Scottish Law Commission
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RESPONSE FORM

DISCUSSION PAPER ON ADULTS WITH INCAPACITY

We hope that by using this form it will be easier for you to respond to the questions set out in the Discussion Paper. The form reproduces the questions as summarised at the end of the paper and allows you to enter comments in a box after each one. At the end of the form, there is also space for any general comments you may have.

Please ensure that, prior to submitting your comments, you read notes 1-2 on page ii of the Discussion Paper.

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List of questions

1. We would welcome views from consultees on the likely impact of any reforms resulting from this Discussion Paper on the groups identified in paragraphs 1.15 to 1.19 above.

(Para 1.19)

Adrian Ward has written that, "The purpose of adult incapacity legislation is to promote and safeguard the rights and interests of adults whose ability to do so for themselves is impaired by incapacity. There can be no greater intervention in the rights and freedoms of an adult than to transfer to another person the power to make decisions and take action in relation to the adult's own personal welfare, property and finances." We would wholly agree with this statement. It is essential that the human rights of people lacking capacity are respected and protected. Adrian Ward further states there is always a tendency for focus to shift more from the purpose of the legislation to its procedures, implying this is at the expense of firmly holding on to the purpose of the legislation. We believe, however, that justice cannot be properly achieved and the rights of individuals lacking capacity respected, unless these processes are closely examined as part of any review of the legislation. There is a need to focus on the proportionality and the practicability of the procedures established in the legislation in order to ensure that justice is achieved in the law's implementation. An over-reliance on judicial procedures whereby a universalist approach is taken to seeking welfare guardianship whenever individuals lack capacity to make key decisions about their care and treatment will result in an unsustainable demand on the statutory services involved in implementing the legislation. The net result will be a process of professional assessment, application and judicial decision making which is cursory, routine and overly bureaucratic. It will provide only the semblance of the rights of the individual being protected.

In answering questions 1 and 2, we believe it is important first to examine the current law on a more fundamental level. The consultation focuses primarily on the question of deprivation of liberty and the associated requirement that the law be used to sanction such a deprivation of liberty. We believe that one of the fundamental problems with the law at present, in addition to its lack of clarity on the circumstances in which the law must be used, is that it takes a "one-size-fits-all" approach. The result is that welfare guardianship is used at times where there is no question at all as to the deprivation of the liberty of the adult – merely that the adult lacks capacity to make decisions or take actions that affect his/her health/welfare. It is important in considering any amendment to the legislation to first differentiate and review the use of the legislation for adults with incapacity where there are no concerns about the adult having their liberty deprived or restricted. The basic questions that need to be addressed are: "Is it necessary to seek welfare guardianship in cases where there is no perceived deprivation of liberty or severe restriction on an individual's liberty?", and, if so, "Does the law have to have the same processes for adults in both cases?" The Mental Welfare Commission as well as the Office of the Public Guardian have proposed adopting a system of graded guardianship to allow for greater proportionality and efficiency in the use of the

legislation.

At present, the same processes for applying for and supervising welfare guardianship exist for adults in widely different circumstances. Welfare guardianship is used, for instance, where a young adult with learning disability or those around him strongly object to the restrictions that are being placed on the adult as part of a care and support plan which the application seeks authority for imposing. It is also used, however, in situations where an older person with severe dementia at the end of their life is receiving palliative care in a care home where everyone is happy with the nature and quality of the care. It will not be possible to amend the legislation to set out clearly when the Act must be used without first looking more fundamentally at the triggers and mechanisms for when and how it may be used. We will discuss below in answer to Question 2 the issue of deprivation of liberty and the implications for how this is defined in teasing out the possible impact of proposed reforms.

As a result of the current legislation, local authorities, health services, the Courts and the Scottish Legal Aid Board have to respond to a system that is demand-led. Statutory services have very little ability to influence the level of this demand. The widespread use of the legislation has created intolerable resource demands for statutory services both at the application stage and in the requirements for the subsequent supervision of guardians and the visiting of both guardians and adults. In many ways the law is a victim of its own success.

The law, as it stand, is imploding under its own weight. Last year alone (2011-12) there were 1766 approved welfare guardianship applications. These required, at the application stage, the following:

- **1766 Mental Health Officer reports;**
- **3532 medical reports (half by GPs, half by Approved Medical Practitioners); approximately 450 court appearances by local authority solicitors, an indeterminate amount of MHO appearances;**
- **an indeterminate but significant amount of additional independent medical, social work and safeguarder reports, often following the granting of an additional 300 interim orders;**

The nearly 7000 extant welfare guardianship cases require:

> **supervisory visits for all the approximately 7000 extant welfare guardianship cases (65% private guardians, 35% Chief Social Work Officers). This requires local authorities to undertake 14,000 visits per year to adults on welfare guardianship and over 9,000 supervisory visits to their guardians. (We are aware that these statutory duties often are not being carried out by local authorities.)**

There has also been a dramatic rise in the provision of Civil Legal Aid in the last two years – up from £1,484,000 in 2009/10 to £2,229,000 in 2011/12. This is a rise of 50% in two years at a time when approved orders rose by just over 25%.

If, as suggested in the consultation paper, all approved guardianship orders were to

be judicially reviewed on an annual basis, the resource implications would be staggering, no matter what system was devised to satisfy Human Rights legislation. Presumably these reviews would require medical and MHO reports, if not actual court hearings. There are several factors that have to be taken into consideration here:

- **As of the end of September 2012 there were just under 7000 extant guardianship cases. Of these, 67% had been granted on an indefinite basis. In 2012, 45% of all orders were granted on an indefinite basis (down from approximately 70% of orders a few years back).**

- **It might be safe to assume that some cases would be recalled before the review process. At present, however, orders are rarely recalled before they expire. In 2011/12 there were only 9 recalls of welfare guardianship made by local authorities and no record of any recall by the courts.**

- **In 2011/12 there were only 112 renewals of welfare guardianship. This means that more than 6000 orders were not subject to review other than what may have been an annual cursory review for care management purposes. More intensive reviews may have been undertaken by social work for other reasons but not specifically to consider the continuation of the guardianship. Supervisory visits to guardians and visits to adults on welfare guardianship required of local authorities often do not take place. When they do, they are rarely undertaken by Mental Health Officers and do not routinely consider whether the order continues to be necessary. Formal annual judicial reviews would likely require over 6000 additional MHO and AMP (psychiatric) reports annually. In addition, there has been an annual rate of growth of extant welfare guardianship orders of over 10%. In 2011/12 this increase was 16%.**

- **Annual reviews would create a dramatic increase in the draw on Civil Legal Aid at a time when the status quo has already resulted in an increase in the Legal Aid budget for AWI applications of over 50%.**

- **Given the fact that all with an interest would have to receive intimation of such annual reviews, it is likely that many renewals would result in challenges, requiring further professional input and court time not required at present.**

It would be difficult, if not impossible, to graft formal regular statutory judicial reviews on to the present Act in such a way as to make it practicable to implement. This again leads us to the conclusion that a graded form of guardianship, where the systems of application, supervision and renewal are proportionate to the circumstances of the individual case, is the only practicable way forward.

At present the guardian's welfare powers authorised by the Sheriff can, and often do, include powers to deprive the adult of their liberty. Powers are often granted as well to consent to necessary medical treatment and to make sure that services are provided to enhance the adult's quality of life. Often, for private individuals, however, welfare guardianship is seen mainly as a means to continue to have a say in the adult's care. There have been differences in interpretation since the inception of the

Act as to whether such powers are necessary where there is no perceived deprivation of liberty. It is not clear, for example, whether guardianship is necessary in every occasion where an adult requires to be moved from hospital to a care home.

The Adult Support and Protection (Scotland) Act 2007 included an amendment to the Social Work (Scotland) Act 1968 (13ZA). This clarified the authority of local authorities to provide services, including residential care services to individuals, to meet their assessed needs. Guidance states that this section can be used where the adult, while lacking capacity, is compliant and there is no disagreement about the measure from any interested party. This only applies to actions taken by the local authority. There is no parallel route available for private individuals. It is not possible to tell how often 13ZA is used by local authorities as justification for implementing a care plan where an adult lacks the capacity to give informed consent. We are not aware of local authorities keeping central records of its use and there is no national monitoring.

We believe, where there is no question of a deprivation of, or serious restriction on, the liberty of an adult, there needs to be some less formal process than the present process of making an application to the sheriff court with all the required reports.

The following outline is being put forward to further discussion as to how a system of graded welfare guardianship might address some of the fundamental issues raised above:

<u>Level 1</u>: The proxy would have powers and duties similar to the "named person" under the 2003 Act. There would be a duty for health and social care providers to consult the Level 1 Guardian before making an intervention concerning the welfare or medical treatment of an adult who lacks capacity. This would be stronger than the present principle in that the duty would apply "unless it is impracticable to do so". If the Level 1 Guardian and the health and social care providers cannot agree on an intervention regarding the welfare or medical treatment of an adult who lacks capacity to make this decision, neither would have the legal authority under this provision of the Act to consent or refuse consent and resolution using another level of guardianship, or authority from other legislation, should be considered or used.

An application could be made to, and approved by, the local authority. It could be specified that these are directed to the Chief Social Work Officer whose responsibility for approving the application would remain, though the task of assessment would be delegated. The applicant would be required to have his/her suitability verified by a member of a prescribed class of professions ("passport signatory" type of person). There would not have to be a certificate of incapacity by a doctor. The Chief Social Work Officer would intimate the appointment to the adult and anyone known to be providing care for medical or welfare matters (or alternatively it could be the responsibility of the level 1 guardian to do this). Any challenge to the appointment from any person with an interest (including the adult) should result in the applicant for a Level 1 Guardianship having to consider an application for another level of guardianship. It could be made possible for anyone with an interest to put forward an application at one of the other two levels.

<u>Level 2:</u> This proxy would have powers and duties similar to the local authority under

section 13ZA. This would include: the authority to promote social welfare and make arrangements to provide or secure the provision of facilities as they may consider suitable; determining the services the adult would receive; making basic decisions about dress, diet, education, association, etc; and, may authorise the adult's place of residence or their medical treatment. It cannot be used if the adult resists, if there is dispute or if the adult would be deprived of their liberty or have it severely restricted.

The application would specify the powers sought and would include a medical certificate of incapacity and a report from a health or social care practitioner with qualifications/experience/training/knowledge of the adult and applicant as to the suitability of the applicant and the appropriateness of the powers sought. Supervision of the guardian would be set out in Regulations as at present. The level 2 guardian would be appointed by the Chief Social Work Officer who would require a report from a supervising officer on the use of the powers at intervals set out in Regulations. The local authority would investigate any complaint about the functions of the guardian. Challenges to the appointment, removal of authority, or making the authority subject to supervision may be remitted to the Sheriff in the form of an application for full welfare guardianship. Alternatively, the sheriff court can be given similar authority as it currently has in relation to welfare proxies under s 3 and 20 of the Act. The sheriff could be given the authority to change a level 2 guardianship to a level 3 guardianship at his own discretion.

<u>Level 3:</u> This would be used where it is believed that the powers sought, if implemented, would entail a deprivation or severe restriction of liberty of the adult or where there is a dispute as to the action needed in relation to welfare or treatment matters. It would be the only level of guardianship that requires court authorisation, under a process similar to the present guardianship application. Authority to consent or refuse consent, arguably, should require level 3 guardianship. Applications would continue to require two medical recommendations/reports and reports by an MHO on the necessity of level 3 powers and the suitability of the proposed guardian. There would remain a requirement on local authorities to take forward applications where necessary and no one else is doing so. It would still be possible to appoint the Chief Social Work Officer as welfare guardian. . This form of guardianship would require periodic judicial review to comply with human rights legislation. Supervision of the guardian and the visiting of the adult would remain local authority statutory duties as set out in Regulations.

Principles and Safeguards

The Principles of the Act would still apply to welfare guardianship at all levels. The existing protections that exist in the legislation such as sections 3, 9, 10, 14, and 20 would all be retained. Sections 57(2), 59(1) (b), 70 and 71 would only be retained in respect of level 3 guardianship.

We feel such a model would have the following benefits:

- **Promotes the rights of family and carers**
- **Reduction in court time**

- **Reduction in MHO duties**
- **Reduction in GP and Consultant Psychiatrist duties**
- **Reduces costs and complexity for private guardians**
- **Reduction in Legal Aid costs**
- **Simpler mechanisms for basic consultation and authorising decisions**

With such a change we would acknowledge there are certain potential drawbacks:

- **Loss of judicial scrutiny for level 1 and 2 cases.**
- **Ongoing problem of what constitutes "deprivation of liberty"**
- **More discussion needed on what powers can be exercised at which level of guardianship**
- **External scrutiny by the Mental Welfare Commission is lost, except for level 3 guardianship. (Arguably, this is where the Commission should concentrate its efforts).**
- **Increased cost for Level 1 and 2 applicants from what exists at present. There may be problems with payments for medical reports under Level 2 as no Legal Aid available. It may be possible to regulate the charges on these centrally.**

In examining how the present law is being used it is helpful to look at who is being placed on welfare guardianship. The breakdown of new orders in 2011/12 by the diagnosis causing the adult's impaired capacity was:

- **Dementia - 51%**
- **Learning Disability - 37%**
- **Acquired Brain Injury/Alcohol Related Brain Damage/Mental Illness – 11%**

Last year we visited 566 people on guardianship. Based on our experience of visiting people on guardianship over the years, we decided to focus more on people with certain diagnoses than others. This was because issues in relation to care and treatment not being in accordance with the Principles of the Act or, at times, the powers which had been granted, were more likely to occur, when they did, with people with Learning Disability, Acquired Brain Injury, Alcohol Related Brain Damage and Mental Illness. It is more often in these cases that disputes have arisen and concerns expressed in relation to the management of the adult's care and the way the guardianship was being managed – although this was still in a minority of cases. It is also in these cases that the adults are more able to express a view when they are dissatisfied. We adjusted the balance of the people we visited with this in mind. The breakdown of visits we undertook to people on guardianship in 2011/12 by the diagnosis causing the adult's impaired capacity was:

- **Learning Disability – 50%**
- **Dementia – 29%**
- **Acquired Brain Injury/Alcohol Related Brain Damage/Mental Illness – 19%**

In our visits to adults on welfare guardianship, one of the areas we explored was that of restrictions placed on the adults as part of their routine management. As we agree that the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance, the information we collected includes a number of situations where the restrictions would not likely have been considered a deprivation of liberty (for instance, allowing someone access to outdoor activities, travel and association with friends and/or relatives, but not being allowed off the unit unescorted because of concerns re safety). In looking at the above models it should be noted that out of these 566 visits to adults on welfare guardianship undertaken by the Commission in 2011/12, in only 28% of the cases did we observe that the adult was subject to one or more of the following restrictions:

- **Restraint (The use of physical means, including management of aggression techniques to control or restrict behavioural changes)**
- **Seclusion (The use of a person's bedroom or other identified area to isolate the person and prevent contact with peers as a means of managing significant behavioural changes)**
- **Use of CCTV**
- **Correspondence**
- **Freedom to leave residence unassisted (We did not consider that a locked door, in and of itself, represented a restriction on the person's liberty.)**
- **Other (specify)**

In only 5% of the visits undertaken did we feel that restrictions were being imposed without proper legal authority. The above does indicate, however, that even when we skew our visiting sample so that we are more likely to see people where there are significant restrictions placed on them in order to manage their care safely, this only amounted to 28% of the people we visited. This suggests that for the totality of all the orders granted, the percentage of those for whom restrictions are imposed or their liberty deprived would be considerably less.

Although we are aware of the contrary arguments and the decisions taken in *Muldoon* and *Docherty,* in our view this is persuasive evidence that the Act as it is being used at present is largely being used in situations where the adult is not being deprived of their liberty. In addition, our practitioners were asked to note those situations where there were concerns that the Principles of the AWI Act were not being adhered to. This was noted as a concern in relation to only 48 (8%) of those seen. In all cases where we had concerns, we followed these up with the guardian, the guardian's supervisor, the care provider and, at times, the care manager. In

some cases we scheduled return visits.

2. In addition, we would welcome information from consultees which could contribute to an assessment of the numbers of people with incapacity in Scotland who are cared for in residential facilities where they experience some restriction on their liberty.

Para 1.19)

Comments on question 2

We think that this starts from the wrong premise. The consultation document focuses on the implications of the Bournewood decision, and, as a result, does not address the fact that severe restrictions on the liberty of individuals, as well as the deprivation of their liberty, can take place in the community, in small domestic units, not just in residential facilities. It is important to look more widely at this group to get a more accurate impression of the potential implications of any legislative reform.

Estimates vary somewhat, with Alzheimer Scotland estimating there are approximately 27,000 people with dementia in care homes. It is also estimated that 18,000 have severe dementia, though many of these people will be cared for outwith care homes, often in their own or a relative's home. It is estimated there are approximately 120,000 people with learning disability in Scotland. The Government, in *Making the Right Move,* the policy document that preceded the AWI legislation, estimated that 20,000 of these people would have learning disability of such severity that they would be unable to manage their own affairs. Of the remaining 100,000, many will be affected to such a degree that they lack capacity to make key decisions or take key actions in respect of their care and support. One estimate is that there are at present approximately 2400 people with learning disability in care homes and over 5400 people with learning disability in supported accommodation. The Government estimated that there were approximately 20,000 people at any one time who have lost some or all capacity as a result of accident or illness. It is not clear whether this estimate included people affected by Alcohol Related Brain Damage which is acknowledged to be significantly under-reported.

There is no clear way of estimating how many people who lack capacity are currently being cared for on an informal basis in general hospitals though some intelligence may be gleaned from ISD reports.

What is clear, however, in looking at the above estimates, is that there are far more people for whom welfare guardianship could potentially be used than are currently on guardianship, and this is true across all the diagnostic categories causing the incapacity. No doubt a small percentage of these people will be having significant restrictions placed upon them as part of formal care and support plans. Others may have restrictions placed on them on an informal basis by families caring for a loved one who lacks capacity to care for themselves and make their own choices.

3. Do consultees have any observations on our summary of case-law from the European Court of Human Rights?

(Para 2.86)

Comments on question 3

No comment

4. Do consultees have any comments on the structure and/or operation of the Deprivation of Liberty Safeguards in England and Wales?

(Para 4.30)

Comments on question 4

From what we have learned from colleagues in England and Wales, we would echo the findings of the Mental Health Alliance, the Care Quality Commission, the Mental Health Lawyers Association and the research undertaken by the South London and Maudsley Foundation Trust as reported in paras 4.27, 4.28, 4.29 and 4.30 of the discussion paper.

5. Do consultees have any comments on our summary of English case-law?

(Para 4.64)

Comments on question 5

No comment

6. Do consultees have any comments on our discussion of comparative law?

(Para 5.58)

Comments on question 6

No comment

7. Do consultees agree that the present lack of clarity on deprivation of liberty in Scots incapacity law is unsatisfactory?

(Para 6.39)

Comments on question 7

We feel that the lack of clarity on deprivation of liberty is unsatisfactory. It has to be seen, however, within the context of general confusion and uncertainty as to when welfare guardianship should be used. As suggested above, we believe there is an argument that welfare guardianship powers should be sought and secured in cases where there is a likelihood of a deprivation of liberty or severe restrictions upon the liberty of an individual. If greater clarity could be achieved, probably best through focussing on this in the Code of Practice, it would be very helpful and would fit in well with what we are suggesting in terms of establishing graded forms of guardianship in which all cases where there is a perceived or potential deprivation of liberty would require Level 3, full welfare guardianship approved by the sheriff court. We feel, however, that guidance should also include circumstances where a person is having their liberty significantly restricted and/or deprived in community settings, not just in institutional care.

8. Would it be desirable for there to be greater specification in Scotland on what is to be regarded as deprivation of liberty, beyond a cross reference to Article 5?

(Para 6.41)

Comments on question 8

As stated above, this is best addressed in Codes of Practice. The circumstances of individual cases will vary so much that it would be difficult to set out either in the primary legislation or in Regulations. Professional judgement will always come into play and it is essential that this is informed by the issue being addressed in the Code of Practice. The Code of Practice for the Mental Capacity Act provides some good examples as outlined in para 4.6. There are, perhaps, other factors which could be further explored as well:

- **Sedation being used to prevent a person from leaving a hospital or care establishment**
- **Force being used to prevent a person from leaving a hospital or care establishment**
- **More than non-coercive insistence and direction being used in non-emergency situation to ensure that a resisting patient receives necessary treatment**
- **Denying freedom of movement and association of person within the hospital or care setting (use of seclusion).**
- **Curtailing communication with those outside the establishment by restricting or denying the ability to make or receive phone calls or to send or receive mail or e-mail.**

9. Should Scots law provide that there cannot be informal admission to a hospital for the treatment of mental disorder of people who lack the capacity to consent to that admission?

(Para 6.44)

Comments on question 9

We would strongly object to such a change in the legislation. This would be a significant departure from established law and practice which would be distressing for many relatives, confusing for some patients and very demanding on the time of MHOs, consultant psychiatrists, and the Mental Health Tribunal as well as creating a further demand on the Legal Aid budget - all without any tangible benefit for these adults. S 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003 offers a safeguard here in that it allows any person with an interest (including the Mental Welfare Commission) to apply to the Tribunal for an order requiring the managers of the hospital to cease to detain the patient where a person is being detained without the protection of the Act. A similar provision relating to people who it is felt are being detained in community facilities without the benefit of incapacity law would be helpful.

What is not addressed here is the question of admission of people to hospital for physical healthcare reasons who lack capacity to consent. There needs to be clarity as to the authority under which such care is provided. It would be helpful to examine the parameters of Part 5 of the Act re the nature of treatments allowed, the setting in which it is delivered and the arrangements for transporting adults to where the treatment is to be provided..

10. If so,

(a) should people who lack capacity be admitted to hospitals for the treatment of mental disorder using the mechanisms set out in the 2003 Act, or should their admission to hospital be authorised under incapacity legislation?

(b) what approach should be adopted to those who are already in hospitals on a long-term basis?

(Para 6.44)

Comments on question 10

N/A

11. Would there be benefit in a statutory provision to the effect that the family or carers of a person with incapacity who are willing and able to provide a home for that person should not be prevented from doing so?

(Para 6.51)

Comments on question 11

No. This is not necessary as it is addressed in the Principles which state both that the views of the nearest relative and primary carer of the adult have to be taken into consideration, any action taken has to benefit the adult and cannot be achieved any other way, and that the present and past wishes and feelings of the adult must be taken into consideration. It also assumes that families or carers always have the best interest of the adult with incapacity at heart. Sadly, with a small percentage of people, this will not be the case.

At present there would need to be a good reason – risk to an adult who lacked capacity to look after their own interests as a result of the actions or lack of action of family or carers, for example,- for the State to intervene and prevent the family from caring for the adult. It has occurred occasionally that families and local authorities have submitted competing applications when family members are assessed as not being suitable guardians. This issue would be best addressed by considering the creation of graded forms of guardianship as outlined above.

12. If so, should that provision be an additional principle in section 1 of the Act?

(Para 6.51)

Comments on question 12

No – the current principles should be sufficient although it might be helpful if more people were encouraged to write an advance directive so that in the event of their losing capacity their pre-existing wishes might be more easily determined, facilitating adherence to that aspect of the Principles of the legislation.

13. Do consultees agree that provision to the effect that certain measures do not constitute deprivation of liberty would be of assistance?

(Para 6.68)

It would be helpful for this to be addressed in the Code of Practice. Again, the Code of Practice for the Mental Capacity Act may offer some guidance here. The following, for example, could be discussed as factors which in and of themselves would not be likely to constitute a deprivation of liberty in most cases:

- **Restraint to prevent harm to a person who lacks capacity where this is proportionate to the likelihood and seriousness of the harm**
- **Preventing a person from leaving a care home or hospital unaccompanied because there is a risk that they would try to cross a road in a dangerous way**

- **A locked door on a ward or unit, in itself, is not as important as the ability of the adult to exercise a right of egress**
- **A temporary refusal to let a patient leave hospital or a care establishment without an escort for the purpose of safeguarding the patient, not the public**
- **Placing reasonable limitations on the visiting of the patient by relatives or carers**
- **Dissuading or distracting a confused patient/resident from attempting to leave the ward or unit, using non-coercive insistence and direction in non-emergency situations to ensure that a resisting patient receives necessary treatment**

14. If so, what should those measures be?

(Para 6.68)

Comments on question 14

See above

15. Should such provision be in legislation or in guidance?

(Para 6.68)

Comments on question 15

Guidance – preferably in Code of Practice

16. Would there be benefit in provision to the effect that deprivation of liberty occurs whenever the management of a facility exercise complete and effective control over the assessment, treatment, care, residence and movement of an adult?

(Para 6.70)

Comments on question 16

It would be helpful if not too prescriptive or definitive.

17. If so, should such a provision be in legislation or in guidance?

(Para 6.70)

Comments on question 17

Guidance-preferably the Code of Practice

18. Should Scots law define circumstances in which the consent of a substitute decision-maker would represent sufficient authorisation for an adult lacking capacity to be accommodated in conditions which would otherwise amount to deprivation of liberty?

(Para 6.74)

19. If so, what should those circumstances be?

(Para 6.74)

Comments on question 19

Again, there needs to be a thorough discussion in the Code of Practice regarding the factors to consider in determining whether someone is being deprived of their liberty or having it severely restricted. As stated above, we feel that such restrictions should only be possible when granted by the court. While we believe that the courts already have this authority and regularly exercise it, it would be helpful to address in the Code of Practice the types of specific powers that should be sought in applications when their use is anticipated. It is important to avoid the proxy believing they have implicit powers ,as can happen at present, especially when the interpretation of the wider scope of the powers results in action which severely restricts the rights of the individual.

20. Should there be circumstances in which such consent would not be sufficient?

(Para 6.74)

Comments on question 20

21. Do consultees consider that the Adults with Incapacity (Scotland) Act 2000 should make clear that an attorney acting under a welfare power of attorney has the power to deprive, or authorise others to deprive, an adult with incapacity of his or her liberty?

(Para 6.76)

Comments on question 21

No – this is too dangerous a step to take because it will always be too difficult to guard against and/or establish the existence of undue influence on the person granting the power of attorney. The Commission's investigation report *Powers of Attorney and their Safeguards* clearly showed how easy it is for those certifying a Power of Attorney to not be aware of the presence of undue influence upon the granter. It would be difficult to put in place sufficient safeguards as it is likely that they would often only be considered after the damage has been done. Take, for example, a hypothetical case where a woman has an abusive partner who gets her to persuade her mother to grant such a power of attorney and then is forced by her partner to use these powers to place her in a care home against her will. Her house may have been cleared and sold before anyone else with an interest, including the State, is aware of this and attempts to use the Act's safeguards to protect her.

The Commission is often contacted by relatives who learned of the existence of a Power of Attorney well after it had been granted by a family member to another family member and are concerned about how the powers are being used.

In addition, people change their mind. Relationships and circumstances change over the years. POAs granted years previously may be forgotten. They may have been granted to an ex-partner, for example.

One possible protection that could be introduced may be that the attorney be required to notify the OPG when it is anticipated that the welfare Power of Attorney will be enacted. This would then enable the OPG to notify the local authority of the welfare powers being used rather than when they are registered. There could also be a requirement that the attorney is required to notify anyone with an interest and that the names of those with an interest could be included on the form which is signed granting the Power of Attorney.

It has yet to be seen to what extent the increase in the granting of Powers of Attorney will impact upon the level of use of welfare guardianship. There is no doubt that it will have a moderating effect. And this may already be happening. Even though the growth in welfare guardianship applications and orders granted does not appear to have been slowed down, it may be that the growth would have been even greater had there not been such a large uptake of Powers of Attorney. Of course, we do not know how many of these POAs have actually been acted upon. What has to be considered, however, is that over 80% of POAs granted have been granted by people over the age of 70. In terms of welfare guardianship, in 2011/12 only 48% of the orders granted were in respect of people who were over 70. This would suggest that the likely impact will be mostly felt in respect of limiting the need for guardianship in relation to people with dementia - unless, the public's attitude toward and knowledge of Powers of Attorney changes and they are taken out at a much younger age. In respect of people with Learning Disability, Acquired Brain Injury and Alcohol Related Brain Damage it is unlikely that there will ever be a substantial increase in the granting of POAs by people with these conditions.

22. If so, should the existence of such a power depend on whether there is provision to that effect in the power of attorney document?

(Para 6.76)

Comments on question 22

N/A

23. If such a power can be conferred upon and exercised by a person acting under a power of attorney, what steps could be introduced to enable the adult to access prompt review of the deprivation by a Court, and periodic review thereafter?

(Para 6.76)

Comments on question 23

N/A

24. Do you agree that the Adults with Incapacity (Scotland) Act 2000 should be amended to provide that a guardian with welfare powers may deprive an adult of his or her liberty, or authorise another person to do so, if such a power is expressly conferred by the Court?

(Para 6.77)

Comments on question 24

As there seem to be differing opinions about this at present, it may be helpful to have this stipulated in legislation.

25. Do consultees agree that the existing provisions regarding intervention orders should be amended to provide for deprivation of liberty to be authorised by the Court, by a specific type of intervention order?

(Para 6.78)

Comments on question 25

We refer to the above comments on graded guardianship in response to Question 1.

26. What procedures and evidential requirements should apply to any new form of court order authorising deprivation of liberty for a person with incapacity?

(Para 6.81)

Comments on question 26

The same as exist at present in respect of guardianship applications with the added expectation that specific powers are sought for all anticipated significant restrictions on the liberty of the adult as well as anticipated deprivation of the adult's liberty.

27. Would there be benefit in a statutory provision entitling an adult or other persons acting on his or her behalf to apply to the sheriff court for an order requiring the managers of residential premises to cease unlawful detention of the adult?

(Para 6.83)

Comments on question 27

As stated above, something similar to S 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003 would be helpful – but not just in respect of adults in residential settings. This should apply wherever someone with incapacity is being deprived of their liberty in community settings.

General Comments

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Thank you for taking the time to respond to this Discussion Paper. Your comments are appreciated and will be taken into consideration when preparing a report containing our final recommendations.