare decisions in the event of incapacity), it contains very little in relation to advance decisions regarding medical treatment.

The "Best Interest" provisions in Head 3 of the Scheme require that the person's past and present wishes and feelings (and, in particular, any relevant written statement made by

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<sup>72</sup> Law Reform Commission, Report on Vulnerable Adults and the Law (Report 83, 2006)

<sup>73</sup> Law Reform Commission, Report on Bioethics: Advance Care Directives (Report 94, 2009)

<sup>74</sup> *Ibid*, para 1.83

<sup>75</sup> *Ibid*, para 1.83

<sup>76</sup> Tim Exworthy, "Psychiatric Advance Care Decisions - An Opportunity Missed" (2004), *Journal of Mental Health Law* 129.

him or her when he or she had capacity), beliefs and values that would be likely to influence his or her decision and other factors he or she would be likely to consider be considered insofar as they are reasonably ascertainable.<sup>77</sup> However, the Scheme does not go on to provide any framework regulating the creation and validity of advance decisions.

There is an argument that capacity legislation would be a suitable location for such a framework and legislators should take the opportunity to engage with all aspects of incapacity, including the issue of formally recognizing advance decisions and that, therefore, the Scheme should cover this area. Notwithstanding the Scheme's shortcomings in relation to providing a framework for supported decision-making and advance directives, the Scheme also fails to set out how its provisions will interact with the provisions of the Mental Health Act.

### **3.3. Interaction between the Scheme and the Mental Health Act:**

The issue of mental capacity is relevant in the context of the Mental Health Act which deals with the involuntary detention and treatment of persons with mental health difficulties. For instance, the definition of "mental disorder" in the Mental Health Act includes a reference to impaired judgment which would appear to be a reference to incapacity. In addition, Part 4 of the Mental Health Act (consent to treatment), expressly refers to capacity.

As noted earlier, Article 12(2) of the CRPD requires State parties to recognise "that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life". Therefore, if Ireland is to comply with the CRPD, it is crucial that the presumption of capacity, and the time-specific and issue-specific functional approach to capacity and the guiding principles and definition of "best interests" set out in the Scheme (which seek to promote the autonomy of the individual) apply equally to all persons, including those involuntarily admitted under the Mental Health Act.

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<sup>77</sup> Department of Justice, Equality and Law Reform, Scheme of Mental Capacity Bill 2008. Head 3 (1) (iii).

The concern would be that by not amending the Mental Health Act to comply with any new capacity legislation people may be administered treatment against their will or may be unnecessarily detained because they have been diagnosed with a mental disorder under the provisions of the Mental Health Act.

Therefore, it would seem that in order to comply with Article 12 of the CRPD, the Mental Health Act would need to be amended to ensure that the functional and time-specific approach to capacity, the guiding principles and the definition of “best interests” set out in the Scheme, apply equally to persons involuntarily admitted under the provisions of the Mental Health Act.

### **3.4 Observations on the Scheme.**

As noted earlier, the Government has stated that the reforms proposed in the Scheme will enable the State to meet its obligations under the CRPD, insofar as it relates to legal capacity issues. There is a common presumption of capacity, which the new legislation will expressly provide for if enacted. This will protect people against paternalistic inappropriate assumptions about capacity and the type of life that they should lead. The Scheme adopts a time-specific and issue-specific functional approach to capacity and any reform of the law in this area is to be welcomed. However, as noted earlier, there are certain issues the Scheme falls silent on which should be addressed before it is transposed into law. For instance, the lack of a framework for supported decision-making and the need for a more independent assessment of capacity should be addressed. There are other concerns that arise in relation to the proposed Scheme which could raise questions as to whether it will comply with the CRPD.

For example, it would seem that existing wards of court will not be able to automatically benefit from the Scheme if enacted into law. Under Head 41 on transitional provisions, existing wards must actively make an application for a review of a declaration that a person lacks capacity to make decisions. Head 41 (1) states:

“... it shall be open to a person to whom this Act applies who has been taken into wardship under the jurisdiction of the High Court or Circuit Court existing at the time immediately before this Act comes into force, to make an application to the court for a review of his or her position, and such application shall be treated as if it were an application under Head 14 for a review of a declaration that the person lacks capacity to make a decision or decisions.”

Arguably, the Scheme should make such a review mandatory and should specify a time period in which the review has to take place. If the Scheme remains unchanged, wards of court would appear to be treated in a less favorable manner and again this would seem to be contrary to the equality provisions of the CRPD.

There is a form of informal decision-making provided for in the Scheme. However, there does not seem to be adequate safeguards put in place in respect of this. For example, there is provision for the regular review of decisions on capacity under Head 14. The court is required to review decisions at regular intervals but not periods longer than 36 months. The Irish Human Rights Commission (IHRC) notes in their observation paper on the Scheme<sup>78</sup> that this does not adequately reflect the time-specific and issue specific nature of capacity: “The IHRC considers that an interval of 36 months (three years) for a review of the court’s decision is too long. It is certainly arguable that this timeframe fails to satisfy the requirement of “regular review” under the UN Convention on the Rights of Persons with Disabilities”.<sup>79</sup>

In conclusion, the Scheme fails to set out how its provisions will interact with the existing provisions on capacity under the Mental Health Act. The positive aspects of the Scheme should have equal application to everyone including patients under the Mental Health Act.<sup>80</sup>

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<sup>78</sup> Irish Human Rights Commission, Observations on the Scheme of Mental Capacity Bill 2008. Available at: <http://www.ihrc.ie/publications/list/observations-on-the-scheme-of-the-mental-capacity/>

<sup>79</sup> *ibid* at page 15.

<sup>80</sup> For further discussion and recommendations on the Scheme from a Human Right perspective see Amnesty International: Submission on the Scheme of Mental Capacity Bill 2008, available at [www.amnesty.ie](http://www.amnesty.ie). In addition, see IHRC Observation paper on the Scheme, available at [www.ihrc.ie](http://www.ihrc.ie).

## **Chapter 4. Advance Healthcare Decisions Bill 2010.**

### **Introduction:**

This chapter will consider if the Advance Healthcare Decisions Bill 2010 (the “Bill”), if enacted would comply with the relevant international human rights standards, namely the CRPD. The Bill will be discussed in the context of how it will relate to people with disabilities, particularly people being treated under the Mental Health Act. The relationship between the Mental Health Act and the proposed Bill will be considered as this will have significant impact on the overall reform of mental capacity law in Ireland.

For instance, will the time-specific and issue-specific functional approach towards capacity adopted in the Bill apply equally to persons being treated under the Mental Health Act? Furthermore, if a person makes an advance directive under the Bill and subsequently is diagnosed with a mental disorder and is being treated under the Mental Health Act, can that advance directive be overridden if the treating doctor believes it to be in the patient’s best interests?

### **4.1. Background:**

Campbell highlights in her article a case study by Ronald Dworkin which illustrates in a succinct manner some of the issues involved in making an advance decision.<sup>81</sup>

“Margo is a 54-year-old woman who has just been diagnosed with Alzheimer's disease. Margo directs, by means of a living will, that she should not receive treatment for any serious life-threatening disease she may contract after she becomes incompetent, a decision which is motivated by a desire to avoid the anguish she associates with Alzheimer's disease. However, when Margo becomes incompetent, she seems to enjoy her life and takes great pleasure in attending art classes and in meeting guests. Indeed, a young doctor who visits her describes her

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<sup>81</sup> Elizabeth Campbell, “The case for Living Wills in Ireland” *Medico-Legal Journal of Ireland* (2006) 12 (1)

as the happiest person he has ever met. Nevertheless, should Margo contract a serious life-threatening condition at this stage, her prior instructions insist that treatment must not be administered. Adhering to her directions seems unthinkable in the context of her present comfortable state, as doing so would compromise her well-being and could expedite her death. Nevertheless, ignoring her instructions may fail to respect Margo's right to autonomy and self-determination.”<sup>82</sup>

This example highlights some of the exceptionally difficult philosophical and ethical questions which arise vis-à-vis advance decisions. In this context, the Bill is a welcome piece of legislation which aims to address many issues that arise in relation to advance decisions. However, I believe that the proposed Bill, if enacted, will exclude from its scope people who are being treated under the Mental Health Act and by doing this will not comply with certain provisions of the CRPD such as non-discrimination, equality of opportunity, accessibility and full and effective participation in society for all persons with disabilities.<sup>83</sup>

### **Purpose of the Bill:**

The Explanatory Memorandum of the Bill states the “purpose of this Bill is to make provision for the creation of an Advance Health Care Directive which formally records the wishes of an individual at a time when they have the capacity to do make decisions in relation to future health care decision that may arise in the future and at a time when the person no longer has the capacity to take a decision... The rationale for permitting such a document is that it ensures due regard to a person’s right of dignity, bodily integrity, privacy and autonomy (in accordance with the principals of the Mental Capacity Bill 2008)”.<sup>84</sup>

The Explanatory Memorandum further states that the enactment of the Bill would place the State in conformity with international obligations created by the CRPD. In addition,

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<sup>82</sup> *ibid.* p.1

<sup>83</sup> Convention on the Rights of Persons with Disabilities. Article 3.

<sup>84</sup> Advance Healthcare Decisions Bill 2010.

the Bill, if enacted will amend the Powers of Attorney Act 1996 to allow for attorneys under that Act to take healthcare treatment decisions.

As noted above, the Bill is in keeping with the recommendations of the LRCs consultation paper and the explanatory memorandum notes that the Bill is in line with the LRC's consultation paper on advance care directives. The LRC published its Report on Bioethics: Advance Care Directives in 2009.<sup>85</sup> In this report the Commission gives a comprehensive analysis of the emergence and development of advance directives together with a detailed legislative framework for advance directives.

### **LRC Report Bioethics: Advance Healthcare Directives. (The “Report”)**

The LRC Report involves an examination of whether a legislative framework should be put in place for advance directives. This Report follows a previous Consultation Paper by the LRC and this Report sets out the LRC's final recommendations on advance directives, together with a draft Mental Capacity (Advance Care Directives) Bill intended to implement those recommendations.

The main issues discussed by the LRC in the Report include the origins and emergence of advance directives in the context of advances in health care and the move towards informed decision making. The Report discusses the emergence of the debate on advance directives in Ireland. The Report further discusses the importance of third parties, often called healthcare proxies in the process of making an advance directive. In addition, an amendment needed to the Powers of Attorney Act 1996 to include healthcare decisions is discussed. These issues in the Report form the basis on which the Advance Healthcare Decisions Bill 2010 was made. It is important to note that advance directives are a part of the law of mental capacity and need to be considered in that wider setting. Therefore, the proposed mental capacity legislation and the issues of capacity under the Mental Health Act will have a significant impact on how the legislative framework for advance decisions will operate.

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<sup>85</sup> Law Reform Commission Report, Bioethics: Advance Care Directives (LRC 94-2009)

It is important to note that the LRC Report pointed out that the scope of the Report does not extend to advance directives involving mental health care. Having said that, the LRC acknowledged that advance directives made in the context of a recurring illness history and the use of effective medication during previous psychiatric episodes could have positive benefits in terms of quality of life, increased autonomy and the reduced need for hospitalisation. However the LRC decided that the matter needed separate analyses and recommended that the proposed legislative framework not apply to advance directives involving mental health care.

### **Advances in health care:**

Advance in medical treatment and technology in developed countries means that people are now living longer, including those with a serious illness or disease. These advances have also meant that in certain situations life can be sustained where, normally, a person would have died. In certain circumstances these developments have led some to fear that they may or may not be given relevant treatment or may be kept alive by life prolonging treatment after they have lost their mental capacity to make their own treatment decisions.

Another major development in health care treatment in recent years has involved the movement toward a rights based approach whereby the patients have the right to make informed decisions about their treatment. This is a significant shift from a paternalistic approach where decisions about healthcare treatment were primarily for healthcare professionals. For example, the current wards of court system is based on an extremely paternalistic approach to capacity. The process involves the complete removal of decision-making capacity from an individual. An approach towards informed decision-making is also linked with adopting a functional approach towards capacity whereby a person understands the treatment decisions being considered at the time it is being made.

### **Health care proxies and powers of attorney:**

Third parties may often be involved in the decision-making process whereby a person has expressed their wishes in an advance directive. This arises from the practical reality that, when the time comes to make a specific decision the person who made the advance directive is unable to give their views directly. Another person could be nominated to make these decisions, called a health care proxy. The LRC recommends that a health care proxy can be appointed under an advance directive. A health care proxy will usually be a close friend or relative and due to this close relationship can provide valuable information and insight into the patient's wishes which can further supplement the provisions of the advance directive.

Under an enduring power of attorney (EPA) made in accordance with the Powers of Attorney Act 1996 (discussed above in chapter 1) a person with capacity (the donor) may appoint a person (the donee) to make certain decisions outlined in the EPA in the event of the donor's incapacity. However, currently, healthcare decisions are excluded as mentioned in chapter 1. Therefore, the Powers of Attorney Act would need to be amended to include healthcare decisions. Similar to a health care proxy, an EPA would usually be a close friend or relative.

### **International developments:**

The Law Commission for England and Wales proposed in their review of mental capacity law that an "advance refusal of treatment" should have legal standing.<sup>86</sup> This was implemented in the English Mental Capacity Act 2005 which will be discussed further in chapter 5. It is interesting to note that as far back as 1995, Tomkin and Hanafin proposed that the Irish legislature adopt the recommendations of the Law Commission for England and Wales in its review of mental capacity law that advance directives be placed on a statutory footing.<sup>87</sup>

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<sup>86</sup> Law Commission for England and Wales, Report on Mental Incapacity (No 231 1995), para 5.16.

<sup>87</sup> Tomkin and Hanafin "Medical Treatment at Life's End: The Need for Legislation" (1995) *Medico-Legal Journal of Ireland* 3 at 9.

In 2009, the Council of Europe’s Committee of Experts on Family Law published a Draft Recommendation on Principles Concerning Continuing Powers of Attorney and Advance Directives for Incapacity.<sup>88</sup> The draft Recommendation refers to the requirements to promote autonomy in the CRPD. Moreover, the draft Recommendation proposes that Member States “promote self-determination for capable adults by introducing legislation on continuing powers of attorney and advance directives”.<sup>89</sup>

### **Advance directives in Ireland.**

While advance directives have been a part of American legislation and policy since 1976 such instruments have only recently been the focus of attention in the Irish courts.<sup>90</sup> In the LRC Consultation Paper on advance directives<sup>91</sup> it highlights that there is an indirect reference to advance directives in the case of *Re A Ward of Court (No 2)*<sup>92</sup>. This seminal Supreme Court judgement suggests that advance directives would be upheld in this jurisdiction. The Court recognised the right of the Ward, if she were mentally competent, to forego treatment or to direct that treatment be withdrawn even if that would cause her death. This right is grounded in the rights to privacy, dignity and bodily integrity under the Irish Constitution.

Campbell<sup>93</sup> cites an obiter statement of O’Flaherty J. when considering the appropriate test to apply in the case, noted that he found it “impossible to adapt the idea of the ‘substituted judgment’ to the circumstances of this case” and stated that it may only be appropriate to do so “where the person had the foresight to provide for future eventualities”.<sup>94</sup> The substituted judgment standard, referred to by O’Flaherty J. seeks to determine the treatment an incompetent person would choose if they were competent and aware of their current condition. This would seem to suggest that, if the individual in

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<sup>88</sup> Available at [www.coe.int](http://www.coe.int)

<sup>89</sup> *Ibid*, last accessed on 20/04/2011

<sup>90</sup> The first advance directive legislation was enacted in 1976 by the Californian legislature which was mirrored subsequently by other states. California Natural Death Act, Cal. Health and Safety Code 7185-7195 (West Supp. 1976).

<sup>91</sup> Law Reform Commission, Consultation Paper: Bioethics Advance Care Directives, (LRC CP-51)

<sup>92</sup> [1996] 2 IR 79 at 133.

<sup>93</sup> Elizabeth Campbell, “The case for Living Wills in Ireland” *Medico-Legal Journal of Ireland* (2006) 12 (1)

<sup>94</sup> *Re a Ward of Court*, op. cit., at 132-133.

question had the requisite foresight and expressed their wishes concerning the treatment to be administered in an instrument, such as an advance directive, their preferences would be respected by an Irish court.<sup>95</sup>

Above are some of the background issues which relate to the creation of the Advance Healthcare Decision Bill 2010. Indeed, in the Explanatory Memorandum to the Bill, it stated the need for the Bill “seems to follow from the relevant case law (including the decision of the Supreme Court in *In re a Ward of Court (withholding medical treatment) (No. 2) (1996) 2 IR 79*) and is in keeping with the recommendations of the Law Reform Commission’s 2008 Consultation Paper *Bioethics: Advance Care Directives* (LRC CP 51-2008).”<sup>96</sup>

#### **4.2. Interaction between the Bill and the Mental Health Act.**

Advance directives form part of the law of mental capacity. As noted throughout this thesis the issue of mental capacity is highly relevant in the context of the Mental Health Act. It is important to note that the Mental Health Act does not provide for advance directives that would allow a person with a mental health problem to set out in advance how they want to be treated in circumstances where they become involuntary detained. The fear would be that by not amending the Mental Health Act to comply with the Bill people being treated under the Mental Health Act would not be able to make an advance directive as they might be deemed to lack capacity under the provisions of the Mental Health Act. Arguably, this would be contrary to the equality provisions outlined in the CRPD.

As noted earlier, there is no definition of capacity in the Mental Health Act. Capacity is referred to as the ability to consent. It would seem that the standard for assessing whether a person lacks capacity is far lower in the Mental Health Act than the proposed Bill (and the Scheme). The different standards of assessing capacity means that a person being treated under the Mental Health Act could be assessed as lacking capacity to make an

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<sup>95</sup> This is noted by the LRC in its Consultation Paper on Law and the Elderly at para. 3.48.

<sup>96</sup> Advance Healthcare Decisions Bill 2010

advance directive far easier than someone not being treated under the Mental Health Act.

As discussed in the previous chapter, the interplay between the proposed mental capacity legislation, the Scheme, and the Mental Health Act is important in the context of recognising the provisions in Article 12 of the CRPD, “that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. In addition, it is important that the provisions in the Bill apply equally to all persons, including those involuntarily detained under the Mental Health Act.

### **Section 59 of the Mental Health Act:**

As previously discussed, section 59 of the Mental Health Act provides for the administration of Electro-convulsive Therapy (ECT) to persons unable or unwilling to consent. There are some procedural safeguards provided for in that the Act requires the opinion of a second consultant psychiatrist in order for the treatment to be administered without consent. However, a major shortcoming in the legislation is that there is no requirement that the second opinion be independent. As the law currently stands a person who does not want treatment can be treated even though their refusal is a competent one. This shortcoming in the legislation arguably raises certain significant human rights concerns in relation to capacity issues.

For instance, if a person makes an advance decision under the Bill indicating that they do not want to receive ECT treatment and that person subsequently becomes mentally ill and is made a patient under the Mental Health Act, it could be argued that the responsible consultant psychiatrist (RCP), under the provisions of section 59 of the Mental Health Act, could administer ECT to the patient despite the fact that there is an advance decision indicating that the patient is unwilling to receive it.

Notwithstanding the shortcoming in section 59, the Bill specifically states that an advance decision is not applicable to treatment that is lawful under the Mental Health Act<sup>97</sup>. This would indicate that a person could not even make an advance decision

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<sup>97</sup> Advance Healthcare Decisions Bill 2010 s.6 (8) (c).

indicating that they do not want to receive ECT if they came within the ambit of the Mental Health Act. Amnesty International has made a submission in relation to the proposed amendment of section 59 of the Mental Health Act.<sup>98</sup> In this submission they note that the right of a patient who has capacity to refuse ECT must be unequivocally protected by section 59. “The Act is clearly currently in breach of human rights standards as the use of the word ‘unwilling’ denies the right of a competent patient to refuse ECT.”<sup>99</sup> In addition, they further state in their recommendations that ECT cannot be administered if it would conflict with: “A valid advance directive of the person as regards ECT.”<sup>100</sup> They refer to the approach found in section 58A (5) (c) of the Mental Health Act 1983 (England and Wales) (as amended), which provides that ECT cannot be administered to a person who lacks capacity if to do so would conflict with an advance decision.<sup>101</sup>

If the Bill were enacted as it is, a person would not be able to make a valid advance directive regarding ECT. ECT is a treatment that is lawful under the Mental Health Act and section 6(8) (c) of the Bill states that an advance decision is not applicable to treatment that is lawful having regard to the Mental Health Act. Moreover, if the Bill did include advance decisions regarding refusal of treatment in the Mental Health Act, these could be ignored if the person was deemed to be unable and unwilling for the purposes of the Mental Health Act if certain conditions were satisfied.

#### **4.3. Observations on the Bill.**

It is stated in the memorandum of the Bill that the enactment of the Bill would place the State in harmony with international obligations created by the CRPD. However, I believe that even if the Bill is enacted, the State will fall short of these obligations. In particular, in relation to Article 12 of the CRPD, which guarantees equal recognition before the law and expressly states that “persons with disabilities enjoy legal capacity on an equal basis

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<sup>98</sup> Amnesty International, “Submission to the Department of Health and Children in relation to the proposed amendment of section 59 of the Mental Health Act 2001 and related matters”.

<sup>99</sup> *Ibid* p 2.

<sup>100</sup> *Ibid* p 5.

<sup>101</sup> Mental Health Act 1983, as inserted by s.27 of the Mental Health Act 2007 (England and Wales)

with others in all aspects of life”? As discussed above, if the Mental Health Act is not amended to comply with the Bill, this will exclude people that are being treated under the Mental Health Act from full and effective participation in society guaranteed by the CRPD. Furthermore the issues raised above in relation to s.59 of the Mental Health Act raise some serious human rights concerns in relation to capacity and how it is assessed for people with disabilities and the lack of proper safeguards for people who are deemed to lack capacity.

### **International obligations:**

The functional time-specific and issue specific approach to capacity provided for in the Bill would seem to comply with the international standards for assessing capacity. However, as argued above, if the Bill will exclude people being treated under the Mental Health Act from its scope it would seem to fall short of the guiding principles of the CRPD; in particular, non-discrimination, full and effective participation and inclusion in society, equality of opportunity and accessibility.<sup>102</sup>

### **Capacity:**

The Bill provides for a presumption of capacity unless there is evidence to the contrary. The Bill adopts a time and issue-specific approach to capacity in line with the Scheme and the CRPD. However, similar to the Scheme, the Bill lacks a clear definition of incapacity. This can be contrasted with the recent Mental Capacity legislation in England and Wales. The English legislation goes further when defining whether a person lacks capacity. The Mental Capacity Act 2005 has a similar functional approach to defining capacity and has included a definition of incapacity which includes mental disorder as a necessary ingredient. Essentially the requirement for the presence of a mental disorder in the 2005 Act was to exclude conditions such as personality disorders and addictions from the remit of capacity law. The implications of this and the omission of this requirement from the proposed Irish legislation will be considered in the next chapter.

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<sup>102</sup> Convention on the Rights of Persons with Disabilities. Article 3.

## **Who assesses capacity?**

As with all legislation concerning capacity, the issue of who decides a person lacks capacity will always raise problematic issues. When making healthcare decisions it will usually be a medical practitioner who will make the assessment. To protect the rights of the patient it is important that there be an independent assessment also. As seen with section 59 of the Mental Health Act, the lack of an independent assessment could lead to the possibility of a person's competent wishes being ignored.

It is unclear in the Bill who would be responsible for deciding if a person lacked capacity to make an advance decision. In section 5 of the Bill, for an advance decision to be valid it must be signed by a medical practitioner stating that the person has the capacity to do so.<sup>103</sup> This would indicate that it would be the job of a medical practitioner. However there does not seem to be any safeguards in the Bill providing for an independent assessment. Moreover, if someone is deemed incapable of making an advance decision, there does not seem to be anything in the Bill that provides for a review of that decision.

## **Informed decision-making:**

As mentioned above there is a shift in the Bill from the paternalistic nature concerning decisions about healthcare. There is a more rights based approach toward healthcare decisions whereby patients are more involved in making decisions and healthcare professionals are informing the patient more of different types of treatments available to them. The Bill in itself is an indication of a shift towards a more rights based approach as it enables people to make their own decisions about how they wish to be treated.

## **Exclusion of Advance Decisions in a Mental Health Context from the Bill:**

An advance decision in a mental health context would allow a competent individual to specify their treatment preferences in advance of an incapacitating mental health crisis. It

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<sup>103</sup> Advance Healthcare Decisions Bill 2010 s.5 (2) (d)

is clear that these types of advance decisions do not fall within the scope of the Bill. Firstly, as mentioned before the LRC did not deal with advance directives in a mental health context in their papers and the Bill specifically states that an advance decision is not applicable to treatment that is lawful having regard to the provisions of the Mental Health Act.<sup>104</sup>

It would seem that by limiting the scope of the Bill in this respect there is an implicit exclusion of advance decisions generally relating to treatment for people with mental or psychiatric difficulties in circumstances that are other than end of life. This would seem to be a missed opportunity as the Bill along with the proposed Scheme of Mental Capacity Bill 2008 would be an appropriate place for such a mechanism. Furthermore, including psychiatric advance directives in the Bill would make the legislation more compliant with the provisions in the CRPD as it would not discriminate against persons being treated under the mental health act who want to plan their treatment.

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<sup>104</sup> Advance Healthcare Decisions Bill 2010 s.6 (8) (c).

## **Chapter 5. International Developments.**

This chapter will look at the situation in England and Wales in relation to their capacity and mental health legislation. England and Wales have recently enacted capacity legislation (the Mental Capacity Act 2005) and have amended their mental health legislation (the Mental Health Act 2007). The issues discussed previously relating to the proposed capacity legislation in Ireland (the Scheme of Mental Capacity Bill 2008 and the Advance Healthcare Decisions Bill 2010) along with the Mental Health Act will be considered in light of the changes made in England and Wales. In addition, Northern Ireland has reviewed their capacity and mental health legislation. The Northern Irish Bamford Review was published in 2007 and sets out a radical framework for future legislation in the North of Ireland, stating that there should be a single framework for the reform of mental health legislation and the introduction of capacity legislation.<sup>105</sup>

### **5.1. The Mental Capacity Act 2005: (England and Wales)**

The Mental Capacity Act 2005 (the 2005 Act) provides a legal framework for governing decision-making for people who lack the capacity to make particular decisions for themselves. The provision and principles of the English Act are in many respects similar to the Irish 2008 Scheme discussed in chapter 3. It contains a presumption of capacity; it adopts a time and issue-specific functional approach towards capacity and it applies the Best Interests principle. However unlike the Irish Scheme, the 2005 Act has included a definition of incapacity which includes a mental disorder as a necessary ingredient. In addition, the 2005 Act makes provision for advance decisions to refuse treatment; has established an independent mental advocacy service and is clear on how its provision will relate to mental health legislation.

#### **People who lack capacity:**

Section 2 of the 2005 Act states that a “person lacks capacity in relation to a matter if at

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<sup>105</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007.

the material time he is unable to make a decision for himself in relation to the matter because of an impairment of or a disturbance in the functioning of, mind or brain.”<sup>106</sup> This is the definition of mental disorder in the Mental Health Act.<sup>107</sup> The requirement for the presence of a mental disorder is omitted from the Irish Scheme. As noted in the previous chapter the requirement of a mental disorder was to exclude conditions such as personality disorders and addictions from the remit of capacity law. However, Donnelly notes that from a rights perspective the requirement for the presence of a mental disorder should be left out of capacity legislation.

“This requirement was recommended by the Law Commission for England and Wales as a means of making sure that the test for capacity would not “catch large numbers of people who make unusual or unwise decisions.” Its goal was to ensure that “normal” people (ie people who did not suffer from impairments) would be free to make decisions without having their capacity challenged. However, it is doubtful that the requirement will actually achieve this objective. The requirement is defined in such a broad way that it is unlikely to provide much in the way of protection for patients who make unusual or unwise decisions. Furthermore, the linkage of incapacity with an impairment of the mind or brain associates mental incapacity with mental illness or disability and could lead unreasonable assumptions to be made regarding the capacity of people with these conditions.”<sup>108</sup>

### **Advance decisions:**

There is no provision for advance decisions in the Irish Capacity Bill. However there has subsequently been the initiation of the Advance Healthcare Decisions Bill 2010 which will make provision for the advance refusal of treatment. The provisions in the Irish Bill are very similar to the provisions relating to advance decisions in the English Mental Capacity Act 2005. Advance decisions are a part of the law of mental capacity; therefore,

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<sup>106</sup> Mental Capacity Act 2005 s.2 (1).

<sup>107</sup> Mental Health Act 1983 s.1

<sup>108</sup> Mary Donnelly, “Legislating for Incapacity: Developing a Rights-based Framework. DULJ 395-(2008) 15(1) p.11.

it would seem that capacity legislation would be the most appropriate place for such a mechanism. It could be argued that due to some of the moral and ethical implications that advance decisions present the consideration of including such a provision in the Scheme could have delayed its progress. However, as the Scheme has still not yet been enacted it could be argued that a provision for advance decisions similar to the English 2005 Act should be included in it rather than having a separate piece of legislation.

### **Advocacy:**

An advocacy service is appointed and consulted when important decisions are to be made for a person who lacks capacity, if that person has no family or friends other than paid carers. The 2005 Act in England provides for advocacy through the establishment of an Independent Mental Capacity Advocate Service (IMCA). Section 36 of the 2005 Act lists the functions of the advocates. The function of the advocate is to ensure the fullest possible participation by the person lacking capacity in the decision-making process. This includes obtaining relevant information, ascertaining the person's wishes, beliefs and values, ascertaining alternative courses of action and, if relevant, obtaining further medical opinions regarding treatment. In addition, section 36 allows advocates to challenge or provide assistance for the purposes of challenging any relevant decision relating to the person lacking capacity.<sup>109</sup>

Neither the LRC's proposals for capacity legislation nor the Scheme as published contain provisions relating to advocacy. Donnelly notes that "people lacking the capacity to make decisions may well lack the basic abilities necessary to assert their interests and rights. For this reason, a legislative structure based on rights must include provision for advocacy so as to ensure the delivery of these rights in practice."<sup>110</sup>

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<sup>109</sup> Mental Capacity Act 2005 s.36

<sup>110</sup> Mary Donnelly, "Legislating for Incapacity: Developing a Rights-based Framework. DULJ 395-(2008) 15(1) p.21.

### **Interplay with mental health legislation:**

Section 28 of the 2005 Act relates to treatment that is regulated by the Mental Health Act 1983 Act (as amended).<sup>111</sup> Essentially, the 2005 Act does not apply to any treatment for mental disorder which is given in accordance with the rules about compulsory treatment set out in part 4 of the 1983 Act. The reason for this is to ensure that the specific statutory safeguards which the Act provides in relation to compulsory psychiatric treatment must always be afforded to whom that Act applies.<sup>112</sup> However, in relation to certain advance decisions the 2005 Act will apply.

The 2007 Mental Health Act provides for recognition of the past and present wishes and feelings of the patient but failed to give statutory recognition to advance directives. However in relation to ECT, there is an exception where a valid advance decision made under the 2005 Capacity Act to refuse ECT will be recognised under the Mental Health Act 1983. Section 27 of the Mental Health Act 2007 amended the 1983 Act and introduced new safeguard in relation to ECT.<sup>113</sup> The new section provides that ECT cannot be given if to do so would conflict with an advance directive made under the 2005 Act.

### **5.2. Northern Ireland:**

The Mental Capacity Act 2005 and the Mental Health Act 1983 only apply in England and Wales and not Northern Ireland or Scotland. In Northern Ireland an independent review (the Bamford Review) was set up in 2002 to look at the law, policy and provisions which affected people with mental health needs or a learning disability. The Bamford Review proposed a “single comprehensive legislative framework for the reform of mental legislation and for the introduction of capacity legislation in Northern Ireland”.<sup>114</sup> The review proposes that there should be a presumption of capacity, the Best Interests

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<sup>111</sup> Mental Health Act 1983 as amended by the Mental Health Act 2007.

<sup>112</sup> Mental Capacity Act 2005 s.28, Explanatory Notes.

<sup>113</sup> Mental Health Act 1983 s.58A. Introduced by section 27 of the Mental Health Act 2007.

<sup>114</sup> The Bamford Review of Mental Health and Learning Disability (Northern Ireland) 2007.

principle and equal recognition before the law for all persons with disabilities.<sup>115</sup>

The Review proposes that certain provisions of the English Mental Capacity Act 2005 should be introduced. For instance, the requirement for the presence of a mental disorder as a necessary ingredient for defining the incapacity of a person. In addition, the recognition of advance decisions regarding treatment and having independent advocates.<sup>116</sup>

Leonard and McLaughlin note that the Bamford Review raises the possibility that in future all mental health legislation may essentially be capacity legislation.<sup>117</sup> From the point of view of the CRPD this possibility would be a welcome one as patients being treated under mental health legislation would have their capacity assessed the same way everyone else has. In addition, they could benefit from certain provision which may not have been afforded to them under mental health legislation such as advance decisions.

However the Northern Ireland Executive's response to the Review is that having a single piece of legislation dealing with capacity and mental health issues would be very complex and difficult to interpret. The Executive accepts that the Review has established an "intrinsic link between mental health and mental capacity legislation", but considers that the proposals would be best delivered in two pieces of legislation which would include (like England) amendment to mental health legislation and the introduction of capacity legislation.<sup>118</sup>

### **5.3. Ireland:**

The proposed reforming legislation in Ireland (the Scheme and the 2010 Bill) in relation to capacity would have more in common with the recent changes in England and Wales than the proposed changes in Northern Ireland. Ireland intends to introduce capacity legislation (the Scheme) that is in line with the CRPD and the new government has singled out mental health as a key social justice issue its wants to tackle. It would seem

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<sup>115</sup> The Bamford Review, A Comprehensive Legal Framework, Executive Summary, p6-7.

<sup>116</sup> *Ibid* p7-8.

<sup>117</sup> Peter Leonard and Martin McLaughlin, "Capacity Legislation for Ireland: filling the legislative gaps. *Ir J Psych Med* 2009; 26(4): 165-168.

<sup>118</sup> Delivering the Bamford Vision, The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability, Draft for consideration by NI Executive, Chapter 7.

that the recent changes in England are almost the same as the proposed changes intended for Ireland. In this instance the 2005 Act and the recently amended Mental Health Act 1983 in England and Wales can act as a benchmark for Ireland.

As mentioned above the Irish Scheme of Mental Capacity Bill is in many respects similar to the 2005 Act in England. However there are certain issues which the Scheme differs on and certain provisions that it has not included compared to the 2005 Act. For instance, the omission of the presence of mental disorder when defining incapacity has been noted by Donnelly above as being the right decision as it associates mental incapacity with mental illness or disability. However, Leonard and McLaughlin note that the “absence of a diagnostic component to the definition of capacity contained in the Bill (the Scheme) could broaden the application of this legislation beyond persons with disorders of the brain or mind. This could pose significant practical difficulties. The lack of a clear, well drafted definition of incapacity makes it unclear how incapacity can actually be clinically measured in accordance with this statute.”<sup>119</sup>

In relation to advocacy, the absence of such a provision in the Scheme constitutes a flaw in the proposed structure. As noted by Donnelly above, people lacking capacity may well lack the ability to assert their interests therefore any proposed capacity legislation must include a provision for advocacy. In relation to advance decisions, the Advance Healthcare Decisions Bill does not create anything new that is not provided for in the provisions relating to advance decisions in the English 2005 Act. Therefore, as the Scheme has not yet been enacted there is a strong argument that the legislators should take the opportunity to include recognition of advance decisions which are an aspect of capacity law.

The English 2005 Act states that it will not apply to treatment that are lawful under the Mental Health Act 1983. The reasons for this were that the specific safeguards which the 1983 Act provides must be afforded to those to whom that Act applies. The Advance Healthcare Decisions Bill contains a similar provision to the 2005 Act in England in

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<sup>119</sup> Peter Leonard and Martin McLaughlin, “Capacity Legislation for Ireland: filling the legislative gaps. *Ir J Psych Med* 2009; 26(4): 165-168.

relation to Mental Health Act matters. The provisions in the Bill will not apply to treatment that is lawful under the Mental Health Act.<sup>120</sup> However, an advance decision under the 2005 Act will apply to the Mental Health Act 1983 if it is to refuse ECT. There is no such provision in the Irish Bill or the Mental Health Act. This is a stark contrast as not only does the English Mental Health Act recognize advance decisions concerning ECT, the safeguard in relation to ECT are far more comprehensive and independent than that in the Irish Mental Health Act. As mentioned before the provision relating to ECT, section 59, in the Irish Mental Health Act allows ECT to be administered to a competent unwilling patient. A second opinion must be obtained but does not have to be independent.

Section 58A of the Mental Health Act 1983 (inserted by section 27 of the Mental Health Act 2007) in England deals with the safeguards relating to ECT. Under this section for a person to be administered ECT without consent he must be certified by a registered medical practitioner as not being “capable of understanding the nature, purpose and likely effects of the treatment; but that it is appropriate for the treatment to be given”.<sup>121</sup> Moreover, the treatment cannot be given if it conflicts with a valid advance directive. In addition, the initial assessment for determining if the patient is capable of understanding the treatment must not be carried out by the treating clinician or the approved clinician in charge of the treatment in question. Furthermore, before giving a certificate under this section the registered medical practitioner concerned “shall consult two other persons who have been professionally concerned with the patient’s medical treatment but, of those persons, one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner; and neither shall be the responsible clinician (if there is one) or the approved clinician in charge of the treatment in question.”<sup>122</sup>

It is clear that the safeguards concerning ECT in the English Mental Health Act are far more comprehensive and independent than the safeguards afforded to patients in the Irish Mental Health Act. Furthermore, the English Act has recognizes advance decisions in

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<sup>120</sup> Advance Healthcare Decisions Bill 2010 s.6 (8) (c).

<sup>121</sup> Mental Health Act 1983 s58A (5) (a) (b).

<sup>122</sup> Mental Health Act 1983 s58A (6) (a) (b).

relation to ECT. The recognition of advance decisions in the English Act is limited but it is a step in the right direction in recognizing the rights of persons with disabilities being treated under mental health legislation in participating more in their treatment.

## **Chapter 6. Conclusions.**

The mental health policy “A Vision for Change”<sup>123</sup> has been in place since 2006 and aims to provide a person centred, accessible, community based framework for people with mental illness. It proposes a holistic view of mental illness and recommends a multi-disciplinary approach. An expert group of different professional disciplines, health service managers, researchers, voluntary organisation and service user groups developed this policy. There is now an opportunity for Ireland to engage in meaningful reform in this area by reviewing the Mental Health Act in consultation with service users, carers and other stakeholders, and introduce mental capacity legislation in line with the CRPD. This chapter aims to summarise the issues raised throughout this paper in relation to the proposed capacity legislation (the Scheme and the Bill) and the current mental health legislation (the Mental Health Act).

### **6.1. The Scheme of Mental Capacity Bill 2008:**

People who lack capacity are among the most vulnerable members of our society. Therefore the introduction of appropriate capacity legislation is essential to ensure the protection of their rights and interests. In this regard the Scheme of Mental Capacity Bill 2008 is a welcome and much needed piece of legislation. The Scheme places a presumption of capacity on statutory footing and adopts a time and issue-specific functional approach towards capacity. The proposed Scheme is intended to bring Ireland in line with the CRPD in relation to capacity issues. However, there are certain issues which need to be addressed if the Scheme is to provide for meaningful reform in this area. These issues were discussed in chapter 3 and broadly speaking question whether the Scheme would fulfil its obligations under the CRPD.

Some of these issues discussed include the lack of a framework for supported decision-making which is an important element of a social model of disability which is promoted

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<sup>123</sup> “A Vision for Change” Report of the Expert Group on Mental Health Policy. 2006, Department of Health and Children.

by the CRPD. In addition, the Scheme is to replace the current wards of court system. However, if the Scheme is enacted, current wards will not have their wardship status automatically reviewed. Arguably, such a review should be mandatory so as not exclude people from its scope who may benefit from its provisions. Critically, the Scheme is silent on how its provisions will impact on the Mental Health Act.

It would seem clear that the Mental Health Act would need to be amended to ensure that the functional and time and issue-specific approach to capacity and guiding principles and definition of best interests set out in the Scheme apply equally to people being treated under the Mental Health Act.

In relation to advocacy, discussed in the previous chapter, the Scheme should address this issue by including an independent advocacy service in its provisions. Along with a framework for supported decision-making, this would ensure that there are adequate supports in place for people who lack capacity. Such an approach would bring the Scheme in line with Article 12 of the CRPD which places an obligation on State Parties to “take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”.<sup>124</sup> In relation to advance decisions there is still an opportunity, as the Scheme has not been enacted, to include such a mechanism in its provisions and I would argue that if possible advance decisions should be brought within the ambit of the Scheme.

## **6.2. The Advance Healthcare Decisions Bill 2010:**

The purpose behind the Bill is to provide for a patient’s dignity, bodily integrity, privacy and autonomy during the later stages of life. As mentioned in chapter 4, the growing importance of advance decision-making arises from a development in advances in health care and a more overall patient centered approach to treatment. The Bill provides for a presumption of capacity and adopts a functional approach towards capacity. However as argued above, it would seem that the appropriate place for such a mechanism would be

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<sup>124</sup> Convention on the Rights of Persons with Disabilities. Article 12 (3), available at <http://www2.ohchr.org>

in capacity legislation itself as by having it as a stand-alone measure there is a risk that it will exclude people from its scope. The approach taken in the English Mental Capacity Act 2005 discussed in the previous chapter would be more favorable whereby there is a specific advance decision provision.

### **6.3. The Mental Health Act 2001:**

The government has committed to review the Mental Health Act in their programme for government.<sup>125</sup> This review will provide a fresh opportunity to evaluate the Mental Health Act in light of human rights standards, in particular, the CRPD. As discussed, there are serious human rights concerns in relation to section 59. On the 24<sup>th</sup> of March 2011 the Mental Health (Involuntary Procedures) (Amendment) Bill 2008 was passed by the Seanad.<sup>126</sup> This Bill, if enacted into law, will amend section 59 of the Mental Health Act to delete the term “or unwilling”. The purpose of this amendment is to recognise the right of a competent patient to refuse ECT. However, the other issues relating to the safeguards in section 59 have not been addressed in this Bill. There need to be a more independent assessment in determining if a patient is unable to give consent in relation to ECT. As discussed in the previous chapter, the approach taken in England and Wales is one the government should look to when reviewing the Mental Health Act in relation to its provisions on ECT. In addition, there is no definition of capacity in the Act, however, there is a presumption of capacity but it is not sufficiently stated in the Act and there is a need to address this. This is important from a human rights perspective as it reinforces that treatment cannot be given without the consent of the person receiving treatment. The Mental Health Act needs to be amended so as it recognizes the functional approach towards capacity provided for in the Scheme.

The Mental Health Act does not provide for advance decisions. The English Mental Health Act has limited recognition of advance decisions concerning ECT. There is an opportunity for the government when reviewing the Mental Health Act to consider providing a mechanism for advance decisions for patients under that Act to plan their

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<sup>125</sup> Programme for Government 2011, Department of the Taoiseach

<sup>126</sup> Available at <http://www.oireachtas.ie>

treatment in consultation with their clinician. In many ways advance directives in a mental health context are less ambiguous than general advance directives (refusing treatment at end of life). Individuals with mental illness usually have a diagnosis before formulating an advance decision making it easier to predict treatment choices. The advance decision is less likely to be drafted in vague or ambiguous terms if the executor is familiar with the condition and range of treatments.

For Ireland to ratify the CRPD and to comply with the spirit and purpose of the Convention it needs to engage in a meaningful reform in the area of mental health and introduce capacity legislation which will comply with Article 12 of the Convention.

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