Centre for
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& Capacity Law

mentalwelfare
commission for scotland

Scotland's Mental Health and Capacity Law: the Case for Reform

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Contents

Executive summary

At the start of the twenty-first century, Scotland was regarded as a world leader in terms of principled and rights based mental health and capacity law to protect the rights of people with mental illness, learning disability, dementia and associated conditions. In particular, it sought to restrict interventions concerning persons with mental disorder and to maximise individual autonomy even in situations where such interventions were deemed necessary.

However, since the enactment of the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003, international human rights law and practices in this field has developed further. This has called into question the fundamental assumptions that underpin our legislation and, indeed, mental health and capacity law in many other jurisdictions.

The UK became a state party to the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and its Optional Protocol in 2009. The UN Committee on the Rights of Persons with Disabilities that oversees the UNCRPD has adopted a radical critique of mental health and capacity law. It argues that the justification for any form of non-consensual intervention based, even in part, on a diagnostic label such as 'mental disorder' and the use of capacity assessments is inherently discriminatory. For this reason, the Committee considers that all forced treatment and substitute decision-making should be abolished and replaced by a new framework of supported decision-making.

At the same time, the European Court of Human Rights, in interpreting the European Convention on Human Rights (ECHR), has also challenged the conflation of detention and compulsory treatment, arguing that each requires separate justification and safeguards.

Globally, we are witnessing other jurisdictions beginning to respond to the 'paradigm shift' presented by the UNCRPD although none have yet legislated in a way which the UN Committee would regard as fully compliant. The Mental Capacity (Northern Ireland) Act, that combines mental health and capacity law within a single framework and removes any diagnostic threshold, was, for example, enacted in 2016.

Within Scotland, whilst there remains widespread support for the principles of the 2000 and 2003 Acts, there is concern that individuals may remain disempowered and unable effectively to assert their rights, and that balancing safeguards and rights to appropriate care have been undermined by resource constraints.

The Scottish Government has announced a review of the position of learning disability and autism within the 2003 Act's definition of 'mental disorder' and is also reviewing

Scottish incapacity legislation, to respond to the UN Convention and to case law extending the understanding of what constitutes a 'deprivation of liberty'. This is likely to bring into question the relationship between incapacity and mental health law.

If Scotland is to lead the field again we need to reform our own law. With a view to further discuss and consider this, the Mental Welfare Commission for Scotland and the Centre for Mental Health and Capacity Law at Edinburgh Napier University therefore jointly held three roundtable events during the autumn of 2016. The aim of the discussion was to highlight and analyse key issues in Scottish mental health and capacity legislation, and to review future opportunities for reform. The topics explored at these events and trends that developed from them form the foundation of this report; namely graded guardianship, the possibility of unified legislation and capacity issues. The report was also enriched by information gathered during a Mental Welfare Commission parallel exercise involving discussions with people with lived experience and carers.

Report and conclusions

The resultant report provides an analysis and discussion of some of the major issues faced by Scottish mental health and capacity legislation. It places them not only in the current Scottish legal context but also in the context of recent developments in international law. It is hoped that this will make a useful contribution to the debate on mental health and capacity law reform in Scotland.

A number of broad conclusions can be discerned from this exercise:

(1) In order to ensure compliance with developing international human rights standards, notably those identified in the UNCRPD and ECHR, there is a need to revisit and, where necessary reframe, our mental health and capacity law. This applies to both how such law is framed and how it is implemented.

(2) Much more can be done to maximise the autonomy and exercise of legal capacity of individuals with mental disorder, even where significant impairments of decision making capacity exist, so that genuine non-discriminatory respect is afforded for an individual's rights, will and preferences. There needs to be a serious and careful engagement with what affording such respect actually entails, particularly if Scottish law and its implementation is to facilitate the enabling and empowering of individuals with mental disorder.

Moreover, our existing mental health, capacity and adult support and protection legislation in Scotland applies a diagnostic threshold linked wholly or partly to mental disorder and capacity assessments which is potentially discriminatory. Any reform

must therefore be accompanied by revisiting how ‘capacity’ and ‘significantly impaired decision making ability’ is assessed by clinicians and practitioners.

(3) There is a need to rationalise and provide greater synergy between the 2000 and 2003 Acts and the Adult Support and Protection (Scotland) Act 2007 to ensure that where an individual potentially falls to be considered under more than one piece of legislation this is effectively and consistently achieved. To this end, there is considerable support for transferring 2000 Act (and perhaps also 2007 Act) jurisdiction to the Mental Health Tribunal for Scotland and this should accordingly be rigorously investigated.

(4) While there was general support for the principle of unified legislation amongst the stakeholders consulted, it was less clear that there was an appetite for making its immediate introduction a policy priority. However, there did appear to enthusiasm for short to mid-term incremental changes taking the above matters into account which may or may not ultimately pave the way for unified legislation. This needs to be further explored, particularly with the involvement of service users as, indeed, Article 4(3) UNCRPD requires.

Report recommendations

In light of the above, the following recommendations are made:

Recommendation 1: There should be a long-term programme of law reform, covering all forms of non-consensual decision making affecting people with mental disorders. This should work towards a coherent and non-discriminatory legislative framework which reflects UNCRPD and ECHR requirements and gives effect to the rights, will and preferences of the individual. Further, in accordance with Article 4(3) UNCRPD, persons with lived experience of mental disorder must be actively consulted in any reform process.

Recommendation 2: There should be an explicit aim of increased convergence of the legislation over time, particularly with respect to the criteria justifying intervention.

Recommendation 3: There should be a single judicial forum to oversee non-consensual interventions. The balance of views favours the Mental Health Chamber of the new tribunal structure as the appropriate forum.

Recommendation 4: Within the reform programme, priority should be given to the problems with the law which have the most significant negative effect on the lives and rights of people who are subject to them. The first priority should be to reform the Adults with Incapacity (Scotland) Act 2000.

Recommendation 5: The Adults with Incapacity (Scotland) Act 2000 reform should build on proposals for 'graded guardianship', which have attracted widespread support. It should also take account of the proposals to address UNCRPD compliance set out in the Essex Autonomy Project *Three Jurisdictions Report*.

Recommendation 6: The 'design principles' set out in para 6(a) of Chapter Three should be used to guide reform relating to guardianship.

Recommendation 7: Graded guardianship should also replace parts 3 and 4 of the Adults with Incapacity (Scotland) Act 2000 and DWP appointeeship.

Recommendation 8: As part of the programme of reform, consideration should be given to the replacement of the 'SIDMA' test in the Mental Health (Care and Treatment) (Scotland) Act 2003 by a capacity test. However, the priorities before considering such legislative change should be (a) to improve practice and develop consistent standards across medicine, psychology and the law on the assessment of capacity and (b) to identify and implement practical steps to enhance decision making autonomy whenever non-consensual interventions are being considered.

Foreword

The authors would particularly like to thank Professor Genevra Richardson for chairing the roundtables that led to its production. Her long-standing expertise in and experience of mental health law reform and guidance of the roundtable discussion was invaluable.

Further thanks are given to Dr Paul Hutton, Dr Lucy Series, Andrew Dawson, Professor Roy McClelland and Pearse McCusker, who provided presentations at the seminars, and to all those who attended the meetings providing the high quality of discussion that led to this report. Finally, thanks must go to Erin Bonnar (Mental Welfare Commission), Rebecca McGregor (Research Assistant, Centre for Mental Health and Capacity Law, Edinburgh Napier University) and Emma Miller (Final Year Law student, Edinburgh Napier University) for note-taking at the roundtables and for their support in the production of the report.

The Mental Welfare Commission conducted a parallel exercise involving discussions with people with lived experience and carers about the use of capacity as a justification for compulsory care and treatment. A report on that exercise is published alongside this report, and has informed this report, particularly our discussions on capacity as a justification for intervention.

This report was written by Colin McKay, Chief Executive of the Mental Welfare Commission for Scotland, and Professor Jill Stavert, Director of the Centre for Mental Health and Capacity Law and Business School Director of Research, Edinburgh Napier University.

Chapter 1:

BACKGROUND

1. Introduction

The start of the twenty-first century saw Scotland as a world leader in terms of principled and rights based law to protect the rights of people with mental illness, learning disability, dementia and associated conditions. International human rights law in this field has developed further since then and we need to reform our own law if we are to regain that position. It is hoped that this exercise will make a useful contribution to the debate on mental health and capacity law reform in Scotland.

The summary of facts, conclusions and recommendations of this report are largely based on three roundtable events held in November and December 2016, chaired by Professor Genevra Richardson[1], involving leading interests in mental health and capacity law (please see the appendices for details of participants and the roundtable agendas). The exercise was conducted jointly by the Mental Welfare Commission for Scotland, led by Colin McKay (Chief Executive) and the Centre for Mental Health and Capacity Law at Edinburgh Napier University, led by Professor Jill Stavert (Centre Director).

The overall aim of the roundtables was to review key issues concerning the legal framework for non-consensual care, treatment and support in Scotland, and to consider possible options for reform. The roundtables considered:

(1) Graded Guardianship;

(2) Unified Mental Health and Capacity Legislation; and

(3) The Basis for Intervention and Non-Consensual Care and Treatment,

although there was inevitably some overlap between the discussions at each event. Each roundtable followed a similar format. A briefing paper summarising the law and relevant issues was distributed to participants prior to each event, and experts were invited to give short presentations on the day to further assist discussion. Such discussions were recorded in manuscript note form.

We have tried to give a fair account of the main issues discussed at the roundtables in this report. We found a significant degree of consensus about the way forward, which we have sought to reflect in our conclusions. However, responsibility for the report and the recommendations is solely that of the authors.

[1] The Dickson Poon School of Law, King's College London.

Importantly, the impact of any mental health and capacity law is felt primarily by people with mental disorder. It is therefore essential that the voices of persons with lived experience are included and help shape any reforms of law, policy and practice. The Mental Welfare Commission conducted a parallel exercise involving discussions with people with lived experience and carers about the use of capacity as a justification for compulsory care and treatment, and the roundtable findings have been supplemented by the information gathered at such events. Much more detailed and in depth involvement of people with lived experience will be required as a next step to law reform.

2. Legal framework

The current law is contained in the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act). These statutes brought about a radical modernisation of Scots law, following a decade of policy development, including the Scottish Law Commission *Report on Incapable Adults*[2] (1995) and the Millan Committee report *New Directions: Review of the Mental Health (Scotland) Act 1984* (2001)[3].

The 2000 and 2003 Acts were noteworthy for being based on principles that must inform and be applied in the context of decisions regarding interventions and non-consensual care and treatment, which were set out in the legislation. They earned Scotland an international reputation for being a leading example of a country that had created good legislative practice[4].

Before interventions and non-consensual care and treatment may be considered under the 2000 Act an individual must be assessed as being 'incapable' and for such considerations under the 2003 Act they must be assessed as having 'significantly impaired decision-making ability'. Both concepts essentially derive from capacity assessments and will be discussed more in Chapter Four. The Adult Support and Protection (Scotland) Act 2007 ('the 2007 Act') relates to 'adults at risk'[5] which is broader but may include individuals who lack capacity.

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[2] Scottish Law Commission, *Report on Incapable Adults* (Scot Law Com No 151, September 1995) <https://www.scotlawcom.gov.uk/files/5013/2758/0994/rep151_1.pdf> accessed 20 March 2017 (SLC Report on Incapable Adults).

[3] Scottish Executive, 'New Directions: Review of the Mental Health (Scotland) Act 1984' (SE/2001/56, January 2001) <http://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf > accessed 20 March 2017 (Millan Report).

[4] See, for example, Jennifer Fischer, 'A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalised Persons with Mental Illness' (2006) 29 Hastings International and Comparative Law Review 153, 175.

[5] Defined as persons aged 16 years of age or over who are:
'(a) are unable to safeguard their own well-being, property, rights or other interests,
(b) are at risk of harm, and

A key objective of the principles that underpin these Acts is to ensure that the individual's autonomy is preserved insofar as it is possible when interventions and non-consensual care and treatment are being considered. They also apply during their implementation. The starting point of the 2000 and 2003 Act is an implied one of a rebuttable presumption of capacity. Assessments of capacity must be decision-specific, and the individual's present and past wishes and feelings must be taken into account in so far as it is reasonably and practically possible in all decisions made concerning them and during the implementation of interventions[6]. An intervention must provide a benefit[7] that cannot be otherwise achieved and be the least restrictive option[8] in the particular circumstances. The 2003 Act also specifically states that unless justification can be shown, the patient must not be treated less favorably than a non-patient might be treated in a comparable situation and a patient's abilities, background and characteristics must be taken into account[9]. In addition, the 2000 Act specifically provides that those responsible for implementing interventions must encourage and develop the individual's skills regarding their property, financial affairs and personal welfare[10].

The 2003 Act also established the Mental Health Tribunal for Scotland as the forum to consider applications for, and appeals against, non-consensual care and treatment of individuals with mental disorder.

A third pillar was added to the framework for non-consensual care and treatment via the 2007 Act. This Act, which is underpinned by principles which are largely the same as those in the 2000 and 2003 Act, was originally intended as a relatively minor updating of the law, drawing on a Scottish Law Commission report on Vulnerable Adults[11]. The powers it grants to local authorities and others are also relatively circumscribed and short term. Despite this, however, the 2007 Act has become a very significant aspect of social work provision for older people and people with disabilities.

> (c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.'(s 3(1))

and who are deemed to be at risk if

> '(a) another person's conduct is causing (or is likely to cause) the adult to be harmed, or
> (b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.' (s 3(2))

[6] 2000 Act, s 1(4); 2003 Act, s 1 (3)(a) and s 1(8); 2007 Act, s 2(b)

[7] 2000 Act, s 1(2); 2003 Act, s 1(3)(f)

[8] 2000 Act, s 1(3); 2003 Act, s 1(4)

[9] 2003 Act, ss 1(3)(g)-(h)

[10] 2000 Act, s 1(5)

[11] Scottish Law Commission, *Report on Vulnerable Adults* (Scot Law Com No 158, 1997) <https://www.scotlawcom.gov.uk/files/8412/7989/7469/rep158.pdf> accessed 20 March 2017.

We understand that the majority of 2007 Act interventions have involved people with mental illness, dementia or learning disability.

There have been some minor amendments to the 2000 Act by, for instance, the 2007 Act[12]. The Mental Health (Scotland) Act 2015 also amended the 2003 Act and gave effect to some of the recommendations of the McManus Committee, following their report in 2009[13], although such changes are, on the whole, technical adjustments[14]. Additionally, the enactment of the Mental Health (Scotland) Act 2015 reinvigorated the debate, which had also been considered by the Millan Committee[15], about whether people with learning disabilities should fall within the remit of mental health legislation. This has prompted a review of the Mental Health (Care and Treatment) (Scotland) Act 2003 as it concerns people with learning disabilities and autism[16], which will also consider the role of psychologists within the Act, and the use of psychotropic medication.

3. The use of mental health and capacity law in Scotland and the challenges faced

Whilst, to date, there have been few successful court challenges to the Scottish legal framework[17], it does face some national and international challenges, many of which have been identified in responses to the 2016 Scottish Government consultation on the Scottish Law Commission Report on Adults with Incapacity[18]. These are summarised in the following sections.

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[12] For example, the introduction of the requirement that where applications are made under the 2000 Act sheriffs must take in take into account the adult's wishes and feelings as expressed by their independent advocate (2000 Act, s 3(5A) as inserted by the 2007 Act, s 55) and the requirement that when making a continuing or welfare power of attorney the granter must have considered how they will be determined to be incapable (2000 Act, ss 15(3)(ba) and 16(3)(ba) as inserted by 2007 Act, ss 57(1)(a) and 57(2)(a)).

[13] Scottish Government, 'Limited Review of the Mental Health (Care and Treatment)(Scotland) Act 2003: Report' (March 2009) <http://www.gov.scot/Resource/Doc/281409/0084966.pdf > accessed 20 March 2017.

[14] The Mental Health (Scotland) Act 2015 (s 37) also requires the Scottish Ministers to carry out a review of the arrangements for investigating the deaths of mental health patients in hospital for treatment within three years of 24 December 2015.

[15] At the time of the Millan Review there was no consensus on this and so the definition of 'mental disorder' in the 2003 Act (s 328) includes learning disability.

[16] Scottish Government, 'Review of Learning Disability and Autism in the Mental Health (Scotland) Act 2003: Findings from a Scoping Exercise' (December 2016) <http://www.gov.scot/Resource/0051/00512868.pdf> accessed 20 March 2017.

[17] One exception is the Supreme Court ruling in *RM (AP) v The Scottish Ministers* [2012] UKSC 58 that the Government had failed to introduce regulations to extend the right to appeal against the level of security to units beyond the State Hospital. This was partially remedied by the 2015 Act which extended the right to medium secure units.

[18] Scottish Government, 'Consultation on the Scottish Law Commission's Review of Adults with Incapacity' (December 2015) <https://consult.scotland.gov.uk/integration-partnerships/report-on-adults-with-incapacity/user_uploads/410293-p3.pdf-1> accessed 20 March 2017; Scottish Government, 'Analysis of

a. Increased use of mental health and capacity law

There has been a significant and longstanding trend of increased use of both mental health and incapacity legislation in Scotland. Chapter 2 gives details of the very substantial and continuing rise in the use of guardianship under the 2000 Act. The number of people being detained under the 2003 Act has also increased by roughly 4% per year since 2011/12 and the use of compulsion under this Act is now higher than in the last year of the previous legislation (the Mental Health (Scotland) Act 1984)[19].The reasons for these increases are not wholly clear. Similar rises have been seen in England and Wales[20]. Contributing factors are likely to include greater awareness of the legislation, demographic changes and service redesign.

b. Application of legislative principles

The principles that underpin the 2000 and 2003 Acts continue to be widely supported. However, there are questions about the extent to which the principles regarding respect for individual's wishes and feelings, benefit, and least restrictive options, are truly reflected in decisions concerning interventions and non-consensual care and treatment. Some critics have suggested[21] that the Acts were characterised as promoting and protecting the rights of people with psychosocial or intellectual impairments but in practice operate to provide legal protection for professionals to take decisions which the person may not agree with. Indeed, research has indicated that there exists a lack of awareness and application of the principles of the legislation amongst health care staff[22]. Moreover, it would also appear that the principle of

Responses to the Scottish Government's Consultation on the Scottish Law Commission's Review of Adults with Incapacity' (June 2016) <http://www.gov.scot/Resource/0050/00502699.pdf > accessed 20 March 2017.

[19] Mental Welfare Commission for Scotland, 'Mental Health Act Monitoring 2015-16' (September 2016) <http://www.mwcscot.org.uk/media/342871/mental_health_act_monitoring_2015-16.pdf> accessed 13 April 2017.

[20] In terms of use of mental health legislation see, for example, NHS Digital, 'Inpatients Formally Detained in Hospitals under the Mental Health Act 1983, and Patients Subject to Supervised Community Treatment - Uses of the Mental Health Act: Annual Statistics, 2015/2016' (30 November 2016) <http://www.content.digital.nhs.uk/catalogue/PUB22571/inp-det-m-h-a-1983-sup-com-eng-15-16-rep.pdf> accessed 20 March 2017.

Applications to the Court of Protection regarding persons who lack capacity also appear to be increasing although this seems not to be attributable to deputyship (the equivalent of guardianship) applications but largely attributable to those regarding deprivations of liberty. See, for example, Ministry of Justice, 'Family Court Statistics Quarterly: July to September 2016' (15 December 2016) <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577502/family-court-statistics-quarterly.pdf> accessed 20 March 2017.

[21] See for example, People First (Scotland), 'Citizens' Grand Jury Report: Care, Protection and Human Rights or Danger, Neglect and Human Wrongs?' (May 2011) <http://www.viascotland.org.uk/webfm_send/304/citizens-grand-jury-report.pdf> accessed 20 March 2017.

[22] See, for example, Scottish Human Rights Commission, 'Getting it Right? Human Rights in Scotland' (October 2012) 69 and 102-103 <http://www.snaprights.info/wp-content/uploads/2016/01/Getting-it-Right-An-Overview-of-Human-Rights-in-Scotland.pdf> accessed 20 March 2017; Mental Welfare Commission for Scotland, 'Visit and Monitoring Report - Intensive Psychiatric Care in Scotland 2015' (March 2016)

reciprocity - advocated by the Millan Committee[23] and given effect in the 2003 Act[24] - might not be being fully applied. It is arguable that the rights of the state to impose treatment on the person are clearly articulated and can be given direct effect, while the rights of the individual to support are set out in ways which are difficult to enforce, and which have had limited practical effect[25].

c. Developments promoting change

Such increased use of the legislation and concerns about its operation are taking place against a backdrop of wider national and international developments.

d. Human rights developments

Domestic law in this area is increasingly influenced by developing international human rights law and practice, in particular the European Convention on Human Rights (ECHR), and the UN Convention on the Rights of Persons with Disabilities (UNCRPD). In 2016, a report by the Mental Welfare Commission and the Scottish Human Rights Commission[26] called for the next mental health strategy to be explicitly based around a human rights approach. This has been reflected in the Scottish Government's *Mental Health Strategy 2017-2027*, which was published on 30 March 2017[27], although greater clarity is awaited on how its proposed outcomes will be achieved.

Under existing constitutional arrangements pertaining to Scotland's devolved legislation and its implementation, the actions of the Scottish Ministers and of public bodies must be compatible with ECHR rights and can be enforced through our national

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<http://www.mwcscot.org.uk/media/315618/intensive_psychiatric_case_in_scotland_report_final.pdf> accessed 20 March 2017.

[23] SLC Report on Incapable Adults (n 2), Recommendation 3.3

[24] Mental Health (Care and Treatment) (Scotland) Act 2003, s1(6)

[25] Mental Welfare Commission for Scotland, 'Visit and Monitoring Report: Visits to People on Longer Term Community-Based Compulsory Treatment Orders' (December 2015) <http://www.mwcscot.org.uk/media/243429/ccto_visit_report.pdf> accessed 20 March 2017;
Mental Welfare Commission for Scotland, 'Visit and Monitoring Report: Suspension of Detention Visits (May-Dec 2014)' (July 2015) <http://www.mwcscot.org.uk/media/233726/suspension_of_detention_report_final_1.pdf> accessed 20 March 2017;
Mental Welfare Commission for Scotland, 'Visit and Monitoring Report: Updated Survey of Recorded Matters' (October 2014) <http://www.mwcscot.org.uk/media/203366/updated_survey_of_recorded_matters__2_.pdf> accessed 20 March 2017.

[26] Scottish Human Rights Commission and Mental Welfare Commission for Scotland, 'Human Rights in Mental Health Care in Scotland: A Report on Progress Towards Meeting Commitment 5 of the Mental Health Strategy mental health strategy for Scotland: 2012-2015' (September 2015) <http://www.mwcscot.org.uk/media/240757/human_rights_in_mental_health_care_in_scotland.pdf > accessed 20 March 2017.

[27] Scottish Government, 'Mental Health Strategy: 2017-2027' (30 March 2017) <http://www.gov.scot/Resource/0051/00516047.pdf> accessed 30 March 2017.

courts and tribunals[28]. UNCRPD rights are not enforceable in the same way but the UK, as a state party to the UNCRPD, is bound under international law to comply with it. Moreover, devolved legislation and the actions of the Scottish Ministers can be prevented by the UK Government if they contravene UNCRPD rights[29]. The European Court of Human Rights should also interpret ECHR rights with reference to the UNCRPD, the latter Convention being a higher source of international law.

At the time of their adoption, the legislative principles in the 2000 and 2003 Act accurately reflected international human rights standards, namely those of the ECHR. However, in 2014 these instruments precipitated two major shocks to the system, whose implications are still being worked through – the *Cheshire West* judgment of the UK Supreme Court[30], and the UN Committee on the Rights of Persons with Disabilities General Comment No 1[31].

i. European Convention on Human Rights – Deprivation of Liberty

The European Court of Human Rights *Bournewood*[32] 2004 ruling made it clear that persons who lack capacity to consent to a deprivation of liberty must have the protection of Article 5 ECHR compliant legal and procedural safeguards. This raised the issue of who can authorise deprivations of liberty on behalf of persons with incapacity. It also raised the issue of the types of safeguards that are necessary to meet Article 5 requirements and in particular the level of judicial oversight required, in that Article 5(4) states that persons deprived of their liberty are entitled to bring court proceedings to test the lawfulness of such detention. Importantly, such safeguards must be 'real and effective' for persons who lack capacity thus ensuring equality of protection[33]. This resulted in scrutiny of the existing 2000 Act provisions and their compatibility with Article 5.

Arguably, we do not currently have a legal regime which is adequate to meet Article 5 requirements[34]. The Scottish Law Commission was asked to review this and before

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[28] Scotland Act 1998, ss 29(2)(d) and 57(2); Human Rights Act 1998, ss 2, 3 and 6

[29] Scotland Act 1998, ss 35 and 58

[30] *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 1.

[31] Committee on the Rights of Persons with Disabilities, 'General Comment No 1 (2014) Article 12 Equal Recognition before the Law' (CRPD/C/GC/1, 19 May 2014) <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement> accessed 20 March 2017 (General Comment No 1).

[32] *HL v UK* (2005) 40 EHRR 32.

[33] *Stanev v Bulgaria* (2012) 55 EHRR 22; *DD v Lithuania* (2012) ECHR 254; *MH v UK* (2013) ECHR 1008; *Stankov v Bulgaria* App no 25820/07 (ECtHR, 17 March 2015)

[34] It should also be noted that in response to the *Bournewood* ruling the Mental Capacity Act 2005 in England and Wales was updated by the Mental Health Act 2007 by provisions creating 'Deprivation of Liberty Safeguards'

its final report, the UK Supreme Court issued its *Cheshire West* ruling which significantly widened the understanding of 'deprivation of liberty', in the context of Article 5. In reinforcing previous Article 5 ECHR rulings that (a) any person who is "under continuous supervision and control and was not free to leave."[35] is deprived of their liberty and that (b) the right to liberty is too important for assumptions to be made about whether or not a person who lacks capacity consents to their detention,[36] *Cheshire West* potentially extended the concept of deprivation of liberty to virtually any health or social care setting. The Scottish Law Commission final proposals were thus intended to address these issues[37] and the Scottish Government is currently considering reform of the 2000 Act. It is clear, however, that we will need to legislate to achieve Article 5 compliance. The Scottish Government review will also consider UNCRPD compliance.

ii. Convention on the Rights of Persons with Disabilities

Even more significant has been the debate around the implications of the UNCRPD. As previously mentioned, the UK has ratified this Convention, and the Scottish Government is committed to its implementation[38]. There are strong grounds for believing that the 2000 and 2003 Acts are not fully compliant with the UNCRPD.

The UN Committee on the Rights of Persons with Disabilities (the UN Committee) has issued two significant documents, namely the previously mentioned General

(DOLS), including a process of independent authorisation by an accredited professional of any care placement deemed to involve a deprivation of liberty. However, this system has been found wanting and the Law Commission for England and Wales has recently recommended its complete overhaul (Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, March 2017) <http://www.lawcom.gov.uk/wp-content/uploads/2017/03/lc372_mental_capacity.pdf> accessed 20 March 2017.)

[35] *HL v UK* (2005) 40 EHRR 32, paras 91-92; *Stanev v Bulgaria* (2012) 55 EHRR 22, paras 124-128; *Cheshire West* (n 30), para 49 (Lady Hale).

[36] *De Wilde Ooms and Versyp v Belgium* (1971) 1 EHRR 373, paras 64-65; *HL v UK* (2005) 40 EHRR 32, para 90; *Storck v Germany* (2005) 43 EHRR 96, para 75; *Cheshire West* (n 30), para 24 (Lady Hale).

[37] Scottish Law Commission, *Report* on *Adults with Incapacity* (Scot Law Com No 240, October 2014) <http://www.scotlawcom.gov.uk/files/6414/1215/2710/Report_on_Adults_with_Incapacity_-_SLC_240.pdf> accessed 20 March 2017 (SLC Report on Adults with Incapacity).

[38] Scottish Government, 'A Fairer Scotland for Disabled People: Our Delivery Plan to 2021 for the United Nations Convention on the Rights of Persons with Disabilities 2016' (December 2016) <http://www.gov.scot/Resource/0051/00510948.pdf> accessed 20 March 2017 (Scottish Government CRPD Delivery Plan).
The commitment to full implementation of the Convention was also affirmed in the resolution of the Scottish Parliament when the plan was debated on 7 December 2016, see Scottish Parliament, 'Meeting of the Parliament – Thursday 8 December 2016' <http://www.parliament.scot/parliamentarybusiness/report.aspx?r=10675&mode=pdf> accessed 13 April 2017.

Comment No 1 on Article 12 UNCRPD (the right to equal recognition before the law) and its 2015 Guidelines on Article 14 UNCRPD (the right to liberty)[39].

The UN Committee advances a number of key arguments in these documents, which can be summarised as:

- All forms of substitute decision making breach the Convention, and must be replaced by law and practice based on support for the exercise of legal capacity.
- All forms of legal incapacity, detention or compulsory treatment based, even in part, on a diagnosis of mental disorder are discriminatory and should be abolished.
- There should be no forced treatment for mental disorder.
- Decision making based on notions of capacity and incapacity should be replaced by decision making which respects the rights, will and preference of the individual.

If accepted, these arguments would require a fundamental recasting of mental health and incapacity law. The UN Committee will review the UK's compliance with the UNCRPD in 2017. The submission to the Committee by the Scottish Human Rights Commission and other bodies making up the Independent Monitoring Mechanism for the UK highlights several questions about how far mental health and incapacity law is currently compliant with the Convention[40].

That being said, the position of the UN Committee has been controversial, and other commentators have argued that some degree of substitute decision making is appropriate where a person truly lacks the ability to make a meaningful decision[41], and that the UNCRPD neither bans nor should ban all forcible treatment. In other words, there is a need to address the argument that the recognition of equal human dignity may necessitate that autonomy is limited[42] at the same time as acknowledging that

[39] Committee on the Rights of Persons with Disabilities, 'Guidelines on Article14 of the Convention on the Rights of Persons with Disabilities: the Right to Liberty and Security of Persons with Disabilities' (September 2015) <www.ohchr.org/Documents/HRBodies/UNCRPD/GC/GuidelinesArticle14.doc> accessed 20 March 2017 (Article 14 UNCRPD Guidelines).

[40] See <http://www.scottishhumanrights.com/news/new-reports-submitted-to-un-on-disability-rights-in-scotland/> accessed 21 March 2017.

[41] See for example Wayne Martin and others, 'The Essex Autonomy Project - Achieving UNCRPD Compliance – Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If Not, What Next?' (22 September 2014) < https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-Position-Paper-FINAL.pdf> accessed 20 March 2017 (EAP Achieving UNCRPD Compliance) and; Wayne Martin and others, 'Essex Autonomy Project - Three Jurisdictions Report – Towards Compliance with UNCRPD Art.12 in Capacity/Incapacity Legislation across the UK' (6 June 2016) <https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-3J-Final-Report-2016.pdf> accessed 20 March 2017 (EAP Three Jurisdictions Report).

[42] Jillian Craigie, 'Against a Single Understanding of Legal Capacity: Criminal Responsibility and the Convention on the Rights of Persons with Disabilities' (2015) 40 International Journal of Law and Psychiatry 6; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws Compliance with the UNUNCRPD' (2015) 40

too much restriction in the name of 'protection' may increase powerlessness and vulnerability[43]. Indeed, whilst the Committee's position is supported by the UN Working Group on Arbitrary Detention[44], and more recently the Office of the UN High Commissioner for Human Rights[45], most other international and regional human rights bodies accept deprivation of liberty and treatment without consent in certain circumstances subject to strict safeguards (in particular, the UN Human Rights Committee, the UN Committee against Torture, the UN Subcommittee on Prevention of Torture and the European Committee for the Prevention of Torture)[46].

Alongside this, ECHR case law concerning Articles 5 (the right to liberty) and 8 (the right to respect for private and family life)[47] has also increasingly promoted an expansive approach to the exercise of legal capacity[48]. The European Court of Human Rights has indicated that involuntary treatment does not automatically flow from detention even where such detention is lawful[49]. Article 8 must be considered separately in relation to the proposed treatment. If the treatment does not meet the

International Journal of Law and Psychiatry 70, 79; Paul Appelbaum, 'Protecting the Rights of Persons with Disabilities: An International Convention and its Problems' (2016) 67 Psychiatric Services 366, 368.

[43] Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 Syracuse Journal of International Law and Commerce 429-462; Michael Bach and Lana Kerzner, 'A New Paradigm for Protecting Autonomy and the Right to Legal Capacity' (Law Commission of Ontario, 2007).

[44] UN Working Group on Arbitrary Detention, 'Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court' (A/HRC/30/xx, June 2015), Principle 20.

[45] UN High Commissioner for Human Rights, 'Human Rights Council 34th Session, 27 February-24 March 2017 – Mental Health and Human Rights' (A/HRC/34/32, 31 January 2017).

[46] See, for example, Human Rights Committee, 'General Comment No 35: Article 9 (Liberty and Security of the Person)' (CCPR/C/GC/35, 16 December 2014) para 19; UN Committee Against Torture, 'Concluding Observations on the Combined Fifth and Sixth Periodic Reports of the Netherlands, Adopted by the Committee at its Fiftieth Session (6-31 May 2013)' (CAT/C/NLD/CO/5-6, 20 June 2013) para 21.

See also Sub-Committee on Prevention of Torture, 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Regarding the Rights of Persons Institutionalised and Treated Medically without Informed Consent' (UN Doc. CAT/OP/27/2, 26 January 2016); European Committee for the Prevention of Torture, 'CPT Standards' (CPT/Inf/E 2002, 1-Rev.2015) para 52.

[47] For example, *Shtukaturov v Russia* (App no 44009/05) (2012) 54 EHRR 27, paras 87-89; *Sykora v Czech Republic* (App no 23419/07) (2012) ECHR 1960, paras 101-103; *X v Finland* (App no 34806/040) (2012) ECHR 1371, para 220. Rulings such as *HL v UK* (2005) 40 EHRR 32 and *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19 (*Cheshire West*) also reinforce the need for Article 5 ECHR legal and procedural safeguards for persons who lack the capacity to consent to a deprivation of their liberty.

[48] This is also reinforced by Council of Europe, 'Recommendation No. REC(2004)10 of the Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder' (22 September 2004), Articles 7(1), 12, 18-20 and 27-28. See also the World Health Organisation, 'Mental Health Action Plan 2013/2020' (Geneva, 2013). <http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf>, accessed 20 March 2017.

[49] *X v Finland* (App no 34806/040) (2012) ECHR 1371, para 220.

proportionality requirements of Article 8(2), that raises the question of whether the detention is thus justified under Article 5(1)(e).

Nevertheless, the ECHR appears to accept the inevitability in certain situations and subject to strict criteria of interventions and non-consensual care and treatment linked to mental capacity assessments. This has been strongly reinforced in the recent *A-MV v Finland*[50] ruling. This creates tensions with the approach adopted by the UN Committee, although the fact that ECHR rights are given direct effect under Scottish law, whilst UNCRPD rights are not, means that ECHR rights take legal precedence. English court rulings[51] have also increasingly emphasised the importance of ensuring that patients are in control of treatment decisions affecting them[52], and that this principle extends to situations where the person's decision making capacity may be impaired[53].

iii. The Article 12 UNCRPD 'support paradigm'

As stated, the UN Committee has stated that support for the exercise of legal capacity (or 'supported decision making' as it is also referred to) must replace all 'substitute decision making'[54] in order for genuine effect to be given to the will and preferences of an individual with mental disorder[55]. It is clear that such support can take many forms. The UN Committee has emphasised the diversity of such support and has identified broad types of support such as a trusted person or persons, peer support, advocacy, community and neighbourhood support, assistance with and clear communication, technological support and advance planning[56]. It regards such support as only being capable of giving genuine effect to an individual's rights, will and

[50] *A-MV v Finland* App no 53251/13 (ECtHR, 23 March 2017). This ruling appears to acknowledge that the wishes and feelings of an individual who lacks capacity may be overridden in certain situations. It should be noted that the German Federal Constitutional Court in *Bundesverfassungsgericht (BVerfG), Beschluss* vom 26.juli 2016–1 BvL 8/15 ruled that the state has a protection duty to save the health and life of the person with a disability which justified the use of compulsion. However, these rulings appear to be somewhat out of step with the general direction of other international and UK-wide human rights law developments relating persons with mental disorder. It is therefore submitted that at this stage caution should be taken in terms of the weight given to them.

[51] Whilst English court rulings are not binding on Scottish courts they are nevertheless influential.

[52] In particular, the ruling of the UK Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

[53] Examples include decisions of the Court of Protection upholding the right of adults to refuse treatment even in situations where they lack capacity (*Wye Valley NHS Trust v B (Rev 1)* [2015] EWCOP 60 (28 September 2015), *An NHS Trust v DJ* [2012] EWHC 3524 (COP), [2012] MHLO 138)] and of the Court of Appeal stating that, under Article 8 of ECHR, patients must be consulted on decisions not to attempt CPR in the event of cardiac arrest, and relatives must be consulted where it is not possible to consult the patient (*R (Tracey) v Cambridge University Hospital and The Secretary of State for Health with the Resuscitation Council and Others intervening* [2014] EWCA Civ 822).

[54] Defined by the Committee in para 27 of General Comment No 1 (n 31)

[55] General Comment No 1 (n 31), para 7

[56] General Comment No 1 (n 31), paras 17 and 18

preferences in the absence of substitute decision-making regimes, best interests assessments and linkages with mental capacity assessments[57].

Notwithstanding this, a number of issues remain unresolved. There is a lack of clarity in the literature and in practice about the meaning and extent of supported decision-making.[58] It would appear that it might be viewed as support, by various means, with decision-making that falls short of giving the resultant decisions legal recognition and effect; or it may indeed include support for the exercise of legal capacity as is stipulated by Article 12(3) UNCRPD. The Convention also leaves open the question of who exactly should provide the support in each support situation. Article 12 UNCRPD and the UN Committee's General Comment No 1, although clear that the state must ensure access to support for the exercise of legal capacity, do not throw any light on this. It would certainly be much easier to discern who bears responsibility for providing access to and delivering such support under formal arrangements, for example under legislation. It is less clear where support is delivered through informal support arrangements where the state has little or no direct involvement.

Situations involving risk and harm also need to be carefully considered. To some extent this may be addressed by the reference to giving effect to the 'rights, will and preferences' of the individual from which a balancing of autonomy, freedom from abuse and protection of the rights of others is arguably implied[59]. Notwithstanding this, it is still necessary to think more extensively about what precisely is meant by 'support' in such cases and how this can be provided so as to improve both the autonomy of, and outcome for, the individual[60].

Moreover, in addressing situations where it may be impossible to determine an individual's will and preferences, the UN Committee has stated that on these occasions a 'best interpretation' of these should be made[61]. However, whilst some

[57] General Comment No 1 (n 31), para 29

[58] Robert Dinerstein, 'Implementing Legal Capacity under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making' (2012) 19 Human Rights Brief 8-12; Michelle Browning and others, 'Supported Decision-Making: Understanding How its Conceptual Link to Legal Capacity is Influencing the Development of Practice' (2014) Research and Practice in Intellectual and Developmental Disabilities 34, 36-37; Piers Gooding, 'Navigating the 'Flashing Amber Lights' of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns' (2015) 15 Human Rights Law Review 45, 50-52.

[59] EAP Three Jurisdictions Report (n 41)

[60] Genevra Richardson, 'Mental Capacity in the Shadow of Suicide: What Can the Law Do?' (2013) 9(1) International Journal of the Law in Context 87. For more discussion of how the Article 12 support paradigm might be employed in situations or risk and harm see Eilionoir Flynn and Anna Arstein-Kerslake,'State Intervention in the Lives of People with Disabilities: the Case for a Disability-Neutral Framework' (2017) 13(1) International Journal of Law in Context 39.

[61] General Comment No 1 (n 31), para 21

view this as '100% support' in which the individual is deemed to be exercising their legal capacity, that view is not unanimously accepted[62].

At present, there is also a dearth of empirical evidence to inform any move towards supported decision-making. Indeed, the question has been raised as to whether supported decision-making mechanisms can in fact achieve the objectives envisaged by Article 12(3) UNCRPD and General Comment No 1[63]. Whilst there have been several small-scale evaluations indicating that certain types of support have produced some positive results[64] more detailed and comprehensive published research is still awaited.

However, whether or not support for the exercise of legal capacity takes place within a substitute decision-making regime, and despite the unresolved questions concerning the support paradigm, it is clear that Article 12 requires that such support does go beyond merely ensuring an individual's participation, or shared decision-making, in decisions concerning them. It actually requires that access to appropriate support is available to assist the individual make decisions and give effect to such decisions thus respecting and reflecting their rights, will and preferences.

iv. Working with the UNCRPD

Despite the debates surrounding the UNCRPD requirements regarding intervention and non-consensual care and treatment, it appears that there may be an emerging consensus around a number of key insights arising from the Convention:

(1) That much more can and should be done to maximise the autonomy of disabled adults, even if they have significant impairments of decision making capacity.
(2) That this applies both to the framing of the law and the way it operates. In this connection, the role of support for the exercise of legal capacity needs to be further explored.

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[62] Lucy Series, 'Relationships, Autonomy and Legal Capacity: Mental Capacity and Support Paradigms' (2015) 40 International Journal of Law and Psychiatry 80, 86; Eilionoir Flynn & Anna Arstein-Kerslake, 'Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity' (2014) 10(1) International Journal of the Law in Context 81, 94; Gerard Quinn, 'Concept Paper – Personhood and Legal Capacity – Perspectives on the Paradigm Shift of Article 12 CRPD' (HPOD Conference, Harvard University, 20 February 2010); Kristen Booth-Glen, 'Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond' (2012) 44 Columbia Human Rights Law Review 93, 165-167.

[63] Terry Carney, 'Clarifying, Operationalising and Evaluating Supported Decision-Making Models' (2014) 1(1) Research and Practice in in Intellectual and Developmental Disabilities 46; Richardson (n 60).

[64] See, for example, Margaret Wallace, 'Evaluation of the Supported Decision-Making Project, South Australian Office of the Public Advocate', (November 2012) (involving individuals with intellectual disabilities, brain injuries and neurological conditions choosing a trusted person to support them and to make 'support agreements'); Tommy Engman and others, 'A New Profession is Born – Personligt ombud, PO, Socialstyrelsen Fhebe Hjälm' (September 2008); I Nilsson, 'Det lönar sig – ekonomiska effecter av verksamheter med personligt ombud' (Welfare and the County Administrative Board of Skäne County, Stockholm, 2006) (both of which relate to the Public Ombudsman scheme in Skäne, Sweden). See also Series (n 62) 85.

(3) That the use of diagnostic thresholds such as mental disorder is potentially discriminatory: while they may have been justifiable in the past as a safeguard against the misuse of psychiatry, their continued use as a gateway to compulsion is problematic.
(4) Whether or not tests based on capacity are discriminatory, any test based on presence of mental disorder and some impairment falling short of incapacity is also problematic.
(5) That affording respect for 'rights, will and preference' is not simple, since the three may conflict, but there needs to be a serious engagement with what this means for laws which allow a person's apparent wishes to be overborne.

e. The Mental Health Tribunal for Scotland

The Mental Health Tribunal for Scotland was an innovation of the 2003 Act, and has proved popular and effective. From 1 April 2015, tribunals and courts in Scotland were merged to become the Scottish Courts and Tribunal Service[65]. At the same time a unified devolved tribunals structure was established in Scotland under the judicial leadership of the Lord President[66]. The Mental Health Tribunal for Scotland will be transferred to the mental health chamber of the new structure in 2018.

f. Mental Capacity (Northern Ireland) Act 2016: Fused Mental Health and Capacity Law

Northern Ireland has enacted the Mental Capacity (Northern Ireland) Act 2016 which, although not yet in force, is claimed to be the first piece of unified mental health and capacity legislation globally that is not dependent on diagnosis, and which took account of both the UNCRPD and ECHR in its drafting and during its passage through the Northern Ireland Assembly. We may therefore wish to consider the example provided by this legislation in any legislative reform in Scotland.

4. Law reform scoping exercise

Although we are not yet at a crisis, it is clear that significant changes will need to be made to the law if it is to continue to operate effectively. Two major reviews of mental health and incapacity law are now underway. If future challenges are to be avoided, those changes need to reflect a principled and human rights based approach. The aim of the roundtables that were central to this exercise was therefore to explore these issues, identify areas of consensus or difficulty, and map out a possible way forward.

We particularly focused on three key issues:

[65] Courts Reform (Scotland) Act 2014, s 130

[66] Tribunals (Scotland) Act 2014, ss 1 and 2

- **New forms of guardianship**, and whether these would provide a more flexible, proportionate and rights respecting framework for decisions about finances, care and welfare.
- **The possibility of unified legislation**, replacing mental health and capacity law with a new non-discriminatory framework for non-consensual decision making.
- **The gateway to compulsion**, particularly how far capacity might be an appropriate and universal threshold for compulsory measures, whether or not combined with the presence of mental disorder.

The following chapters summarise our findings, draw conclusions from these and make recommendations for further steps to be taken.

Chapter 2

THE BASIS FOR INTERVENTION AND NON-CONSENSUAL CARE AND TREATMENT

1. Background

This chapter/section concerns the basis for intervention and non-consensual care and treatment. Under Scottish legislation, mental capacity assessments are pivotal in terms of involuntary interventions concerning persons with mental disorder. This can be in relation to assessing the appropriateness of interventions concerning medical care and treatment, welfare and property and financial affairs. It can also relate to ensuring that protective safeguards are in place for vulnerable individuals.

2. Human rights and expanding the exercise of legal capacity

a. ECHR

An individual's ability to exercise their autonomy, including their legal capacity, is potentially fundamentally impacted in situations of intervention and non-consensual care and treatment. The ECHR does not specifically identify the right to exercise legal capacity and does accept that involuntary interventions are sometimes necessary, subject to strict criteria. Its jurisprudence concerning Articles 5 (the right to liberty) and 8 (the right to respect for private and family life) has, however, increasingly promoted an approach that reflects the fact that capacity often fluctuates for individuals with mental disorder and that it must be assessed on a functional basis[67] and that the removal of autonomy must be strictly monitored and not arbitrary[68]. Recognising that deprivation of liberty impacts an individual's autonomy, the European Court of Human Rights has also indicated individuals who are deemed to lack capacity to consent to deprivation of liberty arrangements must be protected by special legal and procedural safeguards[69]. It has also indicated that involuntary treatment does not automatically

[67] *Shtukaturov v Russia* (App no 44009/05) (2012) 54 EHRR 27, paras 87-89. This also reflects World Health Organisation (WHO) direction - (WHO, *mhGAP Intervention Guide Version 2.0* (World Health Organisation, 2016).

[68] *Sykora v Czech Republic* (App no 23419/07) (2012) ECHR 1960, paras 101-103; *X v Finland* (App no 34806/040) (2012) ECHR 1371, para 220.

[69] *HL v UK* (2005) 40 EHRR 32; *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19 (*Cheshire West*); *Winterwerp* v *Netherlands* (1979-80) 2 EHRR 387, para 55*, Stanev v Bulgaria* (2012) 55 EHRR 22, paras 168-171; *DD v Lithuania* (2012) ECHR 254, paras 163-167; *MH v UK* (2013) ECHR 1008, para 77; *Cervenka v Czech Republic* (App no 62507/12) (2016) ECHR 880; *Megyeri v Germany* (App no 13770/88) (1992) ECHR 49, para 22.

flow from detention even where such detention is lawful[70]. Article 8 must therefore be considered separately in relation to the proposed treatment, which raises the question as to whether, if detention does not meet the proportionality requirements of Article 8(2), it is thus justified under Article 5(1)(e)[71].

b. UNCRPD

i. Article 12 UNCRPD

As stated, Article 12 (the right to equal recognition before the law) UNCRPD emphasises that everyone, regardless of disability, has an equal right to exercise their legal capacity in such a way that genuinely respects their rights, will and preferences. It also requires that states provide access for persons with disabilities to such support they may require in order to exercise their legal capacity in order that genuine effect can be given to their rights, will and preferences[72].

Whilst arguably going beyond what is actually required by Article 12,[73] the UN Committee in its General Comment No 1 has noted with concern a tendency to conflate mental capacity and legal capacity with persons deemed to have impaired decision-making skills, often because of cognitive or psychosocial disability, having their ability to exercise their legal capacity removed[74]. It has stated that linking mental capacity assessments with the exercise of legal capacity, even where such assessments are decision-specific, is discriminatory in that it allows others to substitute their views of what are 'good decisions' for those of the individual concerned simply on the basis of a diagnosis[75]. Laws allowing for involuntary interventions are thus to be abolished and replaced by supported decision-making arrangements[76]. The UN Committee regards such support as the only means by which it is possible to ascertain and ensure that genuine effect is given to an individual's rights, will and

[70] *X v Finland* (App no 34806/040) (2012) ECHR 1371, para 220. The more recent case of *Hiller v Austria* (App no 1967/14) (2016) ECHR 108, paras 32-37 and 54 refers specifically to Article 14 CRPD, alongside Article 8 of Council of Europe, 'Recommendation No. REC(2004)10 of the Committee of Ministers to Member States concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder' (22 September 2004); Principles 1 and 9 of the UN General Assembly, 'Principles for Protection of Persons with Mental Illness' (A/RES/46/119, 17 December 1991), and; UN High Commissioner for Human Rights' September 2014 statement concerning Article 14 CRPD, in reinforcing the need to adopt the least restrictive alternative and respect the autonomy of psychiatric patients.

[71] Peter Bartlett, 'Reforming the Deprivation of Liberty Safeguards (DOLS): What is it exactly that we want?' (2014) 20(3) Web JCLI < http://webjcli.org/article/view/355/465> accessed 20 March 2017.

[72] Articles 12(3) and (4)

[73] EAP Achieving CRPD Compliance (n 41) 13 and; EAP Three Jurisdictions Report (n 41) 9-10

[74] General Comment No 1 (n 31) para 15

[75] General Comment No 1 (n 31) paras 7, 21 and 27

[76] General Comment No 1 (n 31), paras 3 and 7

preferences[77]. Moreover, in situations 'where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual' a 'best interpretation of will and preferences' should be employed[78]. However, whether this is genuinely the individual exercising their legal capacity, as has been argued[79], is open to debate[80].

By way of reinforcement Article 14 – which recognises that the right to liberty must also be enjoyed equally by all and prohibits detention on the basis of disability – has been interpreted by the UN Committee as disallowing detention and non-consensual treatment premised on a person's mental impairment. This is on the basis that such interventions violate a person's right to liberty as well as the principle of free and informed consent to healthcare and constitute the denial of their legal capacity to make decisions about their care and treatment[81].

Against that, it has been argued that, provided appropriate criteria are met, then it is possible to give effect to an individual's rights, will and preferences even within a regime that allows for decisions to be made for them on the basis of assessments of impaired capabilities[82].

ii. The Article 12 UNCRPD 'support paradigm'

There are several arguments in favour of supported decision-making, including the protection of autonomy and the universal nature of personhood, a reduction of isolation and an increase and enabling of independence and community integration. In other words, supported decision-making, theoretically at least, should reduce the requirement for intervention and non-consensual care and treatment[83].

Support can take many forms. As indicated in Chapter One, the UN Committee has emphasised the diversity of such support, that it must not be linked to mental capacity

[77] General Comment No 1 (n 31), para 29

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[78] General Comment No 1 (n 31), para 21

[79] Flynn and Arstein-Kerslake (n 62) 94

[80] Series (n 62) 86; Quinn (n 62); Booth-Glen (n 62) 165-167

[81] Article 14 UNCRPD Guidelines (n 39)

[82] EAP Three Jurisdictions Report (n 41)

[83] Gavin Davidson and others, 'Supported Decision-Making: A Review of the International Literature' (2015) 38 International Journal of Law and Psychiatry 61, 62; Leslie Salzman, 'Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act' (2010) 81 University of Colorado Law Review 157, 161; John Matthew Jameson 'Guardianship and the Potential of Supported Decision Making with Individuals with Disabilities' (2015) 40(1) Research and Practice for Persons with Severe Disabilities 36.

assessments, that it must be tailored to the individual's needs and that it must be made available irrespective of whether or not the individual decided to take advantage of it[84].

As also previously stated, the UN Committee regards such support as the only means of giving real effect to an individual's rights, will and preferences or a best interpretation of these, where it is impossible to ascertain these[85]. Moreover, despite the current debates surrounding the nature, role and effectiveness of support for the exercise of legal capacity, it is clear that it does go beyond merely ensuring an individual's participation, or shared decision-making, in decisions concerning them, and requires that such support ensures that such decisions actually reflect their rights, will and preferences.

3. Scottish Law: meeting the challenges

In light of these developing human rights standards it is therefore necessary to examine the extent to which existing Scottish incapacity, mental health and adult support and protection legislation provides the necessary framework to ensure that:

(1) An individual with mental disorder is able to exercise their legal capacity on an equal basis with others in relation to interventions and non-consensual care, and is not discriminatorily deprived of their autonomy; and that

(2) Where any interventions are deemed appropriate these do not remove their legal capacity, that is to say, the ability to ensure all decisions made concerning them genuinely reflect their rights, will and preferences; and that

(3) The support paradigm is reflected and given effect through such framework.

This requires a consideration of (1) the capacity thresholds and identified support provisions under such legislation; (2) the desirability of capacity thresholds as the basis for interventions and non-consensual care; (3) how the capacity thresholds and support mechanisms identified in Scottish legislation actually operate; and (4) whether there is a workable alternative to the capacity thresholds.

a. The capacity threshold in Scottish legislation

i. Adults with Incapacity(Scotland) Act 2000

Section 1(6) of the 2000 Act defines an adult[86] as 'incapable' where they are incapable of:

[84] General Comment No 1 (n 31), paras, 17, 18 and 29

[85] General Comment No 1 (n 31), para 21

[86] That is a person who is aged 16 years of age or over (2000 Act, s 1(6))

(1) acting; or
(2) making decisions; or
(3) communicating decisions; or
(4) understanding decisions; or
(5) retaining the memory of decisions

by reason of mental disorder or of an inability to communicate because of physical disability. However, importantly, a person is not deemed to be incapable by reason only of a deficiency of communication if such deficiency can be made good by human or mechanical means[87].

There are few reported cases concerning section 1(6) but in these the sheriff has emphasised that capacity is decision-specific[88] and that in guardianship applications the section 58(1) criteria – that the adult is incapable in relation to decisions about, or of acting to safeguard or promote their interests in, his property, financial affairs or personal welfare, and is likely to continue to be so incapable - must also be satisfied[89].

ii. Mental Health (Care and Treatment) (Scotland) Act 2003

The 2003 Act criteria for emergency detention, short term detention and compulsory treatment orders includes that the patient has a mental disorder and that the patient's ability to make decisions about the provision of medical care is significantly impaired (often referred to as 'SIDMA' in practice)[90]. The SIDMA test is not applied to forensic patients.

Whilst the 2003 Act does not define SIDMA, its Code of Practice makes it clear that it is a concept that is separate to that of "incapacity" as defined under the AWI, but that when assessing a person's decision-making ability similar factors will be considered to those taken into account when assessing incapacity. Moreover, these factors 'could involve consideration of the extent to which the person's mental disorder might adversely affect their ability to believe, understand and retain information concerning their care and treatment, to make decisions based on that information, and to

[87] This therefore largely reflects the criteria in *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819. The Act's Codes of Practice relating to Attorneys, Practitioners authorised to carry out medical treatment and those acting under Intervention or Guardianship Orders reiterate and provide some further guidance on this. For more discussion on s 1(6) AWI see also Adrian D Ward (1) *Adult Incapacity* (W Green 2003), chapter 15 (concerning 'constructing decisions'); and (2) *Adults with Incapacity Legislation* (W Green 2008), 16-17 and; Jill Stavert and Hilary Patrick, *Mental Health, Incapacity and the Law in Scotland* (2nd edn, Bloomsbury Professional 2016), 105-110.

[88] *City of Edinburgh Council v D* 2011 SLT(Sh Ct) 15 at 160-163*; Public Guardian, Applicant* 2011 SLT (Sh Ct) 66 at 55-56; *AD v JG* 2015 WL 178607 at 3.

[89] *Fife Council v The Adult X* 22 December 2005; *City of Edinburgh Council v D* 2011 SLT(Sh Ct) 15 at 160-163*; Public Guardian, Applicant* 2011 SLT (Sh Ct) 66 at 55-56; *AD v JG* 2015 WL 178607 at 3.

[90] s 36(4)(a) and (b), 44(4)(a)and(b), 64(5)(a) and (d)

communicate those decisions to others.'[91] SIDMA is thus a potentially broader concept than the more decision-specific test of incapacity under the 2000 Act, and allows for someone to be subject to compulsion under the 2003 Act whilst still being able to consent to specific treatments.[92]

When reviewing the former Mental Health (Scotland) Act 1984, the Millan Committee considered what would be an ethical justification for treatment without an individual's consent[93]. There was an even divide of opinion in pre-report consultations over whether or not a pure capacity test should be introduced, with the voluntary sector being more in favour of such a test than medical professionals[94]. However, concerns had also been expressed over how to approach fluctuating and ambivalent mental states, risk of harm to others (especially in forensic cases), delayed intervention where a decline in a person's mental state was predictable and those cases where death or serious harm to the individual may occur in the absence of intervention.

The Committee therefore proposed that such threshold should be where there is evidence that an individual's judgement is significantly impaired **as a result of mental disorder** (noting that impaired judgement and mental disorder are not necessarily linked, and that disagreeing with professionals' opinions is not necessarily impaired judgement). It proposed that this was a broadly similar but less legalistic formulation of concept to incapacity, which would be easier to apply in practice. Moreover, it felt that there was no need for a precise threshold of impairment beyond which intervention was permissible. Whether compulsion is justified should be assessed on the basis of impairment but also together with the nature and degree of risk, and the likely benefits of treatment. This was subsequently reflected in the 2003 Act although the Scottish Government replaced the Millan recommendation of 'impaired judgment' with the 'significantly impaired decision-making ability' that now appears in the Act[95].

iii. Adult Support and Protection (Scotland) Act 2007

Whilst the 2007 Act does not include a capacity eligibility test - and, indeed, a capable adult can refuse to agree to or comply with actions taken under the Act – in light of the

[91] Scottish Government, 'Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice - Volume 2 – Civil Compulsory Powers' (2005) para 22. Factors that have to be taken into account when deciding whether to authorise the treatment include the patient's reasons for not consenting, the views of the patient and their named person, any advance statement made by the patient, the likelihood of the treatment alleviating or preventing a deterioration in the patient's condition and that the responsible medical officer determines that it is in the patient's best interests that the treatment be given (s 242(5) 2003 Act).

[92] For further information on SIDMA and its operation see Mental Welfare Commission for Scotland, ''Significantly Impaired Decision-Making Ability' In Individuals with Eating Disorders' (2014) <http://www.mwcscot.org.uk/media/190042/sidma_final.pdf> accessed 20 March 2017.

[93] Millan Report (n 3) paras 5.41-5.44

[94] Millan Report (n 3) chapter 5, paras 22 and 28

[95] Millan Report (n 3) chapter 3, paras 6 and 7

mentioned human rights development and its potential applicability to individuals who may also fall to be considered under the 2000 and 2003 Acts, it is appropriate to include relevant provisions in this briefing document.

The 2007 Act contains provisions designed to support and protect vulnerable adults who are deemed to be 'at risk'. An 'adult[96] at risk' is defined as an adult who is:

a) unable to safeguard their own well-being, property, rights or other interests;
b) at risk of harm[97]; and
c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The 2007 Act Code of Practice, stresses that 'The presence of a particular condition does not automatically mean an adult is an "adult at risk". Someone could, for example, have a disability but be able to safeguard their well-being, and financial and property affairs. It is the whole of an adult's particular circumstances which can combine to make them more vulnerable to harm than others.'[98]

An adult is at risk of harm if another person's conduct is causing (or is likely to cause) the adult to be harmed, or the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm[99]. The Act's Code of Practice makes it clear that because any protection order is a serious intervention in the adult's life such risk must be ***serious*** harm[100].

iv. Legislative principles

The 2000 and 2003 Acts both clearly link mental disorder with impaired decision-making whilst the 2007 Act has, as indicated in Chapter One, a broader definition of vulnerability. However, as also stated in Chapter One, the objectives of the principles that underpin these Acts is to ensure that the individual's autonomy is preserved.

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[96] As with the AWI, this is defined as a person aged 16 or over (2007 Act, s 53).

[97] 'harm' includes all harmful conduct and, in particular:
a) conduct which causes physical harm,
b) conduct which causes psychological harm (for example by causing fear, alarm or distress),
c) unlawful conduct which appropriates or adversely affects property, rights or interests (for example, theft, fraud, embezzlement or extortion),
d) conduct which causes self-harm. (2007 Act, s 53)

[98] Scottish Government, 'Adult Support and Protection (Scotland) Act 2007: Code of Practice' (April 2014) para 12, p 13.

[99] 2007 Act, s 3(2).

[100] Adult Support and Protection (Scotland) Act 2007: Code of Practice (n 98)

v. Support for the exercise of legal capacity

The Acts variously identify forms of support that assist an individual's wishes and feelings to be made known. In terms of advance planning, the 2000 Act contains provisions concerning the granting and operation of powers of attorney[101]. The 2003 Act recognises psychiatric advance statements.[102] Both Acts, but the 2000 Act to a lesser extent, also recognise independent advocacy[103]. The Mental Health (Scotland) Act 2015, amending the 2003 Act, contains provisions that are intended to promote and reinforce the supportive role played by advance statements and independent advocacy[104].

Assistance with communication is also reinforced in each of the 2000, 2003 and 2007 Acts albeit in non-specific terms, and more specifically in their respective Codes of Practice[105] and the 2000 Act also promotes skills development[106]. The 2003 and 2007 Acts further specifically refer to the requirement to allow the patient to participate as fully as possible in care and treatment decisions and to provide information and support to enable them to do so[107].

4. Arguments favouring a capacity threshold

Three main arguments that have been cited in support of the adoption or retention of a capacity threshold:

a. The need to comply with Article 5 ECHR

Articles 5(1)(e) and (4) ECHR link safeguards relating to a deprivation of liberty to mental incapacity[108] and the Scottish Government is currently considering how to address this in relation to adults with incapacity.

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[101] 2000 Act, Part 2

[102] 2003 Act, ss 275-276

[103] 2003 Act, s 259; 2000 Act, s 3(5A)

[104] Mental Health (Scotland) Act 2015, ss 26-27

[105] Scottish Government, 'Code of Practice for Persons Authorised under Intervention Orders and Guardians under the Adults with Incapacity (Scotland) Act 2000' (2011) chapter 1 paras 1.10-1.12; Scottish Government, 'Adults with Incapacity (Scotland) Act 2000: Code of Practice for Continuing and Welfare Attorneys' (March 2011) chapter 1 paras 1.12-1.14; Scottish Government, 'Mental Health (Care and Treatment) (Scotland) Act 2003 - Code of Practice Volume 1' (August 2005) chapter 1, paras 3 and 5; Adult Support and Protection (Scotland) Act 2007: Code of Practice (n 152), chapters 3, paras 6 and 8.

[106] 2000 Act, s 1(5)

[107] 2003 Act, ss 1(3) and 1(4); 2007 Act, s 2(d)

[108] As, it is understood, was the case with the Mental Capacity (Northern Ireland) Act 2016.

b. Avoidance of two-tiered care and treatment situations

Another argument is that the use of capacity thresholds avoids situations arising[109] whereby a person may be deprived of their liberty on the basis of harm and risk but it is not possible to treat them if they retain or regain capacity and refuse such treatment[110].

c. Creating parity of esteem in physical and mental health care and treatment

Creating parity of esteem, and thus avoiding discrimination, in the care and treatment of persons with physical and mental health conditions by the adoption of the same capacity threshold for interventions has also been cited[111]. Indeed, this argument was advanced in the Bamford Report[112] and taken up in the subsequent Mental Capacity (Northern Ireland) Act 2016.

5. Arguments countering a capacity threshold

Arguments countering the adoption of a purely capacity threshold as the basis for intervention have included:

a. Addressing risk and harm issues

Certainly, regimes that over-focus on the inherent status of the individual, including on diagnosis, as a basis for intervention rather than more specifically defining the harm and targeting any perpetrators potentially permit discriminatory interventions. It is also arguable that sole reliance on a capacity threshold will exclude persons with capacity who present a risk to others whilst at the same time, somewhat ironically, include those lacking capacity but who present no risk and would derive no benefit from the intervention[113]. Indeed, it has been argued that concepts of 'mental disorder' and 'harm' provide a more constant, and thus reliable, basis for involuntary intervention than incapacity in terms of planning and sustaining important support, care and treatment required for full recovery[114]. Any government will inevitably also have to

[109] Such as under legislation in parts of North America and Europe and, indeed, under the 2003 Act.

[110] George Szmukler, Rowena Daw and John Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation' (2010) 20 Journal of Mental Health Law 11, 11-12.

[111] In line with Butler-Sloss LJ in *Re T (Adult: Refusal of Treatment)* (1993) Fam 95.

[112] Bamford Review, 'A Comprehensive Legislative Framework for Mental Health and Learning Disability' (August 2007), para 4.64 <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issue-comprehensive-framework.pdf> accessed 20 March 2017.

[113] Paul Appelbaum, 'Harnessing the Power of Fusion? A Valiant but Flawed Effort to Obviate the Need for a Distinct Mental Health Law' (2010) 20 Journal of Mental Health Law 25, 28. See also Craigie (n 42) which considers the tensions that exist in the relationship between legal capacity in relation to personal decisions and criminal acts.

[114] Alec Buchanan, 'The treatment of Mentally Disordered Offenders under Capacity-Based Mental Health Legislation' (2010) 20 Journal of Mental Health Law 40, 41.

consider the extent to which a capacity threshold will adequately address the public policy issue of concerns about risk and harm.[115]

b. Denying appropriate care and treatment

Using the capacity threshold might exclude persons from receiving valuable support where they retain capacity, for example, in the case of persons with mood or eating disorders, or obsessive compulsive disorder[116]. Adopting a purely capacity test may also discourage early and important intervention[117].

c. Applying capacity thresholds in non-health settings

The appropriateness of using such a threshold in situations beyond health settings has also been questioned[118].

It is noted that although there was an even divide of opinion in its pre-report consultations over whether a purely capacity test should be introduced[119]concerns over the limitations of adopting a purely cognitive test of capacity influenced the Millan Committee's reluctance to accept a purely incapacity based test and the adoption of the SIDMA test in the 2003 Act[120].

6. Observations on the use of the capacity and SIDMA tests in Scottish legislation

a. Capacity assessments in general

It would appear that there are currently several factors that impact on the exercise of legal capacity by persons with mental disorder who are faced with possible interventions and non-consensual care. These can be summarised as follows:

(1) Whilst the principles that underpin the operation of the legislation do seek to maximise the exercise of capacity, such principles are not subject to a

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[115] Szmukler, Daw and Dawson (2010) (n 110) 11-14; Kris Gledhill, 'The Model Law Fusing Incapacity and Mental Health Legislation – A Comment on the Forensic Aspects of the Proposal' (2010) 20 Journal of Mental Health Law 47, 54.

[116] Millan Report (n 3) chapter 5, paras 30 and 32

[117] Millan Report (n 3) chapter 5, para 38

[118] Millan Report (n 3) chapter 5, para 31

[119] Millan Report (n 3) chapter 5, paras 22 and 28. The voluntary sector was more in favour of adopting the capacity threshold than medical professionals.

[120] In England and Wales, the Richardson Committee voiced similar concerns (Department of Health, 'Report of the Expert Committee Review of the Mental Health Act 1983' (1999) para 5.97).

hierarchy[121] and the individual's wishes and feelings are not therefore afforded primacy. To meet UNCRPD requirements, consideration would thus have to be given to the introduction of a rebuttable presumption of capacity and making the individual's wishes and feelings paramount[122].

(2) Despite attempts to eschew 'best interests' assessments in decisions regarding interventions under the 2000 Act and the introduction of the benefit and least restrictive alternative requirements, evidence suggests that the best interests test is still applied in many cases including by the judiciary[123]. It has also been argued that the best interests test applied under the Mental Capacity Act 2005 operates in a manner that is more conducive to giving effect to an individual's legal capacity than is suggested by General Comment No 1[124].

(3) Opinions of stakeholders[125] and service users[126] which were sought as part of this exercise raised some important issues concerning the manner in which professionals currently assess capacity under both the 2000 and the 2003 Acts in terms of rigour and consistency, and in terms of acknowledging that capacity fluctuates and is richer than mere cognitive functioning at a given time:

(a) All the stakeholders consulted generally considered that, with the possible exception of social workers and MHOs, assessments of incapacity for the purposes of the 2000 Act are inadequate. There was the opinion that in practice an 'all or nothing', in other words, not a function-specific, approach is often being taken. Moreover, a person's capacity is often being assessed on the basis of comparing a person's current decisions with previous decisions. It was also considered that little thought is given to the full

[121] Although it was stated in *G v West Lothian Council* 2014 (Sh Ct) GWD 40-730 (Lothian)(Edinburgh) that the principle of benefit is the 'overarching' AWI principle (see Alan Eccles, 'G v West Lothian Council' (2015) 8 SLT 35-38) this is, with respect, not specified in the AWI (see Adrian Ward, 'G v West Lothian Council' *Mental Capacity Law Newsletter* (April 2015, issue 55) 9-11.

[122] As suggested by, for example, Recommendation 1 of the EAP Three Jurisdictions Report (n 41) and arguably appears to be promoted in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67.

[123] Adrian Ward and Alex Ruck Keene, 'With or Without Best Interests: the Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000 and Constructing Decisions' (2016) 22 International Journal of Mental Health and Capacity Law 17.

[124] Ibid

[125] Law Reform Scoping Exercise Roundtable 3, 16 December 2016

[126] Mental Welfare Commission for Scotland, 'Capacity, Detention, Supported Decision Making and Mental Ill Health' (May 2017), <http://www.mwcscot.org.uk/media/371015/capacity__detention__supported_decision_making_and_mental_ill_health.pdf> (MWC Capacity, Detention, Supported Decision Making and Mental Ill Health)

consequences of an assessment of incapacity which may extend beyond clinical matters[127].

(b) Similarly, several service users felt that a diagnosis of mental disorder can lead to professionals more often making assumptions that the individual therefore lacks capacity and are reluctant to acknowledge that capacity can and does fluctuate over time in many cases[128]. Indeed, a few, echoing the UN Committee's approach, have questioned the efficacy of others assessing an individual's capacity as discriminatory presumptions, founded on others' backgrounds, prejudices and lack of knowledge, can be made[129]. Capacity assessments can often be made by professionals on the basis of how the individual presents on a given day and with little or no knowledge or involvement of the individual and their background or their carers, family, partners, friends and professionals. However, it was also noted that family and friends, often owing to their proximity to the individual and their situation, may not always be a reliable source of information in terms of ascertaining the individual's will and preferences[130]. The impact of positive and negative relationships on decision-making and therefore assessments of capacity needs to be more thoroughly explored.[131] Indeed, the UN Committee, in adopting the social model and support paradigm also recognises the importance of relationships with trusted others as a means of support for the exercise of legal capacity[132] whilst Article 12(4) also states that conflicts of interest and undue influence must be avoided in support relationships[133].

(c) It was also considered that a dearth of case law guidance on capacity assessment in Scotland - in contrast to the greater number of such Court

[127] Law Reform Scoping Exercise Roundtable 3, 16 December 2016

[128] Certainly, research elsewhere also indicates that capacity is often associated with autonomy, dignity and agency (Liz Pitt and others, 'Researching Recovery from Psychosis: A User-Led Project' (2007) 31 Psychiatric Bulletin 55; Annmarie Grealish and others, 'Qualitative Exploration of Empowerment from the Perspective of Young People with Psychosis' (2011) 20(2) Clinical Psychology and Psychotherapy 136-148.

[129] MWC Capacity, Detention, Supported Decision Making and Mental Ill Health (n 126)

[130] MWC Capacity, Detention, Supported Decision Making and Mental Ill Health (n 126)

[131] Series (n 62)

[132] General Comment No 1 (n 31) para 17

[133] General Comment No 1 (n 31) para 22

of Protection reported Mental Capacity Act 2005 cases in England and Wales – militates against thoroughness and consistency[134].

(4) The question also arises as to the extent to which capacity assessments take into account the influence of emotion on decision-making[135]. Research suggests that decision-making ability, which is often used as an important element of capacity assessments, is often viewed and assessed in terms of information processing, and emotion is ignored, leading to assessments of incapacity being too readily made[136]. This was also borne out by views expressed by services users[137].

b. Specific issues concerning SIDMA

Stakeholder opinion gathered during this exercise also indicated:

(1) A lack of clear guidance for practitioners on how to assess SIDMA creates problems[138]. Assessments are made along very much the same lines as for potentially incapable adults in the AWI. However, whilst in practice persons considered to have SIDMA may also be 'incapable' this is not always the case. The concept of SIDMA was therefore established, as previously mentioned, to take this into account and to allow for involuntary intervention. Whilst a variety of people are consulted through Mental Health Tribunal processes including psychiatrists, psychologists, carers and specialist lawyers, a normative standard on capacity assessment is lacking in Scotland.
(2) It was also noted that the threat of compulsion is sometimes used where an individual is reluctant to consent to treatment. This clearly raises serious questions about whether consent to treatment in such circumstances is a genuine exercise of the individual's autonomy. Again, as with the AWI, it was argued that it would be useful if more of the Mental Health Tribunal for Scotland's first instance cases were published so that a body of relevant jurisprudence could be established.
(3) It was also stated that, from a practical point of view, the 2003 Act and SIDMA assessments can be seen as more flexible allowing for more immediate actions to be taken regarding an individual where interventions under the AWI

[134] Law Reform Scoping Exercise Roundtable 3, 16 December 2016.

[135] Series (n 62); Shari McDaid and Sarah Delaney, 'A Social Approach to Decision-Making Capacity: Exploratory Research with People with Experience of Mental Health Treatment' (2011) 26(6) Disability and Society 729.

[136] Hilary Brown, 'The Role of Emotion in Decision-Making' (2011) 13(4) The Journal of Adult Protection 194-202.

[137] MWC Capacity, Detention, Supported Decision Making and Mental Ill Health (n 126)

[138] Law Reform Scoping Exercise Roundtable 3, 16 December 2016.

may be more appropriate and less restrictive but take much longer to process[139].

Statistics collected by the Mental Welfare Commission for 2013/14, 2014/15 and 2015/16 for treatments given to patients subject to the 2003 Act show that less than 10% of the cases involving drug treatment were given in the face of a capable refusal, but that the figure was over 20% in cases involving artificial feeding[140].

Whether this reflects the nature of the conditions requiring artificial feeding, or that independent authorisations for drug treatment are only required after two months of treatment, is unclear.

Providing treatment in the face of a capable refusal potentially raises the Article 8 ECHR issue in detention situations mentioned above[141].

Moreover, a patient who is subject to a short-term detention certificate may be subject to the same requirement to accept treatment as those subject to a Compulsory Treatment Orders but they do not have the same level of protection in terms of Tribunal oversight. Unfortunately, there is currently no data available of instances of whether drug treatment is given to capable but non-consenting patients subject to short term detention.

c. 'significant risk'

The concept of 'significant risk' is a criterion that operates alongside SIDMA when decisions concerning detention and compulsory treatment are being made[142]. As previously suggested, the presence of 'risk' criteria for intervention creates the potential for actions to be taken that discriminatorily focus on the individual with mental disorder rather than on persons or factors that are responsible for such risk of harm.

At present, there is no official guidance[143] on the concept of 'significant risk' and this may therefore influence clinical and other interpretations of SIDMA.

Whilst a minority of persons in the evidence collected by the Commission[144] opposed detention of persons with mental disorder under any circumstances, a majority agreed

[139] Law Reform Scoping Exercise Roundtable 3, 16 December 2016.

[140] See Mental Welfare Commission for Scotland 'Mental Health Act Monitoring' for these years. Available online at: http://www.mwcscot.org.uk/publications/statistical-monitoring-reports/

[141] *X v Finland* (App no 34806/040) (2012) ECHR 1371

[142] 2003 Act, ss 36(5)(b), 44(5)(d) and 64(5)(c)

[143] Stavert and Patrick (n 87) paras 11.22-11.23

[144] MWC Capacity, Detention, Supported Decision Making and Mental Ill Health (n 126)

that there are situations where detention is necessary, particularly where there is a risk to life and a risk of harm to the individual or to others.

However, whether or not detention was regarded as necessary, a recurrent theme was that the loss of autonomy and dignity that is felt by persons who are subject to detention and non-consensual care and treatment impacts negatively on the individual. This is because it was felt that the removal of autonomy - notably arising through forced treatment, the predominance of drug treatment as opposed to other therapies, the inability to effectively participate in treatment decisions owing to the effects of medication, and restrictions on activities and choices - is not conducive to meaningful treatment and recovery. Nor was community treatment always considered to be an acceptable alternative to detention, again owing to restrictions on autonomy.

Yet, as previously discussed, there is a need to address the 'hard cases' where an individual is at risk of harm or likely to cause harm to others. In this connection, greater consideration should be given to the role that the 2007 Act provisions and criminal law can alternatively play in such situations and whether, therefore, a capacity threshold alone would be sufficient.

d. Support for the exercise of legal capacity

The need to support the exercise of legal capacity at the time decisions about interventions are being considered, and during their implementation, is arguably implied in the principles underpinning each piece of Scottish legislation. However, this is largely confined to providing information and assisting with communication. Moreover, it revolves largely around shared decision-making concerning interventions and non-consensual care, which is not necessarily the same as giving effect to an individual's rights, will and preferences[145].

Specific forms of support are also identified in the legislation but their full potential requires investigation[146]. Greater clarity is also required about exactly when and by whom the support is provided[147]. Moreover, at present the role of the support is reflected in the legislation only in the context of decisions about interventions and their

[145] Although more extensive research is required in relation to a wider cohort of persons with mental disorder and in the context of attempts to maximise the exercise of legal capacity and supported decision-making, a small scale study has indicated that outcomes are not improved when attempts are made to involve persons experiencing psychosis in shared decision-making relating to treatment decisions. (Diana Stovell and others, 'Service User Experiences of Treatment Decision-Making Processes in Psychosis: A Phenomenological Analysis' (2016) 8(4) Psychosis 311-323 <http://www.tandfonline.com/doi/full/10.1080/17522439.2016.1145730> accessed 20 March 2017)

[146] In relation to the AWI, see Recommendations 3, 4, 5 and 7 of the EAP Three Jurisdictions Report (n 41).

[147] Again, in relation to the AWI, see Recommendations 1, 2 and 6 of the EAP Three Jurisdictions Report (n 41).

implementation. It is not reflected in terms of supporting the exercise of legal capacity so that the requirement for legislative interventions is delayed or prevented.

This is in contrast to both the Mental Capacity Act 2005 and the Mental Capacity (Northern Ireland) Act 2016, both of which require that the provision of appropriate support is demonstrated before statutory interventions are considered[148]. That being said, it would appear that there are nevertheless pockets of judicial movement towards this in Scotland. For example, the Sheriffdom of Lothian and the Borders has directed that all 2000 Act applications must contain details of the present and past wishes and feelings of the adult so far as they can be ascertained or, where it is not possible to ascertain these, then a statement as to why this is not possible and any steps that have been taken (including any assistance and/or support provided) to ascertain them[149].

Evidence also suggests[150] that substitute decision-makers under both the 2000 and 2003 Acts are not always appreciative of why and how they have a responsibility to assist the individual to exercise their capacity wherever possible.

7. A new type of threshold?: Delinking mental capacity assessments from eligibility criteria

The UNCRPD provides us with an opportunity to reconsider the principles underlying the 2000 and 2003 Acts and in fact largely reinforces the original objectives behind the introduction of such principles. As both currently stand, neither Act is fully compatible with UNCRPD requirements. It may be that, as was argued in the *Essex Autonomy Project Three Jurisdictions Report*, the 2000 Act is capable of adjustment to meet such requirements[151]. Again, it is worth exploring whether similar adjustments might also be made to the 2003 Act in order to achieve compliance of the 2003 Act, although this task is more complicated whilst the primary objective of the Act is to authorise care and treatment for mental disorder.

This raises the question of whether Scotland could adopt a different type of threshold that would allow for interventions and non-consensual care on a non-discriminatory basis. The removal of the diagnostic threshold and replacing it with a neutral threshold based on, for example, a lack of decision-making ability or on vulnerability may be seen to be a means by which to allay the UN Committee's concerns. However, to what

[148] Mental Capacity Act 2005, s 1(3); Mental Capacity (Northern Ireland) Act 2016, s 5.

[149] Sheriffdom of Lothian and Borders, 'Practice Note No 1 of 2016, Applications under the Adults with Incapacity (Scotland) Act 2000' (March 2016) paras (g) and (k) <https://www.scotcourts.gov.uk/rules-and-practice/practice-notes/sheriff-court-practice-notes-(civil)> accessed 20 March 2017.

[150] Law Reform Exercise Roundtable 3, 16 December 2016

[151] See EAP Three Jurisdictions Report (n 41)

extent would a non-discriminatory threshold test not based on mental capacity assessments be possible and achieve a more effective exercise of legal capacity?

It may be possible to envisage laws that do not adopt a diagnostic threshold as the basis for intervention (such as the Mental Capacity (Northern Ireland) Act 2016). However, no mental health and mental capacity laws currently exist globally that do not partially or wholly adopt a mental capacity test as a means of justifying intervention. It should also be noted that some commentators[152] argue that not all interventions deprive a person of their autonomy and ability to exercise their legal capacity, and in fact are designed to maximise these in situations where an individual is made vulnerable through mental disorder.

There are also concerns that a more neutral test may unnecessarily and discriminatorily expand the reach of the legislation. However, it is arguable that such concerns are in fact premised on such legislation being negatively associated with compulsion and that this could be ameliorated if the approach adopted is more supportive and less focused on the mental disorder and dealing with its feared consequences[153]. This might prevent unnecessary interventions for persons with mental disorder, and, it might also open up support for people who desperately require it but who are currently denied it because they do not meet the diagnostic threshold (e.g. persons with addictions).

If the concept of SIDMA and 2003 Act criteria, particularly that related to risk, for intervention is to be revisited this will require a review of what is actually regarded as acceptable risk. If risk is to be 'downplayed' in the context of mental health care and treatment, does this mean that more people with mental disorder would fall within the auspices of the criminal justice system, and what are the implications from the individual's and state's point of view here?[154]

If Scotland is to pursue the Article 12 UNCRPD support paradigm more effectively it also requires more empirical research, actively involving people with mental disorder, into the types of support that could be offered, and when and how, such support is required. The resourcing implications of a rigorous adoption of the support paradigm will also be required. This requires detailed analysis and evaluation, particularly if it is to redirect the political agenda in terms of care and treatment of people with mental

[152] See, for example, EAP Three Jurisdictions Report (n 41), Roundtable 3 and Mental Welfare Commission for Scotland, 'Capacity, Detention, Supported Decision Making and Mental Ill health' (n 126)

[153] Series (n 62)

[154] See Craigie (n 42) which argues that the legal capacity in civil and criminal settings are two entirely concepts.

disorder, and where involuntary intervention is seen as more cost effective than the provision of support and additional community services[155].

[155] Indeed, the Swedish Personal Ombudsman scheme was found to have delivered significant savings owing to the reduced need for crisis interventions and other services (Nilsson (n 64)). As Series (n 62) writes 'These findings suggest that being able to choose and shape relationships of support can play a vital role in building trust, which in turn increases the likelihood that they will effectively foster personal autonomy. This is a clear strength of support paradigm.'

Chapter 3:

GRADED GUARDIANSHIP IN INCAPACITY LAW

1. Introduction

This chapter reflects proposals which have been advanced by the Mental Welfare Commission for Scotland and the Office of the Public Guardian that the 2000 Act should be amended to introduce a tiered or graded approach to guardianship, with different forms of guardian (or supporter) and different procedures for their appointment.

This suggestion is not new – the Public Guardian set out proposals for such a model several years ago – but is particularly relevant in the context of the challenges presented by the *Cheshire West* decision and subsequent Scottish Law Commission 2014 *Report on Adults with Incapacity*, and the debate around the UNCRPD.

2. Key provisions of Adults with Incapacity (Scotland) Act 2000

At the time of its introduction, the 2000 Act was regarded as visionary, rights based and modern legislation and, in many respects, it remains so. Particularly important are the principles set out in section 1 of the Act, including that:

- There shall be no intervention in the affairs of an adult unless this will benefit the adult, and the benefit cannot reasonably be achieved without that intervention.[156]
- Account must be taken of the past and present wishes of the adult so far as they can be ascertained.[157]
- The adult should be encouraged to exercise whatever residual capacity they possess.[158]

Commentators such as Adrian Ward have highlighted[159] that, unlike the Mental Capacity Act 2005 in England and Wales, the 1995 Scottish Law Commission report and the 2000 Act do not impose a 'best interests' test, but instead focus on 'benefit'. The 'best interests' approach has been heavily criticised by the UN Committee[160].

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[156] s 1(2)

[157] s 1(4)(a)

[158] s 1(5)

[159] SLC Report on Incapable Adults (n 2) 20

[160] General Comment No 1 (n 31) para 21

Part 6 of the 2000 Act sets out the framework of financial and welfare guardianship. Any person claiming an interest may apply for financial and/or welfare guardianship. The application is made to the sheriff court, and requires two medical reports certifying the incapacity of the adult (one of which must be by a doctor approved as having special experience in the diagnosis and treatment of mental disorder). In addition, an application for welfare guardianship requires a report by a mental health officer on the general appropriateness of the order sought, and the suitability of the applicant[161]. An application for financial guardianship requires a report in similar terms by an appropriate person[162]. Any individual (or more than one) may be appointed as a guardian and, in relation to welfare guardianship only, it is possible for the Chief Social Work Officer to be appointed.[163] The guardian may be given powers to deal with particular specified matters, or given a general power to deal with 'all aspects of the personal welfare of the adult', and/or to manage the property or financial affairs of the adult[164].

There are some limitations. A guardian, for instance, cannot place an adult in hospital for treatment of mental disorder against their will, or consent on behalf of the adult to marriage or sexual relations[165]. They may be entitled to consent or refuse consent to other forms of medical treatment, but this is qualified by Part 5 of the 2000 Act which allows a refusal of consent by a guardian to be overridden by an independent medical opinion[166]. The dispute resolution procedure associated with this has been used relatively infrequently[167].

The Office of the Public Guardian supervises and investigates complaints in relation to financial guardians, and may recall the powers of the guardian[168]. The Mental Welfare Commission and the relevant local authority have similar powers and responsibilities in relation to welfare guardians[169]. Any person claiming an interest can apply to the sheriff to have a guardian removed or replaced, or for the sheriff to issue

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[161] s 57

[162] s 57

[163] s 59

[164] s 64

[165] s 64(2). See also *West Lothian Council in respect of Y*, 2014 SLT (Sh Ct) 93

[166] ss 50 and 64(2)(b)

[167] Statistics are published in the 'AWI Act Monitoring' reports published annually by the MWC at http://www.mwcscot.org.uk/publications/statistical-monitoring-reports/ .
In 2015/16 the s50 procedure was only used once see:
<http://www.mwcscot.org.uk/media/342863/2016_awi_report_v3_07.09.2016_final_jw_27.09.16.pdf>

[168] s 73(1)-(2)

[169] s 73(3)

directions as to how the powers of the guardian should be exercised. Gifts are also subject to the oversight of the Office of the Public Guardian[170].

3. How guardianship is being used now

There has been a steady increase in the use of guardianship. In 2015/16[171] there were 2657 applications granted across Scotland, of which 2359 were new orders. This is a 99% increase since 2009/10. 74% of all applications were private – a 115% increase in such applications since 2009/10. There are just over 10,000 currently extant guardianship orders.

The diagnosis of people subject to applications for welfare guardianship in 2015/16[172] breaks down as follows:

- Dementia – 45%
- Learning disability – 41%
- Acquired brain injury – 5%
- Alcohol related brain disorder – 4%
- Mental illness – 3%
- Other – 2%.

The majority of applications are for combined financial and welfare guardianship. Office of the Public Guardian figures for 2015/16 show 1426 combined applications, 1112 welfare guardianship applications, and 140 finance only applications.

Although the Act provides that guardianship powers can be tailored to suit the needs of the adult, there is a tendency for guardianship orders to contain a fairly standard and wide set of powers, including acting as the person's legal representative and power to make decisions on:

- Managing finances
- Care and accommodation, including powers to convey and return the adult
- Consenting to medical treatment
- Education, training, work, holidays
- Determining with whom the adult may consort
- Diet, dress and personal appearance.

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[170] s 66(1)

[171] Mental Welfare Commission for Scotland, 'Adults with Incapacity Act Monitoring Report 2015/16' (September 2016) Table 5.1, p 15 <http://www.mwcscot.org.uk/media/342863/2016_awi_report_v3_07.09.2016_final_jw_27.09.16.pdf> accessed 20 March 2017.

[172] Ibid, Table 4.1, p 11

The default duration of guardianship orders is three years, but this can be varied. The Mental Welfare Commission has raised concerns about the granting of indefinite orders, and these have declined from 71% of new orders in 2009-10 to 26% in 2015/16[173].

Local authorities are expected to visit people subject to welfare guardianships regularly and at least annually, although this was relaxed in 2014 so that such visits may be discontinued if the local authority does not believe they are necessary and there is no objection[174].

4. Problems with the current system

A number of issues have emerged over the years, which have contributed to the suggestion that a more flexible model of guardianship should be developed.

a. Sustainability

From the point of view of public services, the sustainability of the system is questionable. Guardianship and intervention orders are now the largest single category of civil legal aid grants (28% in 2014/15, a rise of 19% in a year).[175]

Preparing Mental Health Officer (MHO) reports for applications is a significant pressure on local authorities, and anecdotal evidence from solicitors is that compliance with the statutory timescales to produce such reports is the exception, not the norm, and some reports take months. The need for two medical reports in straightforward cases has also been questioned. It can reasonably be argued that, like England, the Scottish system is 'broken' – albeit that this is more pronounced in Scotland at the stage of preparing applications.

To date, *Cheshire West* has had a more limited impact than in England. Were it to become the expectation that all adults who may meet the 'deprivation of liberty' test in *Cheshire West* must have a guardian or intervention order, the cost would be enormous, and it is not evident that the SLC proposals would significantly mitigate this[176]. The more widespread adoption of powers of attorney may reduce this cost, but

[173] Ibid, Table 5.1, p 15

[174] The Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014, section 5 <http://www.legislation.gov.uk/ssi/2014/123/made> accessed 20 March 2017, comments available at <http://www.mwcscot.org.uk/good-practice/commission-advice/guidance-on-the-changes-introduced-by-an-amendment-to-the-regulations-concerning-the-supervision-of-welfare-guardians,-in-june-2014/> accessed 20 March 2017.

[175] Scottish Legal Aid Board, 'Annual Report 2014-15' (December 2015) p 14 <http://www.slab.org.uk/common/documents/Annual_report_2014_2015/Annual_Report_2014-15.pdf> accessed 13 April 2017

[176] The English Law Commission have estimated that Cheshire West compliance could cost an additional £1.5 billion a year in England and Wales. See <http://www.lawcom.gov.uk/wp-content/uploads/2015/08/cp222_mental_capacity_impact_assessment.pdf > accessed 20 March 2017.

this is hard to achieve, and there is debate as to how far powers of attorney are able to authorise a deprivation of liberty – indeed it has been questioned whether a welfare guardian can do so without express authorisation[177]. There is also confusion and inconsistent practice over one of the most common and important decisions which is made in relation to an incapable adult – a placement in residential care, either from home or from hospital.

Following the *Bournewood* decision, the Scottish Parliament introduced a new provision (section 13ZA) in the Social Work (Scotland) Act 1968, which sought to provide reassurance that local authorities could provide care services for incapable adults, including making residential placements, without the necessity of a guardianship or intervention order. However, this power is not intended to be used when a deprivation of liberty would result. Although both the Mental Welfare Commission[178] and the Scottish Law Commission[179] have expressed a view that this power is still usable post *Cheshire West*, the extent to which it can be used is doubtful, and there is anecdotal evidence of inconsistent application of this power across the country.

b. Proportionality, timeliness and complexity

Applicants have mixed views of the appointment process. Most welfare guardians surveyed by the Mental Welfare Commission[180] felt it was reasonably straightforward, and most were satisfied with the outcome, although some found the process lengthy

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[177] Jill Stavert, 'Deprivation of Liberty and Adults with Incapacity: a Scottish Perspective' *Mental Capacity Law Newsletter* (January 2015) <http://www.39essex.com/docs/newsletters/deprivation_of_liberty_in_scotland_january_2014.pdf> accessed 20 March 2017:
"Whilst the Act as it currently stands (see Part 6 of the Act) expressly authorises a welfare guardian to act, or not act, in certain ways (for example, a guardian must not place the adult in hospital for treatment for mental disorder against their will, s.64(2)(a)), it does not specifically empower a guardian to consent to a deprivation of liberty on behalf of the adult with incapacity. Nor does the Act expressly provide for the adult with incapacity to have such deprivation of liberty reviewed by the courts. Post-Bournewood the best advice has therefore tended to be that where an individual is unable to give valid consent, even if apparently compliant, to measures that might amount to a deprivation of liberty then there will have to be resort to use of the compulsory provisions in the 2003 Act with its better Article 5 compliant legal and procedural safeguards. However, this would only, of course, be applicable where the individual requires care and treatment for a mental disorder and the 2003 Act's criteria are fulfilled"
See also Mental Welfare Commission for Scotland, 'Good Practice Guide on Common Problems with Power of Attorney' (July 2015) 12-13 <http://www.mwcscot.org.uk/media/233718/common_concerns_with_power_of_attorney_final_2.pdf> accessed 20 March 2017.

[178] Mental Welfare Commission, 'Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision' (17 September 2014) <http://www.mwcscot.org.uk/media/202163/cheshire_west_draft_guidance.pdf> accessed 20 March 2017.

[179] SLC Report on Adults with Incapacity (n 37) paras 4.61-4.63

[180] Mental Welfare Commission for Scotland, 'Adults with Incapacity Act Monitoring 2015/16' (September 2016) <http://www.mwcscot.org.uk/media/342863/2016_awi_report_v3_07.09.2016_final_jw_27.09.16.pdf> accessed 20 March 2017.

and stressful. However, this may partly reflect the fact that, for welfare or combined welfare and financial guardianship, the costs are fully covered by legal aid.

Even if the delays in obtaining MHO reports were reduced, the process takes a number of weeks. Interim orders are possible, but only once an application has been put together, including the requisite three reports. There is no provision for emergency orders, and some people have been kept in hospital rather than accommodated in community services for significant periods of time, pending the conclusion of the legal process.

Financial guardianship requires regular and detailed reporting, whereas the oversight of welfare guardianship can be limited and sporadic. The Public Guardian has expressed concern that the responsibilities of financial guardianship may be too onerous for some guardians. It has become apparent that the level of risk associated with different types of guardian is significantly different, and the current arrangements regarding monitoring and approving financial decisions may not adequately recognise this. The Office of the Public Guardian is developing a new, more tailored supervisory regime.

Some applications have been driven by what appear to be relatively straightforward issues, such as the need to authorise a self-directed support arrangement for social care, or authorise a tenancy agreement. Indeed, there is confusion over whether a tenancy agreement requires a financial or welfare power or both – in practice both tend to be sought.

c. Gaps and overlaps

It is not easy to use guardianship for people who may have capacity for significant periods but may lose it quickly. This may explain the low use of guardianship for people with a mental illness. There are doubts over whether it is possible to have guardianship 'kept in reserve' for those whose conditions may deteriorate again once the framework kept in place by guardianship has been lifted. It has been suggested that this limits the effectiveness of guardianship for conditions such as alcohol related brain disorder.

The interaction between the 2000 Act and the 2003 Act is complex, with overlaps and potential gaps in areas such as treatment for physical conditions related to a mental disorder (especially if the adult resists treatment), and the extent to which guardianship can authorise physical restraint or forcible return to a place of residence. A recent development has, for example, been the use of the 2003 Act to detain a person while in hospital, to allow them to be transferred to a care home under suspension of detention, as a quicker alternative to guardianship.

There are also overlaps with the Adult Support and Protection (Scotland) Act 2007, particularly in relation to investigation of possible abuse by a guardian.

d. Compatibility with human rights

Some argue that the 2000 Act regime is a form of substituted decision making which is incompatible with the requirements of Article 12 UNCPRD, particularly as interpreted by the UN Committee in their General Comment No 1. The Essex Autonomy Project has, for example, undertaken a detailed analysis and concluded that the 2000 Act is 'remediably non-compliant' with the Convention[181].

There is a particular difficulty in that incapacity in the 2000 Act is (except in rare cases of inability to communicate) founded on having a mental disorder. On the face of it, this appears to breach the UNCRPD requirement that measures affecting legal status should be non-discriminatory.

The concept of supported decision making is discernible in the principles[182]. However, the 2000 Act was drafted before the development internationally of more sophisticated models of supported decision making (albeit evidence as to their impact and general applicability is still limited).

In terms of the Act's own principles, there can be seen to be a tension between an increasingly widespread use of guardianship with wide general powers and the principle of no intervention without benefit. This preference for wide powers partly reflects a wish to avoid repeating the complex process of court authorisation should needs change. It was suggested in discussion that the process places too much emphasis on defining the scope of powers at the outset, and too little on to ensure that powers are only used when they are really needed.

The rising number of appointments and other pressures mean that supervision of welfare powers by local authorities and the Mental Welfare Commission is increasingly limited, unless serious concerns are identified[183]. In that context, there are few ways to ensure that the requirement to maximise residual autonomy is given effect, or to address more low level misuse of powers (for example using guardianship as a weapon in family disputes).

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[181] The Essex Autonomy Project highlighted three major changes that would need to be made to 2000 Act in order to make it compliant with Article 12 UNCRPD. Firstly, 2000 Act should incorporate an attributable duty to take steps toward determining the will and preference of the adult in question. Secondly, statutory requirements should be expanded to include support for the exercise of legal capacity. Finally, the "diagnostic threshold" that states that incapacity must derive from a mental disorder is incompatible with the Convention as it stands EAP Three Jurisdictions Report (n 41).

[182] Mental Welfare Commission for Scotland, 'Supported Decision Making Good Practice Guide' (November 2016) <http://www.mwcscot.org.uk/media/348023/mwc_sdm_draft_gp_guide_10__post_board__jw_final.pdf> accessed 20 March 2017.

[183] In 2015/16, the MWC visited 472 adults on welfare guardianship. 41% of private guardians appeared to have no recent supervisory visits by local authorities, and for many of these (64%) there was no evidence that the adult had been visited by the local authority supervisor in the past six months.
Mental Welfare Commission for Scotland, 'Adults with Incapacity Act Monitoring 2015/16' (n 180).

The process of obtaining guardianship is generally not inclusive of the adult, who is rarely in court, and frequently unaware of the process – although some courts have begun to pay more attention to establishing the will and preference of the adult, and being assured that support was made available to assist in this[184].

The lack of frequent review of orders has raised concerns about how well the guardianship regime addresses all the Article 5 issues raised in ECHR case law. Other ECHR rights, particularly the privacy and autonomy rights derived from Article 8, may call into question the widespread use of powers such as to decide with whom the adult shall consort.

The judicial process does not easily accommodate any testing out or early review of a decision such as placing a person in a care home and putting their home up for sale. Once the authority to do so is granted, the judicial process is at an end. For decisions such as this, the ability to go back after some weeks to assess whether the person has settled in new accommodation would be helpful.

e. Interaction with other provisions of the 2000 Act

While guardianship may be administratively the most complex and problematic issue, it is important that reform considers the whole of the 2000 Act against the UNCRPD approach.

It was never intended that everyone who lacked decision-making capacity should be subject to welfare and financial guardianship. The 2000 Act put in place a number of alternative forms of proxy decision making to deal with common situations, but several of these have not been used to the anticipated extent.

Part 3 is a procedure whereby an individual can apply to the Public Guardian for authority to deal with the funds of an incapable adult. This was intended to be used for relatively simple financial arrangements. It was anticipated that there might be as many as 20,000 of these each year, but there are currently fewer than 400. For those who use it, it works well, but it is a costly process to offer for such a small group.

Part 4 allows care homes to apply for authority to manage residents' funds. Again, this appears to be less popular than was anticipated. In the roundtable discussion, it was suggested that there should also be a power for local authorities to carry out basic financial transactions where no one else was in place who could manage finances, and that the system of financial management should not be based around a particular model of care provision.

[184] Sheriffdom of Lothian and Borders, 'Practice Note No 1 of 2016, Applications under the Adults with Incapacity (Scotland) Act 2000' (March 2016) <https://www.scotcourts.gov.uk/rules-and-practice/practice-notes/sheriff-court-practice-notes-(civil)> accessed 20 March 2017.

In developing an improved system, it will be important to evaluate why these provisions have been under-utilised.

By contrast, appointeeship under the procedures set out in the legislation governing welfare benefits is still extremely common. There are few formal safeguards in relation to the appointment, and limited supervision of the use of this power. The principles of the 2000 Act do not apply – although in terms of the UNCRPD, this is clearly a situation where the adult's legal agency is subject to interference. There also appears to be limited DWP co-operation with local authorities to assist councils in exercising their protective functions.

We found a general consensus that appointeeship should be replaced by a Scottish system which fits into the approach of revised incapacity legislation. However, as this is a reserved matter under the Scotland Act 1998 such action will require that the UK Parliament being asked to authorise the Scottish Parliament to legislate to permit it.

Part 2 governing powers of attorney will also need to be reviewed. As discussed above, there is no clarity on how far such powers can or should authorise a deprivation of liberty.

Another difficulty (which runs through the 2000 Act, and is relevant to Chapter Two 'The Basis for Intervention and Non-Consensual Care and Treatment') is the dichotomous nature of powers of attorney.

Welfare powers cannot be used until capacity is deemed to be lost, at which point full powers are effectively taken by the attorney. Although it is possible for financial powers to be used prior to incapacity, this is difficult because the systems used by financial operations are not sufficiently flexible, as they are generally geared up to recognise power of attorney on registration, which signifies incapacity. This makes it hard to use powers of attorney to support an adult who may retain capacity but is experiencing difficulties in making decisions and is inconsistent with the flexible approach to supported decision making which the UNCRPD expects.

There is evidence that the style powers of attorney used by solicitors are increasingly wide in effect. They frequently leave it entirely to the nominated welfare attorney to decide when the adult is incapable, with no requirement for any medical evidence. There are also various clauses purporting to give the attorney power to authorise deprivations of liberty and other substantial interventions such as seclusion or restraint, notwithstanding that these interventions may engage ECHR.

This may be justified as minimising trouble and expense for attorneys when the time for making decisions arises. It can also be argued that maximising the power of a person chosen by the adult when competent is a better reflection of autonomy than leaving the choice to the court. Against that, there are concerns about the level of

safeguards in place when such wide powers are routinely granted, and there is little clarity about whether these powers are indeed compatible with ECHR.

Part 5 of the 2000 Act governs medical treatment. This allows treatment to be authorised by medical professionals, with additional safeguards for particular treatments. However, as already mentioned, guardians and welfare attorneys may have power to authorise (or not) medical care and treatment.

5. Current proposals for reform

The Scottish Law Commission propose[185]:

- A new concept of 'significant restriction of liberty' based on two out of three specified factors being present, which attempts to operationalise the 'acid test' in *Cheshire West*
- A power to allow doctors to authorise a significant restriction of liberty in a hospital, usually for a brief period
- A requirement that a significant restriction of liberty in a community setting must be authorised by a welfare guardian, welfare attorney or the sheriff court
- A power for anyone interested in an adult's welfare to challenge any significant restriction of liberty which lacks legal authority.

Most respondents[186] to the Government consultation on the Scottish Law Commission proposals welcomed the new ability to challenge restriction of liberty without due process. There was a general acceptance of the need for a process to allow doctors to authorise restrictions of liberty in a hospital setting, although some argued that it would be better to combine this with the existing s47 process to authorise medical treatment. The proposals for authorising restriction of liberty in the community were more controversial.

Some argued that they would not solve the problem of an over complex and burdensome procedure.

Some respondents felt the definition of significant restriction was too widely drawn, but may still miss out some of the cases of most concern, particularly where the individual was expressing unhappiness about their care.

There was a concern with whether the proposals fully addressed ECHR case law requiring regular and essentially automatic judicial review of the lawful deprivation of

[185] SLC Report on Adults with Incapacity (n 37)

[186] Scottish Government, 'Scottish Government Consultation on the Scottish Law Commission Report on Adults With Incapacity: Summary of Responses to Consultation' (June 2016) <https://consult.scotland.gov.uk/integration-partnerships/report-on-adults-with-incapacity/user_uploads/00502699.pdf> accessed 20 March 2017.

liberty, particularly where a person cannot object on their own behalf. The focus on the *Cheshire West* problem was felt by some to be too narrow, given the concerns about other issues such as ECHR Article 8 and the UNCRPD.

Several responses to the consultation argued that a graded guardianship model offered potential for a more flexible and proportionate system. While resources were recognised as a key driver, it was also suggested that this was an important opportunity to maximise the autonomy and self-determination of people with disabilities by embracing a shift to an approach giving greater recognition to the concept of supported decision making.

The Scottish Government set out in its action plan on delivery of the UNCRPD[187] that it would work "with disabled people and the organisations that represent them to develop changes to the Adults with Incapacity Act, in relation to deprivation of liberty, and to assess compliance with UNCRPD by 2018".

6. Is graded guardianship a better alternative?

This section outlines what a graded guardianship model might look like, and identifies some key questions which would need to be resolved. The model involves three tiers of guardianship. Only the top tier would require prior judicial authorisation. Any case could be put up to the top tier by any person with an interest, or if certain criteria were met, e.g. dispute between parties, or a level of restriction or intervention that is so significant that judicial authorisation is justified.

a. General 'design principles'

During the graded guardianship roundtable discussion, a set of principles were identified which should inform the detailed development of a new scheme.

(1) It is felt vital that cases can move up and down the system easily and flexibly, without having to start from scratch, and that any review process must be similarly proportionate and flexible.

(2) The system should reflect the reality that the great majority of families and professionals are honest and seeking to benefit the adult. It should minimise the burdens on families and carers. The system should not be too complex, and not expect an unreasonable level of sophistication from non-professionals.

(3) There should be simple solutions for common problems – for example the need for a tenancy to be given up when a person who has been admitted long term to residential care to avoid a build-up of rent arrears.

[187] Scottish Government CRPD Delivery Plan (n 38)

(4) There needs to be recognition of the risk of undue influence, but this should be proportionate, recognising that *influence* may often be benign, that there is even less protection if people operate outside the formal system, and some formal procedural safeguards may offer the appearance of protection but limited meaningful oversight. In line with the principle of non-discrimination, the response to undue influence should draw on the development of approach to other situations not related to disability, such as coercive control of partners and domestic violence.

(5) It should be possible for people involved with the individual (broadly defined) to raise concerns and have these properly addressed. This would include making a referral to the judicial level, but ideally there should be some means of doing this without having to go straight to a judicial hearing. This might be developed from the current complaints and investigation roles of councils, Office of Public Guardian and Mental Welfare Commission, but these might be streamlined, particularly where they overlap.

(6) There is scope for alternative models of dispute resolution to be built in, particularly mediation. This could draw on models such as the legislation concerning additional support needs[188] .

(7) Wherever possible, procedures should build on existing good practice in the assessment and provision of care. For example, there is normally a 4 to 6 week review following a care placement[189], a 12 week period before a person's tenancy may be terminated, and an annual review of care by the local authority. These reviews could incorporate consideration of any issues which may require, for example, upward referral or judicial authorisation.

(8) There should be a central registration process across all levels, probably operated by Office of the Public Guardian, which would identify every case of guardianship.

[188] Education (Additional Support for Learning) (Scotland) Act 2004, s 15

[189] COSLA, 'National Care Home Contract 13/14', 11 <http://www.cosla.gov.uk/sites/default/files/documents/national_care_home_contract_2013-14_final.doc> accessed 20 March 2017; 2016 Amendments available here <http://www.cosla.gov.uk/sites/default/files/documents/minute_of_variation_11_april_2016.pdf > accessed 20 March 2017.

7. Levels of graded guardianship

a. ‘Level 1’

This is intended for straightforward cases. The Mental Welfare Commission have proposed a ‘registered supporter’ model, set out in their response to the Scottish Law Commission as follows:

> “This would be a mechanism to recognise formally a person who supports the adult in decision-making. It would give effect to the concept of supported decision making, as called for by the UN Convention on the Rights of Disabled Persons. It also reflects the fact that many carers and family members still feel excluded and disempowered in dealings with services. Health and care services and other bodies such as banks may refuse to share information with or seek input from those who, in practice, support the adult in day to day living. The lack of formal status raises problems in relation to obligations of confidentiality.
>
> “In our experience, it is this fear of lack of involvement which drives many families to seek guardianship, rather than a wish to control every decision of the adult. A less formal process which is explicitly designed as a model of supported decision making could, apart from its intrinsic value, reduce the pressures of guardianship applications.
>
> “There are various ways in which the appointment could be regularised – including approval by the local authority or registration with a public body (such as the Public Guardian or the Mental Welfare Commission) or the court. There would require to be evidence that, so far as can be ascertained, it is the will and preference of the adult that the appointed person be their supporter. “No-one could be a supporter against the clearly expressed wishes of the adult.
>
> “There could also be a light touch process of certification that the person is suitable to take on the role (perhaps by a “passport signatory” system).
>
> “Any person with an interest (including the adult) could challenge the appointment in the sheriff court, or seek appointment at one of the higher tiers.
>
> “We do not see this role as only being available for people who completely lack capacity – it should also be possible for individuals who have capacity to authorise a person to support them in the exercise of this capacity.
>
> “These are tentative suggestions, and there are a number of supported decision making systems in other jurisdictions which could serve as models.
>
> “In general the powers and duties would reflect the supporter role – health and social care providers and potentially other public and private bodies would have

a duty to consult the supporter before making an intervention concerning the welfare or treatment of the adult.

"Depending on the level of impairment of the adult, the supporter should be authorised to assist the person to make a decision, or should be able to express their view of what would be the will and preference of the person.

"Services would be obliged to have regard to this and would not be able to proceed with a decision which significantly conflicts with the supporter's assessment of the person's will and preference unless another level of guardianship, or authority from other legislation was used."[190]

The Office of the Public Guardian have put forward a slightly different approach. They prefer to retain the term 'guardian' to 'supporter', because they believe the concept of supported decision making should underpin all levels of the new system, and because they envisage the powers as being wider than support[191]. Those powers would include dealing with self-directed support payments and welfare benefits, potentially replacing the appointee system. They could also perhaps include agreeing tenancies. The application would be lodged with the local authority and supervised by them as part of the general supervision of the adult's care package (assuming one exists). It would be registered on a national register held by the Office of the Public Guardian. The Office of the Public Guardian estimate this might cover 20% of current cases.

In addition, review and renewals of these support arrangements will be required and the timescales for this requires consideration.

The Mental Capacity Act 2005 and the Mental Capacity (Northern Ireland) Act 2016 take a different approach to 'every-day' decisions which may not require a formal procedure. Under section 5 of the 2005 Act, and s9 of the 2016 Act, there is a limited exclusion from liability for someone who takes decisions in connection with someone's personal welfare, in the reasonable belief that the person lacked capacity to consent to the decision. This is a statutory form of the common law principle of 'necessity'. No such provision was inserted in the 2000 Act. There may be merit in considering whether this would be of value, but we could not identify any significant body of opinion that such a principle should be inserted.

[190] Mental Welfare Commission response to Scottish Government, 'Consultation on the Scottish Law Commission Report on Adults with Incapacity' (2016) <http://www.mwcscot.org.uk/media/315711/sg_slc_awi_consultation_doc_216.pdf> accessed on 13 April 2017.

[191] Conversely, as has been suggested by the Australian Law Reform Commission, all assistance could be framed as supported decision making, up to and including 'full support', where someone is chosen by the adult or appointed to make decisions for them. See <https://www.alrc.gov.au/publications/supported-decision-making-commonwealth-level> accessed 20 March 2017.

i. Level 1 – issues arising from the Graded Guardianship roundtable

A number of issues regarding Level 1 emerged from the roundtable on Graded Guardianship which can be summarised as follows:

(1) This may be the most innovative aspect of the proposal, in seeking to create a new form of authority which sits somewhere between powers of attorney and guardianship, and between supported and substitute decision making. It will require detailed consideration, but offers an opportunity to design a co-decision-making model, as part of a decisive shift to the UNCRPD support paradigm.

(2) Level 1 was felt to be the appropriate level to replace DWP appointeeship, and to allow a person to give up a tenancy which is no longer occupied.

(3) There is some tension between the desire for maximum flexibility and informality and the need for some process of appeal, supervision and review – although arguably the level of these need not be higher than exists for powers of attorney.

(4) It was felt that it should be possible to reconcile the slightly different approaches of the Office of the Public Guardian and Mental Welfare Commission, although they do highlight an asymmetry between welfare and financial powers. The welfare role at Level 1 is essentially consultative, but it is envisaged that the appointed person will be able to take some financial decisions.

(5) Joint appointments should be possible, including where different people may play different roles. There can be difficulties with these if disputes arise. In some cases an appointment plus a substitute/alternate would be preferable. A dispute could trigger the situation being escalated to Level 2.

(6) It is not proposed that people appointed at Level 1 would have authority to withhold consent to medical treatment, which would continue to be governed by Part 5 of the 2000 Act. However, in line with the intention of increasing collaboration between professionals and families, there could be a requirement that the appointed person be consulted before medical treatment is administered, except in an emergency. This would be consistent with recent case law concerning the application of Article 8 of ECHR to medical decisions, particularly in relation to end of life questions[192].

(7) The appointment could be combined with other similar roles, such as Named Person under the 2003 Act.

[192] *R (Tracey) v Cambridge University Hospital and The Secretary of State for Health with the Resuscitation Council and Others intervening* [2014] EWCA Civ 822 **and** *Winspear v City Hospitals Sunderland NHSFT* [2015] EWHC 3250 (QB), [2015] MHLO 104.

b. ‘Level 2’

This is intended for more complex, but non-contentious cases, including to authorise some care placements where Article 5 ECHR might be engaged. It would only be used where it can be established the person is not capable of making the relevant decisions, even with support.

Importantly, these procedures should be able to be used in cases which may meet the *Cheshire West* acid test, but where the level of interference with the person’s freedoms does not justify a requirement of prior court authorisation.

The Mental Welfare Commission proposed two versions – a development of section 13ZA (a ‘section 13ZA plus’ power) for public authorities, and a loose equivalent for family applications.

To use the new ‘section 13ZA plus’ power, local authorities would be obliged to ensure there was fully documented care planning and assessment of need, which identifies what restrictions of liberty may be involved; to maximise the ability of the adult to participate in the process, including by supports for decision making and access to advocacy, and to involve close family members and carers.

The procedure could not be used where the restrictions reach a threshold which requires ‘Level 3’ approval, or where the will and preference of the adult is being overridden. Any interested party who is unhappy could escalate the case to Level 3.

The Mental Welfare Commission rejected a Deprivation of Liberty Safeguards (DOLS) type model of an independent professional undertaking the authorisation which they viewed as overly bureaucratic, and suggested that the documentation be signed off by a mental health officer of the local authority.

For families, this level seeks to provide what section 13ZA was intended to provide for local authorities – the authority to make arrangements to promote the welfare of the adult. This would include authorising the adult’s place of residence, and agreeing to care packages.

It could not be used against the will of the adult, if the adult resists, or if there is dispute amongst the interested parties.

There would require to be an application which would set out the powers sought. It would include a medical certificate of incapacity and a report from a health or social care practitioner with qualifications/experience/training and knowledge of the adult and applicant, as to the suitability of the applicant and the appropriateness of the powers sought. To reduce duplication of effort, this certification and reporting could be combined with assessments required for other decisions – e.g. an assessment of incapacity for medical treatment, or the development of a care plan.

The Mental Welfare Commission response suggested the application should be submitted to the Chief Social Work Officer. An alternative which attracted support in discussions would be for the Office of the Public Guardian to be the registering authority, as an independent national body which already has a role in checking and registering documentation affecting an adult's legal status.

The Office of the Public Guardian suggest a tailored list of powers should be available at this level with a streamlined process of application. This could potentially be done by lay applicants but would require one medical report on incapacity and a report by a designated professional on necessity of powers. The category of designated professional would be wider than mental health officers. If the Office of the Public Guardian were satisfied that the application was properly made out, and there were no objections (e.g. from the local authority or Mental Welfare Commission), they would register the application.

The Public Guardian would have authority to remit any matter to court where it sees it as necessary. The Office of the Public Guardian would supervise financial powers and the Mental Welfare Commission and local authorities would supervise welfare powers. Again, as with Level 1, timescales for review/renewal are for discussion, but the starting position could be a default three year review.

The Office of the Public Guardian estimates this level may account for around 40% of current cases.

i. Level 2 – Issues arising from the graded guardianship roundtable

Issues regarding Level 2 emerging from the roundtable on graded guardianship can be summarised as follows:

(1) This level was felt to be appropriate to replace Parts 3 and 4 of 2000 Act (Access to Funds and Management of Residents' Finances).

(2) There was a view that the Mental Welfare Commission proposal of two kinds of Level 2 guardianship was needlessly complex.

(3) A difficulty with the Office of the Public Guardian as registering authority could be a confusion of roles if they are to be both the appointing agent and the supervising agent. It was also questioned whether an administrative process of authorisation was UNCRPD compliant.

(4) If the Office of the Public Guardian is to be the registering authority, it is likely that the role would be to check that the application was correctly made out and contained all the appropriate information, but not to undertake a further check on the appropriateness of the appointment. This relatively limited role might alleviate concerns about a conflict with the supervisory responsibility.

(5) Some limited safeguards against abuse could be built in at this stage, for example a check against multiple authorisation for the same person, and perhaps also a PVG check via Disclosure Scotland. If there were any concerns, it would be open to the Office of the Public Guardian to reject an application, to refer it for judicial determination (in other words, to Level 3), or to limit the provision to Level 1.

(6) This model depends on a workable and shared understanding of what is a 'non-contentious' care placement, which does not require prior court authorisation, even if it may be a deprivation of liberty as defined in *Cheshire West.* It was suggested that the distinction, although difficult to define, may not be hard to spot in real life, and that greater attention to the issue of rights, will and preference, rather than deprivation of liberty, may assist. Using this approach, the situation in *Bournewood* could not be authorised at Level 2 (where the applicant, HL, was arguably unhappy about being deprived of his liberty at the hospital), while the situation of *MIG* and *MEG* in *Cheshire West* (both of whom appeared to be quite happy with their living arrangements) could be authorised at that level.

(7) Some basic parameters will need to be set out, drawing on practice as it has evolved in relation to section 13ZA. However, provided there is easy and quick access to appropriate review/upward referral, the detail may be left to develop with experience.

(8) It will be important that any review/upward referral can be expedited in urgent cases, particularly where a decision, once taken, may be unable to be reversed.

(9) The proposed *authorisation* of deprivation of liberty would appear to be compatible with Article 5 ECHR case law. However, Article 5(4) case law also requires that a 'real and effective'[193] ability exists for individuals with capacity issues to challenge the lawfulness of the deprivation of liberty through judicial review (by a court of tribunal). The European Court of Human Rights has noted that automatic judicial review is not essential and that a margin of appreciation exists in terms of how individual states achieve this[194] but safeguards must practically and actively assist the individual in accessing such review[195]. Initiation of such a review must not be left to the discretion of the person/body

[193] *MH v UK* (2013) ECHR 1008, paras 82-86: *Stankov v Bulgaria* App no 25820/07 (ECtHR, 17 March 2015), paras 113 and 170; *DD v Lithuania* (2012) ECHR 254, para 165.

[194] *MH v UK* (2013) ECHR 1008, para 82

[195] *MS v Croatia (No.2)* (2015) ECHR 196 at paras 152-160

who authorised the deprivation of liberty[196] although a third party may do this provided that they are subject to a non-discretionary duty to do[197]. In any reform careful consideration will therefore need to be given regarding achieving Article 5 compatibility where a person who lacks capacity is unable to instigate judicial review and there is no-one else who is willing or able to do this on their behalf. There might, for example, be a role for a body such as the Mental Welfare Commission in reviewing any cases of concern, and where appropriate referring issues of concern for judicial review. However, whether this would go far enough in achieving Article 5 compliance remains to be seem[198].

(10) There was a widespread view that the application process for Level 2 must allow a wider category of reports than from an MHO and a 'section 22' 2003 Act doctor, if the capacity problems of the current system are to be alleviated.

(11) The design principle of aligning the process with best practice in assessing and providing care might suggest that social work and medical reports could come from practitioners involved in the care of the individual, including other social workers and GPs. It could be argued that this involves some conflict of interest, but this was felt to be more practical than a DOLS style model of additional independent assessors in every case.

(12) An alternative view was that the MHO role should be retained, but the burden on them could be substantially reduced, for example by restricting the level of consultation which was required, or expecting the applicant to undertake more of the preparatory work. It was reported that some MHOs have been asked to go to considerable lengths to trace relatives who are out of the country and have no known interest in the adult.

(13) A view was expressed that a judicial body such as the Mental Health Tribunal could authorise Level 2 appointments as well as Grade 3, using a

[196] *DD v Lithuania* (2012) ECHR 254, para 166, *Stanev v Bulgaria* (2012) 55 EHRR 22, paras 174-177 and *Stakov* at para 114.

[197] *Stanev v Bulgaria* (2012) 55 EHRR 22, para 174, *Shtukaturov v Russia* (App no 44009/05) (2012) 54 EHRR 27, para 124 and *MH v UK* (2013) ECHR 1008, paras 92 and 94. The English and Welsh Court of Appeal ruling in *Re x (Court of Protection Practice)* [2015] EWCA Civ 599, 104 (Lady Justice Black) also indicated that the individual with incapacity must also be a party to the proceedings to ensure Article 5 compliance.

[198] Indeed, on the same basis, it remains to be seen whether the scheme recently proposed by the Law Commission for England and Wales that does not allow for automatic judicial review will be fully ECHR compatible (Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, March 2017) <http://www.lawcom.gov.uk/wp-content/uploads/2017/03/lc372_mental_capacity.pdf> accessed 20 March 2017.)

simpler procedure for Level 2 (perhaps paper based applications before single member).

c. ‘Level 3’

This would operate broadly as guardianship operates now. The situations which would necessitate consideration at this level would include where:

(1) The powers sought exceed what is permissible under Level 2: e.g. a serious restriction of liberty such as repeated physical restraint.

(2) There is a dispute as to the action needed.

(3) There is evidence that the powers sought or the person to be appointed may be inconsistent with the will and preference of the adult.

(4) The person’s financial affairs are particularly complex (e.g. the ownership of a family business).

(5) The application is opposed by the local authority or anyone else.

Cases could be brought directly to court or remitted up from Level 1 or Level 2 applications. Such applications would continue to require medical reports and an MHO report on the necessity of powers at this level and the suitability of the proposed guardian. These reports would be required to address relevant UNCRPD or deprivation of liberty issues. Where financial powers are involved, there would be a checklist to confirm the guardian’s ability to administer these.

There would remain a requirement on local authorities to bring an application where necessary and no-one else is doing so. It would still be possible to appoint the Chief Social Work Officer as welfare guardian, and the current provisions regarding supervision by the Office of the Public Guardian, Mental Welfare Commission and local authority would remain.

The main changes from the current system would be:

(1) A greater participation of the adult, with an explicit duty to ascertain their will and preference, and provide support to allow this.

(2) Possibly one medical report by an approved specialist rather than two.

(3) Automatic periodic review – possibly an administrative process of review every one or two years, with a full judicial review at least once every five years.

i. Level 3 – issues arising from the graded guardianship roundtable

Issues regarding Level 3 emerging from the roundtable on Graded Guardianship can be summarised as follows:

1. Requirement for judicial authorisation

There was universal acceptance of the need for a judicial level for the most serious interventions. Apart from the discussion of the forum, the main changes from now might be practical improvements to allow quick decisions to be taken (possibly with a later review) where this was demonstrably in the interests of the adult. The obvious example of this is where an appropriate care place has been found, which will be lost if a decision is not taken quickly.

2. Forum

There was widespread support for the proposal that the appropriate judicial forum for guardianship was a tribunal within the mental health chamber of the new tribunal structure.

One possible concern is the loss of perceived status in situations where a guardian may be acting inappropriately. The experience of the Public Guardian is that a warning that a case may be referred to the Sheriff Court often has a salutary effect, which may not be so obvious in relation to a tribunal.

Against that, there were many perceived advantages to the tribunal, which has now established itself as an efficient, credible and authoritative body. For some, a tribunal was better positioned to balance difficult questions of care and treatment.

It could be argued that the name of the forum is less important than the way it works. The argument that tribunals are less legalistic and more informal and inquisitorial than sheriff courts is not always borne out in practice. Whatever forum is employed it was felt that its key features must include:

- Informality
- An approach which maximises the participation of the adult (although this need not always be at the hearing itself)
- An awareness of the needs of people with mental disorders
- A consistent approach across Scotland
- The development of the case law

There was a clear view that we should move to a single judicial body to consider all cases of non-consensual care – partly because this would facilitate the ultimate fusion of the legislation, but also because many cases currently could be dealt with either through AWI or mental health law, and it is important to have a single place to go to reach a final decision.

3. Terminology

The terminology used is important, as it sets expectations for the nature of the relationship between the adult and the person assisting them to make decisions. There is a view that the term ‘guardianship’ should be replaced by a term which is less suggestive of control and authority over the individual. We have used it in this report for convenience, but it is not our preferred term for the future.

Chapter 4:

UNIFIED LEGISLATION

1. Introduction

In reviewing the former Mental Health (Scotland) Act 1984, the Millan Committee recommended consistency between what became the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) and the Adults with Incapacity (Scotland) Act 2000 (the AWI), and that 'In due course, mental health and incapacity legislation should be consolidated into a single Act.'[199]

The recent legislative and human rights developments relating to interventions and non-consensual care and treatment of persons with mental disorder identified in Chapter One have prompted re-consideration of, amongst other things, the appropriateness of unified legislation for Scotland.

The introduction of unified legislation would undoubtedly involve a major policy, legislative, financial and implementation exercise in Scotland, as evidenced from the Northern Ireland experience. A key question is therefore whether unified legislation that would address the provision of physical and mental health care and treatment, and support and protection, of persons with impaired decision-making ability is likely to deliver sufficient benefits over and above that currently available – or possible if appropriate amendments were made – under the existing legislative framework.

Considerations would therefore necessarily include the eligibility criteria and underpinning principles that would be adopted for such unified legislation (in other words, would it be a capacity-based or other approach), whether it will provide a preferred means of resolving existing deficits relating to current legislation, whether it will provide a framework that is most likely to achieve compatibility with international human rights standards and whether it will be necessary to combine the 2000 Act, 2003 Act, 2007 Act and possibly the sum or provisions from other legislation.

It is therefore useful to first consider arguments favouring the adoption of unified legislation.

[199] Millan Report (n 3) recommendation 2.1

2. Arguments favouring unified legislation

a. Parity of esteem

It is argued that a single system which adopts the same eligibility criteria for all persons with psychiatric and non-psychiatric medical conditions equally promotes fairness and respects non-discrimination.[200] Indeed, the capacity threshold adopted by the Mental Capacity (Northern Ireland) Act 2016 seeks to make no distinction between persons with physical or mental health conditions or intellectual disabilities. This reflects the conclusions of the Bamford Review that, influenced by the rulings in *Re T*[201] and *Re C*[202], the presence of a mental health problem or learning disability should not automatically lead to an assumption that a person is incapable of exercising their rights, and that a person with capacity thus has the right to refuse treatment for physical or mental health conditions and to not allow this is unjust.[203] This notion of non-discrimination very strongly underpins the approach in the UNCRPD to the rights of persons with disabilities including, but not limited to, the rights to health (Article 25), to exercise legal capacity (Article 12) and to liberty (Article 14)[204] and is also increasingly present in developing interpretations of Article 5, 8 and 14 of the European Convention on Human Rights (ECHR).

b. Consistency, clarity and coherency of legislation

Unified legislation also has the potential to remove gaps and create a clearer and more consistent approach for the benefit of vulnerable persons[205] regarding, for example:

(1) The treatment of physical conditions which are related to mental disorder.
(2) The use of force and restraint.
(3) Who bears responsibility for investigations into alleged deficiencies in care.
(4) Access to, and support for, the exercise of legal capacity required by Article 12 UNCRPD (the right to equal recognition before the law/universal exercise of legal capacity).
(5) Protection from abuse.

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[200] John Dawson and George Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 British Journal of Psychiatry 504; Szmukler, Daw and Dawson (2010) (n 110) 11-14; Gledhill (n 115) 54.

[201] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95

[202] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819

[203] Bamford Review, 'Human Rights and Equality of Opportunity' (October 2006) <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/human_rights_and_equality_report.pdf> accessed 20 March 2017; Bamford Review, 'A Comprehensive Legislative Framework for Mental Health and Learning Disability' (August 2007) <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/legal-issue-comprehensive-framework.pdf > accessed 20 March 2017.

[204] As further reinforced and advanced by the Committee on the Rights of Persons with Disabilities in General Comment No 1 (n 31) and Article 14 UNCRPD Guidelines (n 39).

[205] This was seen as desirable by the Millan Report (n 3) para 29.

(6) Removal of separate and possibly conflicting court and tribunal applications and orders.

In this connection it is worth noting that there is considerable potential for two or all of the 2000 Act, 2003 Act and 2007 Act potentially to collectively impact with very real effect on the lives of many individuals with mental disorder.[206] As mentioned in Chapter One, the 2007 Act was intended as a relatively small tidying up exercise following the 2000 and 2003 Acts but has had a far greater impact on social work activity than was originally envisaged.

Any unified legislation would also have to address international human rights requirements and the legitimacy of such legislation must be assessed with these in mind. In the present context, such requirements mainly flow from the ECHR and the UNCRPD as were summarised in Chapter One.

3. Human rights considerations

As stated in Chapter One, the European Court of Human Rights has been increasingly promoting the autonomy of persons with cognitive or psychosocial disabilities. However, the ECHR's acceptance that involuntary interventions are ultimately permissible is at odds with the more expansive view of the exercise of legal capacity and liberty identified, respectively, in Articles 12[207] and 14[208] UNCRPD particularly as interpreted in General Comment No 1 and the Article 14 Guidelines. UNCRPD rights are not legally enforceable in Scotland, thus giving precedence to ECHR rights. But the UNCRPD is nevertheless influential.[209] The 'support paradigm' advanced by Articles 12(3) and 12 (4) UNCRPD[210], and General Comment No. 1, has application and value in terms of supporting the exercise of legal capacity, potentially preventing or delaying interventions and ensuring that an individual's wishes and feelings (or will and preferences) are reflected in all decisions that are made by or concerning that person. Moreover and significantly, the requirement for equality and non-

[206] See Scottish Government, 'Comparison of The Adult Support and Protection (Scotland) Act 2007 (ASP) with The Adults with Incapacity (Scotland) Act 2000 (AWI) and The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCT)' (February 2009) <http://www.gov.scot/Publications/2009/02/25110701/1> accessed 20 March 2017.

[207] Which promotes the universal right to exercise legal capacity (Article 12(1) and 12(2)).

[208] Right to liberty.

[209] The UK, as a state party to the UNCRPD, is bound under international law to comply with it. Devolved legislation and the actions of the Scottish Ministers can be prevented by the UK Government if they contravene UNCRPD rights (ss 35 and 58 Scotland Act 1998) and the European Court of Human Rights should interpret ECHR rights with reference to the UNCRPD, the UNCRPD being a higher source of international law.

[210] States parties should provide access to support for the exercise of legal capacity as is appropriate for persons with disabilities and the context in which such support is provided must be free from undue influence, conflict of interest and have the primary objective of giving effect to the individual's rights, will and preferences.

discrimination in the approach to the realisation of the rights of persons with disabilities permeates the UNCRPD, General Comment No.1 and the Article 14 Guidelines.

In contemplating unified legislation and its intended objectives (particularly that of parity of esteem) the extent to which it gives effect to the right to the highest attainable standard of physical and mental health identified in both the ICESCR and UNCRPD[211] is important. Again, as with UNCRPD rights, ICESCR rights are not legally enforceable in Scotland but, for the same reasons as the UNCRPD, nevertheless have considerable influence.

The Mental Capacity (Northern Ireland) Act 2016 was drafted and enacted with UNCRPD requirements strongly in mind. It adopted what is considered to be a pragmatic approach which took into account Northern Ireland's need to primarily give effect to ECHR rights but one that was, it is argued, compatible with Article 12 if not its interpretation in General Comment No 1.[212]

This is reflected in its promotion of support for decision-making and its definition of what it is to lack capacity that is not entirely linked to mental disorder or disability. It is also reflected in the steps that the Act specifies must be followed before interventions can be justified which includes the requirement to have 'special regard' to the individual's wishes and feelings[213] (although it does retain the best interests test in relation to interventions[214]). The Act's Code of Practice, which is currently in the process of being drafted, will provide more detail as to how this will work in practice.[215] The fact that the Act also aims to not discriminate against persons with mental disorder arguably addresses the requirement of Article 14 UNCRPD that detention should not be predicated on disability.[216]

[211] Noting, again, that Article 25 UNCRPD makes it clear that state parties must '…recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability…'

[212] Colin Harper, Gavin Davidson and Roy McClelland, 'No Longer 'Anomalous, Confusing and Unjust': the Mental Capacity Act (Northern Ireland) 2016' (2016) 22 International Journal of Mental Health and Capacity Law 55-70, 65-66.

[213] 'Explanatory and Financial Memorandum accompanying the Mental Capacity Bill' (NIA Bill 49/11-16-EFM, 8 June 2015) <http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity-bill---efm---as-introduced.pdf> accessed 20 March 2017.

[214] Which, owing to its paternalistic connotations, is not contained in Scottish incapacity or mental health legislation and IS seen as discriminatory in General Comment No 1 (n 31).

[215] Andrew Dawson and Roy McClelland in response to questions at Law Reform Exercise Roundtable 2 on Fused Legislation, 12 November 2016.

[216] Harper, Davidson and McClelland (n 212) 65

4. Considerations for eligibility criteria, principles and operation of unified legislation in Scotland

a. Persons to be potentially subject to the unified legislation

It is essential to ascertain who exactly will fall within the remit of the legislation and what the eligibility test will be. If it is intended that it will include all persons with psychiatric and non-psychiatric medical conditions then decisions would have to be made as to whether or not it will include only persons with impaired capacity or also persons who have capacity but who are 'vulnerable' (such as those who potentially fall to be considered under the 2007 Act), mentally disordered offenders and children and young persons.

During the discussion at the project Roundtable on Fused Legislation a number of themes emerged as follows:

i. Capacity as an eligibility threshold

The issue of persons who might be included under the legislation also raises the question of exactly how their eligibility to be considered is to be assessed. Would a purely capacity threshold be sufficient as is currently adopted under the 2000 Act[217]? Should harm and/or risk also be a deciding factor, a hybrid capacity-risk assessment as it is under the 2003 Act[218] or a completely different threshold be adopted? Would a definition similar to that of significantly impaired decision making ability found in the 2003 Act be more appropriate? Should both continue to be used or a new definition created in light of international human rights developments?

The arguments in favour of adopting a purely capacity threshold or a threshold that also takes risks into account were discussed in Chapter Two. These apply to both single and unified legislation. Certainly, at the Roundtable on Fused Legislation there was broad agreement that if capacity is the central concept then unified legislation appears to be the most appropriate route.

However, the need to address difficult cases where a person might be deemed to have capacity but be at risk of harm, e.g. persons with eating disorders, at risk of suicide, etc., must be considered and the extent to which consequences should be taken into account. Indeed, it was felt that consequences and risk are relevant to capacity tests which appears to accord with Lord Donaldson's statement in *Re T* that the more serious the decision the greater the level of capacity required. Interestingly, it was stated[219]that the inclusion of the 'appreciate test' in the Mental Capacity (Northern

[217] s 1(6)

[218]ss 36, 44 and 64

[219] McClelland, Law Reform Exercise Roundtable 2, 12 November 2016

Ireland) Act 2016 was intended to address such situations and was instrumental in the Northern Ireland Assembly passing the legislation.[220]

ii. Children and young persons

It was noted that the Mental Capacity (Northern Ireland) Act 2016 does not cover children although this was acknowledged as a holding, rather than permanent, arrangement.[221] However, the participants considered that the increased focus on the universality of human rights would render it difficult to exclude them. However, such inclusion must not compromise a child's legitimate care and protection which may be slightly different to that of adults. For example, if a capacity threshold is adopted (as has been adopted under the Education (Scotland) Act 2016 which expands the rights of children with capacity) how would a child who has capacity but refuses care and treatment be treated and to what extent may parents substitute consent/refusal for children who lack capacity? As discussed below, this might be achieved by defining the needs that should be covered rather than the persons who should be covered.

iii. A needs, rather than status, based approach

It was suggested that owing to the increased, and essential, focus on the universality of international human rights, individuals should not be categorised for eligibility on the basis of a particular, narrow, attribute. A broader approach must be adopted to justify intervention based on need, which may indeed include children. In particular it was suggested that a model that could perhaps be adapted and expanded is that provided by the 2007 Act[222] given that its objective is to support a person and enhance their autonomy where they may or may not have capacity.

iv. Support for the exercise for legal capacity

If the eligibility threshold is expanded this would need to be accompanied by a more effective overarching support mechanism. This would avoid the net being cast so wide that those who would currently not meet the criteria for non-consensual intervention but who would benefit from support would not be unnecessarily and intrusively subjected to such intervention. Any intervention would also need to be justified on the basis of need that cannot reasonably be met outside such intervention and that the individual's wishes and feelings have been genuinely represented.

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[220] s 3(1) Mental Capacity (Northern Ireland) Act 2016 states that a person lacks capacity if they are 'unable to make a decision for himself or herself about the matter' and s 4(1)(c) states that they are unable to make such a decision if they are 'not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision'.

[221] Dawson and McClelland, Law Reform Exercise Roundtable 2, 12 November 2016

[222] Pearse McClusker, Law Reform Exercise Roundtable 2, 12 November 2016

That being said, some participants mentioned that the issue of 'need' requires better definition. At present at an operational level the terms 'adult at risk' and 'vulnerable' adult are both being used in relation to the 2007 Act and that this as well as the difficulty in obtaining orders under the Act acts as an impediment to support being provided.

However, as mentioned above, the extent to which the provision of support in order to ensure that individual's will and preferences are given effect can adequately address cases where serious risk and harm are an issue requires further exploration. The use of ordinary civil and criminal law sanctions or the 2007 Act may be appropriate in the case of actual or anticipated harm perpetrated by the individual to others or by others towards the individual. However, where it is self-inflicted this is more difficult.

b. Coherence of legislation and its operation

The fact that individuals can at present be subject to more than one Act and that more comprehensive support can potentially be provided under a single piece of legislation was also cited as potential support for the introduction of unified legislation. If legislation were to be fused then it needed to encompass the 2000, 2003 and 2007 Acts. However, the current definitions about who can be subject to each Act are different and this would require careful consideration before rationalisation. For example, an individual may be deemed to be an adult under the 2000 Act but a child under the 2003 Act.

c. The Mental Health Tribunal for Scotland

The issue of what would be an appropriate institutional structure for unified legislation was discussed and there was general agreement that the Mental Health Tribunal for Scotland would be the most appropriate forum and that it would be capable of assuming this task. This accords with the recommendation made by, amongst others, the Law Society of Scotland sub-committee on Mental Health and Disability in its response to the Scottish Government 2016 consultation on the Scottish Law Commission's Report on Adults with Incapacity.[223]

It was stated at the roundtable that using the Tribunal would have considerable resourcing advantages in that it would hold just the one hearing rather than the current position where cases involving individuals who are potentially subject to the 2000 and 2003 Acts and even the 2007 Act will be held at separate hearings, the 2000 and 20007 Act hearings being held, normally separately, before a sheriff. Moreover, the fact that the Tribunal and Sheriff Courts are now all part of the Courts and Tribunal Service also means that there would be no requirement for transferring resources.

[223] Law Society of Scotland, 'Response to Scottish Government Consultation on the Scottish Law Commission's Report on Adults with Incapacity' (March 2016) 18-21 <http://www.lawscot.org.uk/media/745234/mhd-consultation-on-the-slc-report-on-awi-final-.pdf> accessed 20 March 2017.

Further, whilst there is a need to properly investigate concerns, based on anecdotal accounts, about delays and associated escalating costs associated with 2000 and 2007 Acts cases being heard by the Sheriff Courts, what is clear is that the Tribunal has actively sought to minimise delays and multiple hearings with associated cost benefits. It was also commented that alongside the Tribunal's efficient approach to cases it also takes one that is patient-centred and that there is a need to ensure that this is maintained if its workload is significantly increased by the absorption of 2000 and 2007 Act cases. For example, it was felt important that oral hearings should still be determined by three member panels.

Conclusions and recommendations

1. Conclusions

A number of broad conclusions can be discerned from both the roundtable discussions conducted as part of this law reform scoping exercise and from information gathered during the Mental Welfare Commission parallel exercise involving discussions with people with lived experience and carers.

Firstly, in order to ensure compliance with developing international human rights standards, notably those identified in the UNCRPD and ECHR, there is a need to revisit and, where necessary reframe, our mental health and capacity law. This applies to both how such law is framed and how it is implemented.

Secondly, and in particular, there appeared to be general agreement that much more can be done to maximise the autonomy and exercise of legal capacity of individuals with mental disorder, even where significant impairments of decision making capacity exist, so that genuine non-discriminatory respect is afforded for an individual's rights, will and preferences. It is also acknowledged that there needs to be a serious and careful engagement with what affording such respect actually entails, particularly if Scottish law and its implementation is to facilitate the enabling and empowering of individuals with mental disorder.

Our existing mental health, capacity and adult support and protection legislation in Scotland applies a diagnostic threshold linked wholly or partly to mental disorder and capacity assessments. This is potentially discriminatory and therefore requires a revisiting of whether the eligibility criteria of the 2000, 2003 and 2007 Acts are fit for purpose in terms of compliance with current international human rights standards and allow for individuals with mental disorder to be appropriately and non-discriminately supported and protected.

This must, equally importantly, be accompanied by a revisiting of how 'capacity' and SIDMA is assessed by clinicians and practitioners. The potentially discriminatory nature of SIDMA, in allowing for the non-consensual treatment of those who would otherwise be deemed to have capacity and in light of comments that assessments of it may be heavily influenced by notions of risk, is noted with particular concern. It also requires consideration of the robustness of existing and potential means of support for the exercise of legal capacity.

Thirdly, there is a need to rationalise and provide greater synergy between the 2000, 2003 and 2007 Acts to ensure that where an individual potentially falls to be considered under more than one piece of legislation this is effectively and consistently achieved. To this end, there is considerable support for the transferring of 2000 and

2007 Act jurisdiction to the Mental Health Tribunal for Scotland and this should accordingly be rigorously investigated.

Finally, it was less clear whether there is an overall appetite for the immediate introduction of unified legislation amongst the stakeholders consulted. However, there does seem to be an appetite for short to mid-term incremental changes taking the above matters into account. There was also support for seeking to achieve Article 5 ECHR compatibility in relation to persons with incapacity in health and social care settings and reviewing whether persons with learning disability and autism should be retained within the 2003 Act definition of mental disorder. Such changes may ultimately pave the way for unified legislation. This needs to be further explored, particularly with the involvement of service users as, indeed, Article 4(3) UNCRPD requires[224].

This ambivalence towards the introduction of unified legislation in Scotland is perhaps not surprising. What is notably different between Scotland and Northern Ireland is that the 2016 Act arose out of a very different legislative landscape than that which currently exists in Scotland. At the time of the Bamford Review, which eventually led to the enactment of the 2016 Act, not only was Northern Ireland's mental health legislation outdated but there was an absence of mental capacity legislation.

Moreover, from the Northern Ireland experience it is very apparent that wholesale stakeholder support is essential for the successful enactment and implementation of unified legislation which also brings about a culture change in the approach to the care and treatment of persons with mental disorder. This includes relevant Ministers, MSPs, government departments (for example, justice, health and social work), public authorities, social workers, clinicians, health workers, the police and service users and carers. A further significant aspect in the change of culture is the need to ensure that those responsible for giving effect to it feel able to do this in the absence of fears of personal liability.[225] Finally, such an initiative must be properly resourced if it is to achieve its objectives.

[224] Article 4(3) UNCRPD states: 'in the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.'

[225] s 9 of the Mental Capacity (Northern Ireland) Act 2016, for example, contains a provision protecting persons from liability where in good faith they act in what they consider to be in the best interests of the person who appears to lack capacity.

2. Recommendations

In light of the above, we therefore make the following recommendations:

Recommendation 1: There should be a long-term programme of law reform, covering all forms of non-consensual decision making affecting people with mental disorders. This should work towards a coherent and non-discriminatory legislative framework which reflects UNCRPD and ECHR requirements and gives effect to the rights, will and preferences of the individual. Further, in accordance with Article 4(3) UNCRPD, persons with lived experience of mental disorder must be actively consulted in any reform process.

Recommendation 2: There should be an explicit aim of increased convergence of the legislation over time, particularly with respect to the criteria justifying intervention.

Recommendation 3: There should be a single judicial forum to oversee non-consensual interventions. The balance of views favours the Mental Health Chamber of the new tribunal structure as the appropriate forum.

Recommendation 4: Within the reform programme, priority should be given to the problems with the law which have the most significant negative effect on the lives and rights of people who are subject to them. The first priority should be to reform the Adults with Incapacity (Scotland) Act 2000.

Recommendation 5: The Adults with Incapacity (Scotland) Act 2000 reform should build on proposals for 'graded guardianship', which have attracted widespread support. It should also take account of the proposals to address UNCRPD compliance set out in the Essex Autonomy Project *Three Jurisdictions Report*.

Recommendation 6: The 'design principles' set out in para 6(a) of Chapter Three should be used to guide reform relating to guardianship.

Recommendation 7: Graded guardianship should also replace parts 3 and 4 of the Adults with Incapacity (Scotland) Act 2000 and DWP appointeeship

Recommendation 8: As part of the programme of reform, consideration should be given to the replacement of the 'SIDMA' test in the Mental Health (Care and Treatment) (Scotland) 2003 by a capacity test. However, the priorities before considering such legislative change should be (a) to improve practice and develop consistent standards across medicine, psychology and the law on the assessment of capacity and (b) to identify and implement practical steps to enhance decision making autonomy whenever non-consensual interventions are being considered.

Appendices

1. List of Roundtable Attendees

Chair

Professor Genevra Richardson, The Dickson Poon School of Law, King's College London.

Speakers

Dr Paul Hutton - Associate Professor of Therapeutic Interventions and Lead for Postgraduate Research in the School of Health and Social Care at Edinburgh Napier University

Dr Lucy Series – School of Law and Politics, Cardiff University

Andrew Dawson – Northern Irish Mental Health and Capacity Unit, Mental Health Policy Unit and Mental Capacity Bill Project, Northern Ireland Department of Health

Pearse McCusker – Senior Lecturer, Social Work, Glasgow Caledonian University

Professor Roy McClelland - Queen's University Belfast

Attendees

Adrian Ward – Law Society of Scotland

Alison Clark – British Psychological Society

Alistair Brown – Scottish Association of Social Workers

Cathy Asante – Scottish Human Rights Commission

Colin McKay – Mental Welfare Commission for Scotland

David Cobb – Faculty of Advocates

Erin Bonnar - Mental Welfare Commission for Scotland

Fiona Brown – Office of the Public Guardian

Jan Todd – Solicitor, South Lanarkshire Council

Professor Jill Stavert – Edinburgh Napier University

Dr Joe Morrow – Mental Health Tribunal for Scotland

Kate Fearnley – Mental Welfare Commission for Scotland

Kenneth Campbell – Faculty of Advocates

Kirsty McGrath – Scottish Government

May Dunsmuir – Mental Health Tribunal for Scotland

Mike Diamond – Mental Welfare Commission for Scotland

Owen Miller – Alzheimer Scotland

Rebecca McGregor - Edinburgh Napier University

Rachel Stewart – Scottish Association for Mental Health

Robert Leslie – Social Work Scotland

Roger Smyth – Consultant Psychiatrist in Dept. Psychological Medicine, The University of Edinburgh

Sandra McDonald – Office of the Public Guardian

Seamus McNulty – Royal College of Psychiatry

Shaben Begum – Scottish Independent Advocacy Alliance

Trish Hall – Scottish Association of Social Workers

2. Roundtable Dates and Agendas

Workshop 1: Graded guardianship

Friday 14th October 2016, 12.00-16.00

Venue: The Business School, Edinburgh Napier University,

Boardroom 2/04, Craiglockhart Campus, Edinburgh

AGENDA

12.00 - 12.30: Arrival (Lunch).
12.30 - 12.35: Welcome – Jill Stavert

12.35 - 12.55: Introduction to roundtable and topic – Chair: Professor Genevra Richardson
12.55 - 13.35: Graded Guardianship briefing paper - Sandra McDonald and Colin McKay

13.35-14.00: Short Q and A/observations.
14.00 -14.15: Short comfort break and tea/coffee.
14.15-15.45: Roundtable discussion
15.45-16.00: Summing up and next steps – Professor Genevra Richardson

Workshop 2: 'Fused' legislation

Friday 11th November 2016, 12.00-16.00

Venue: The Business School, Edinburgh Napier University,

Boardroom 2/04, Craiglockhart Campus, Edinburgh

AGENDA

12.00 - 12.30: Arrival (Lunch).
12.30 - 12.35: Welcome and Introduction – Chair: Professor Genevra Richardson
12.35 - 13.05: Briefing

(1) Mental Capacity Act (Northern Ireland) 2016 (background) [20 mins]

Professor Roy McClelland, Queen's University Belfast

(2) Mental Capacity Act (Northern Ireland) 2016 (policy and operational matters)

[20 mins]

Andrew Dawson, Mental Health Policy Unit and Mental Capacity Bill Project, Northern Ireland Department of Health

13.05-14.00: Discussion

14.00-14:15: Tea/coffee break

14.15 – 14.50:

(1) Overview of Fused Legislation briefing paper from Scottish Perspective [15 mins]

Professor Jill Stavert, Edinburgh Napier University

(4) Adult Support and Protection (Scotland) Act 2007 [20 mins]

Pearce McCusker, Glasgow Caledonian University

14.50-15.50: Discussion

15.50-16.00: Summing up and next steps – Professor Genevra Richardson

Workshop 3: Capacity

Friday 16th December 2016, 12.00-16.00

Venue: The Business School, Edinburgh Napier University,

Boardroom 2/04, Craiglockhart Campus, Edinburgh

AGENDA

12.00 - 12.30: Arrival (Lunch)
12.30 - 12.35: Welcome and Introduction – Chair: Professor Genevra Richardson
12.35 – 14.00: Exercising legal capacity

12.35-12.45: (1) Introduction – Professor Jill Stavert

12.45-13.05: (2) Understanding and supporting the autonomy of people with severe mental illness: Recent developments in Scotland - Dr Paul Hutton, Edinburgh Napier University

13.05-14.05: Discussion

14.05-14:15: Tea/coffee break

14.15 – 15.15: Beyond capacity

14.15-14.35: Article 12 UNCRPD: New directions for legal capacity - Dr Lucy Series, Cardiff University

14.35- 15.15: Discussion

15.15-15.30: Summing up of roundtable 3 – Professor Genevra Richardson

15.30-15.50: Discussion of all roundtable topics

15.50-16.00: Summing up – Professor Genevra Richardson


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Mental Welfare Commission (May 17)