Adults with Incapacity (Scotland) Act 2000 – Proposals for Reform
Scottish Government consultation

Response by Mental Welfare Commission for Scotland

April 2018

Consultation Questions

Chapter Three – restrictions on liberty

1. *Do you agree with the overall approach taken to address issues around significant restrictions on a person's liberty?*

   In particular we are suggesting that significant restrictions on liberty be defined as the following;

   - *The adult is under continuous supervision and control and is not free to leave the premises*
   - *Barriers are used to limit the adult to particular areas of premises*
   - *The adult's actions are controlled by physical force, the use of restraints, the administration of medication or close observation and surveillance*

   Do you agree with this approach? Please give reasons for your answers.

Generally no, although our answer greatly depends on what this definition is used for.

Firstly we assume the list is disjunctive – in other words only one of the bullet points needs to be satisfied - but this needs to be clear.

We raised a number of concerns in our response[1] to the similar question in the Scottish Government's consultation on the Scottish Law Commission *Report on Adults with Incapacity (Scot Law Com No 240)*, which are still relevant.

We refer to that response for full details but in summary, the definition is too mechanistic to capture significant 'objective' restrictions on liberty, and does not do enough to recognise 'subjective' restrictions – i.e. what the adult themselves feels about the restriction. We also suspect it would apply to almost everyone with learning disability or dementia in a care home, particularly as the SLC requirement that two out of the three factors needed to be met appears to have been dropped.

This definition had a particular role in the SLC proposals in their report, but the proposals in this paper are very different, and it is not obvious that the test should continue to be used.

It appears the main purpose of the test is to provide a threshold which would move a case from potentially a Grade 1 guardianship to Grade 2 or 3. We go on to argue that Grade 1 needs substantial revision, and this threshold would be less relevant in that event.

We certainly want to avoid any definition which has the inadvertent effect of broadening the impact of *Cheshire West* – i.e. requiring even more cases to be authorised by a judicial body, in the absence of any concerns about the decisions being made.

[1] https://www.mwcscot.org.uk/media/315711/sg_slc_awi_consultation_doc_216.pdf

Indeed, if we need a statutory definition relating to deprivation of liberty at all, it may be a narrower one to divide cases which fall within the *Cheshire West* 'acid test': between those which require a legal process which is adequate to satisfy Article 5 of ECHR, and those which require a more thorough judicial examination. We say more about this in our response to Chapter 7.

2. *Are there any other issues we need to consider here?*

It is not clear how the definition is meant to address dynamic situations – restraint or close observation may be a one-off or rare situation, and it is not clear how far it is intended that this requires prior judicial authorisation.

Any definition needs to be tested against its use in family as well as institutional settings. We are concerned to see evidence that the DOLS regime in England is increasingly being used where people are living in their family home. While of course, we need appropriate protection against abuse and ill-treatment in families, requiring anyone who cares for their severely disabled relative to go through a process of official authorisation is not the best way to do this.

Even where people in domestic settings are not subject to continuous supervision, questions arise as to whether actions require to be justified under AWI powers – an example would be locking a person in their home between visits by relatives and carers to avoid them leaving the house and getting lost.

Our reference above to the 'subjective' element raises a fundamental strand of our response to the whole paper – that reform should be directed at ensuring more respect is paid to the will and preferences of adults, whether or not they are capable. That requires less of a focus on determining whether the person is 'incapable', and a greater degree of concern for maximising their autonomy and involvement in decisions. Even if someone is incapable, or not fully capable, they have wishes, views and feelings which should be respected unless there is a compelling reason not to.

In the context of restrictions of liberty, the law should therefore be directed at establishing whether or not the person *assents* to the decision – in other words whether the decision reflects their will and preference, or the best interpretation thereof. Acting in a way inconsistent with will and preference is at least as important and deserving of safeguards as particular degrees of 'objective' restriction of liberty, so may require an additional level of scrutiny. In turn, this reinforces the need to establish what the person's will and preference are when making decisions.

Chapter Four – Principles of AWI legislation

3. *Do you agree that we need to amend the principles of the AWI legislation to reflect Article 12 of the UNCRPD?*

On balance, yes.

We recognise the difficulties with the s1 principles outlined in the *Three Jurisdictions report* of the Essex Autonomy Project[2] and generally endorse their recommendations.

However, we would enter two important caveats. In advising on the operation of the Act, our experience is that the current principles are extremely useful in identifying issues which must be considered and weighed. Changing these without explaining how this might change decisions may create confusion. And it is important to avoid creating an over-elaborate list of principles which suggests that people making interventions should apply a complex mechanistic algorithm to reach a 'correct' decision.

The primary concerns in relation to Article 12 have been the requirement to respect the rights, will and preference of the person, and to provide access to the support people require in exercising legal capacity. We recognise that both of these need to be given greater weight although, as we say later, the issue may be more about the application of the principles than their wording.

4. *Does our proposed new principle achieve that?*

To an extent, in relation to the requirement to support the adult to exercise legal capacity, but we believe it is problematic as drafted.

This is because it is not clear how it is intended to operate in the context of the Act, and if it has the same effect as the existing principles at s1(1) to (5). These assume incapacity has been established, and set out how interventions should be decided upon. This principle appears to be modelled on s1(4) of the Mental Capacity Act of Northern Ireland 2016, which is about how one determines capacity, not how makes an intervention.

In other words, if help and support will allow the person to make a decision, are we saying that the person is not in fact incapable, and so no intervention under the Act is authorised? If this is the aim, a qualification of s1(6) would seem to work better than a new principle.

The phrase 'unless it can be demonstrated' is also problematic. To whom must this be demonstrated? Wording similar to s1(2) would seem to work better ('unless the person responsible for authorising or effecting the intervention is satisfied').

[2] (2016) *Three Jurisdictions Report: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK*. Essex Autonomy Project: https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-3J-Final-Report-2016.pdf

5. *Is a further principle required to ensure an adult's will and preferences are not contravened unless it is necessary and proportionate to do so?*

We are broadly in favour of this suggestion as more closely reflecting the UNCRPD, and being more in line with an approach of support and empowerment. However it would be necessary to consider how it relates to s1(4)(a) – the requirement to take account of the present and past wishes and feelings of the adult, and s1(5) – the principle of maximising residual autonomy.

It will also be necessary to decide whether this principle has primacy over other principles.

We would caveat that a strongly worded principle may create legal uncertainty about when it is necessary and proportionate not to respect the adult's will and preference, and substantial guidance and training would be needed.

6. *Are there any other changes you consider may be required to the principles of the AWI legislation?*

Please give reasons for your answers.

Yes.

The precise wording of the principles is less important than the extent to which they are given effect, including in the processes of determining a person's powers. We do not believe the principles are always effectively applied in, for example, court processes and certification of incapacity by doctors. We note that some sheriff courts are increasingly taking an interest in what support has been given to establishing the will and preference of the adult, but a more fundamental shift to seeking to do this routinely for all interventions is required.

Also, the interventions which need to respect the principles generally happen in the exercise of powers, not at the time of appointment, so it is important to consider how to make these principles more likely to be observed. Too often guardians, care staff etc. don't know the principles exist or what they mean.

The suggestion by the EAP that there should be attributable duties to ensure the principles are applied is a helpful one, which needs to be supplemented by greater education and information for everyone who makes AWI interventions.

In anticipation of possible future unification, it is worth considering if any of the Millan principles in the Mental Health (Care and Treatment) (Scotland) Act 2003 should be adopted.

Chapter Five – Powers of attorney and official supporter

7. *Do you agree that there is a need to clarify the use of powers of attorney in situations that might give rise to restrictions on a person's liberty?*

Yes. As the consultation sets out, there is a lack of clarity on the extent to which attorneys can authorise deprivation of liberty and other restrictive interventions. This can lead on the one hand to unnecessary duplication of processes, expense and delay and, on the other hand, to highly intrusive or restrictive interventions being authorised which should be subject to proactive independent scrutiny.

7.1 If so, do you consider that the proposal for advance consent provisions will address the issue?
Please give reasons for your answers.

Not completely.

Firstly, it is not clear at this stage what safeguards are envisaged (e.g. what 'specific wording' is proposed, and what 'criteria' must be met, and how the 'regular reviews' would be conducted).

We would be hesitant in placing too much store on 'specific wording' in relation to more serious interventions. In recent years, solicitors have drafted increasingly complex and all-encompassing powers of attorney explicitly authorising a wide range of interventions, recognising that these may breach ECHR, and nonetheless purportedly authorising them. We are not convinced that granters routinely consider whether these conditions apply to the likely situations they may experience in future.

This issue is one that arises frequently, and we have recently issued an advice note summarising our view[3].

We are sympathetic to the argument that a person holding a power of attorney which explicitly authorises them to agree to a residential care placement might be dismayed to be told that they must nonetheless seek guardianship or an intervention order, especially if an appropriate placement is delayed as a consequence.

Assuming ECHR Article 5 issues can be overcome, we believe it should be possible for someone granting a power of attorney explicitly to authorise a placement in a residential care home, even if the nature of the placement might constitute a deprivation of liberty in terms of the *Cheshire West* test.

On the other hand, we do not believe that a power of attorney should allow completely unfettered discretion to authorise any form of restrictive intervention. Some interventions (e.g. seclusion, repeated and significant restraint) should require judicial authorisation. Also, we do not believe a power of attorney should be enough to allow an adult to be moved

[3] https://www.mwcscot.org.uk/media/395908/poa_restrictions_liberty.pdf

against their will or to overcome their persistent resistance to a significant restriction of liberty.

As with guardianship, there should be a threshold which should require escalation to a judicial process. Subject to that, it may be reasonable to create a presumption that a validly created power of attorney generally expresses the will and preference of the adult and should be given effect unless to do so would be inconsistent with the principles of the legislation.

We agree that new review procedures should be developed, although they should apply generally, not only to the proposed new advance consent conditions. We frequently advise in disputes that an interested party can refer the issue to the sheriff, under s20 or s3. Our impression is that this is rarely done. If the forum moves to the tribunal, it may be possible to create a more accessible form of supervision and review in cases where difficulties arise.

The alternative route where disputes arise on welfare issues is investigation by local authorities under s10, which may lead to a local authority application for guardianship. This is a fallback for very serious problems, but is not quick, and local authorities do not have the capacity to arbitrate in the family disputes which frequently arise.

We suggest that a more accessible review power by the tribunal should be supported with a formal mediation scheme which seeks to resolve disputes between family members, and between attorneys and public bodies.

This should be supplemented by more support and consultation when powers of attorney are created. Currently this can be done without the knowledge of other family members, and attorneys may assume powers without others who have an interest in the adult being informed.

More broadly, we suggest that improvements to the power of attorney provisions in AWI should be taken forward in the context of creating a more streamlined, integrated and accessible approach to anticipatory care planning, looking at their place alongside advance treatment decisions, appointments of named persons and advance statements in mental health, end of life care etc.

8. *Is there a need to clarify how and when a power of attorney should be activated?*

Yes. While we understand the desire for convenience and speed, we do not think it is appropriate or safe that powers which depend on incapacity can be taken simply on the basis that the attorney has decided the person is no longer capable of making decisions.

As we discuss later, we favour a form of supported or co-decision making which would allow a person to have some authority to support a person in decisions prior to incapacity. Since this does not depend on a finding of incapacity, the commencement of this power could be immediate or based on a more flexible range of circumstances.

8.1 If you have answered yes and have views on how this should be done, please comment here.

We favour certification of incapacity by a medical practitioner, or other professionals who may be authorised to certify incapacity in an application for guardianship. Consideration would need to be given to whether a fee should be paid out of public funds, since this will still be much cheaper than pursuing guardianship.

In line with the principle that incapacity is decision specific, it may also be necessary for the certification to specify what decisions the adult should no longer take on their own behalf.

9. Do you think there would be value in creating a role of official supporter?

Yes, with caveats.

We generally agree that the Act needs to give greater recognition to a more flexible notion of supported decision making, rather than the unhelpful binary model of a supporter having no authority prior to incapacity then full authority after incapacity. However, it is important not to make the range of options unduly complex, with multiple overlapping types of supporter or guardian.

The recent experience of the Mental Health (Scotland) Act 2015, which has added 'listed initiators' to named persons and other people with various rights of participation demonstrates the difficulties which can arise.

A better approach may be to make powers of attorney and guardianship more flexible and better integrated, so that an adult can authorise others to provide them support whether or not incapable, up to and including making decisions on their behalf once incapable. This should sit alongside a procedure whereby an adult who cannot make such an appointment can have such support.

Currently in welfare matters, it is hard for an adult to grant clear authority to authorise a supporter or co-decision maker, since welfare powers explicitly depend on incapacity.

There is some precedent in financial issues where an attorney can act on behalf of an adult while the adult is capable, but even there it could still be helpful to articulate more clearly what a supporter or co-decision maker would do.

The basic powers a supporter would need are around access to information, the right to participate in discussions and meetings, and the authority to ensure that any decision-making procedures include adequate support to maximise the autonomy of the adult.

Models have been established in other countries which should be reviewed, including the Decision-making assistant in Ireland. We also believe the model being proposed by People First holds promise, although we recognise that they advocate this as a replacement for substitute decision making, not to sit alongside it.

To date, the international models have not been extensively used or fully validated, so we believe the legislation should allow for a flexible process of experimentation and development.

9.1 If you have answered yes, please give us your views on how an official supporter might be appointed.

By the adult in a simple process, preferably as part of an integrated anticipatory care approach. As we discuss in responding to chapter 7, this should be combined with an alternative by which a person could be authorised to act in this role where the adult is not able explicitly to grant the power – a version of G1 guardianship.

10. Countries that have created a role of supported decision maker have used different names, such as supportive attorney in Australia, or a 'Godman' in Sweden, meaning custodian. We have suggested 'official supporter' Do you think this is the right term or is another term preferred?

No, we do not think this is the right term. 'Official' implies holding some kind of public office or appointment, when the role is one that would normally be chosen by the adult and would be a relative or trusted friend or adviser. 'Nominated supporter' would be better, or simply 'supporter' or 'co-decision-maker'. The analogous procedure for a modified form of Grade 1 guardianship might be an 'authorised' or 'registered' supporter.

Chapter Six - Capacity Assessments

11. Should we give consideration to extending the range of professionals who can carry out capacity assessments for the purposes of guardianship orders?

Yes.

11.1 If you answered yes, can you please suggest which professionals should be considered for this purpose?

Appropriately qualified psychologists. Many of the formal tools for assessing decision making ability, particularly in people with long term conditions, have been developed by psychologists and they can potentially offer detailed and evidence-based assessments.

Although not asked, we believe this could also apply to certifying capacity when granting powers of attorney (and certifying incapacity where required to trigger powers), and potentially certifying whether appropriate supports have been given.

Chapter Seven – Graded Guardianship

12. Do you agree with the proposal for a 3 grade guardianship system? Please give reasons for your answer.

We generally support the idea of a flexible and integrated system with tiered levels of intervention which are appropriate to the complexity and significance of the issues involved.

Current AWI processes are over-bureaucratic and do not lend themselves to timeous action responsive to need.

However, we believe the proposals as drafted require significant modification, for reasons set out below.

Before suggesting exactly how the new system should operate, we believe it is important to set out the guiding principles which should inform its design. Many of these are set out at pages 51-52 of our publication with Edinburgh Napier University *Scotland's Mental Health and Capacity Law: the Case for Reform*[4], including that the system should have simple solutions for common problems, and not expect an unreasonable level of sophistication from non-professionals.

In general, we believe that it ought to be possible for an adult with a significant learning disability or dementia to live an ordinary life in the community, particularly in a domestic setting, without this having to be authorised by a judicial process.

Informal care should often be just that. Judicial authorisation should be for situations where there is a reason to be concerned that the person's needs are not being met, their rights (including respect for their will and preference) are not being upheld, or there is a substantial dispute. Alongside judicial processes, there should be robust safeguards to protect vulnerable adults from abuse or ill-treatment, whether or not they lack capacity.

We also believe that it should be possible for an adult to live in supported accommodation, or for a self-directed support package to be established, without a judicial process. We do not believe that grade 1 as drafted is the right way to achieve this, but that should be an outcome of reforms.

Inevitably, relatives and carers will be supporting adults with impairments in making choices on a range of issues, without necessarily having been independently authorised to do so. In some cases, that support will necessarily involve making a decision for the person.

While we understand why it might be felt desirable to regulate that through a formal process such as guardianship, our experience of the AWI Act has been that it currently incentivise the taking of more powers than are necessary. It is also a cumbersome mechanism to resolve disputes, although there is benefit in having the court to resolve serious issues.

[4] https://www.mwcscot.org.uk/media/371023/scotland_s_mental_health_and_capacity_law.pdf

We should also seek to avoid a 'DOLS' scenario of numerous formal assessments taking place which duplicate care planning, and do little to improve care and treatment in the great majority of cases.

13. *Our intention at grade 1 is to create a system that is easy to use and provides enough flexibility to cover a wide range of situations with appropriate safeguards. Do you think the proposal achieves this? Please give reasons for your answer.*

No. We believe this requires significant modification, particularly with respect to the powers which are proposed. Our view is that these are too wide.

An administrative process of registration, if introduced, should be restricted to basic management of simple financial affairs, and welfare powers which would allow the applicant to provide support in decision making – e.g. the right to access records, attend meetings and be consulted before major decisions affecting the adult's welfare are taken.

Also, it should be possible for the registered supporter to help to implement a decision the adult has made – for example if the adult wants to live in a supported tenancy but cannot sign a tenancy agreement, the supporter could sign the necessary documentation. This is not the same as deciding where the person should live, and is a practical way of giving effect to the aims of Article 12 of the UNCRPD.

This range of powers would be similar to the welfare powers that might apply to a modified version of the official supporter proposal.

There should be no power at this level to override the will and preference of the adult.

We also have concerns about the process. It is hard to imagine that applicants completing this form would do anything other than seek all the powers which are available.

We agree that a social worker rather than an MHO would be appropriate to prepare the report. Increasingly MHOs do not have client caseloads, and this change would allow a social worker who is working with the adult to prepare the report as part of the wider care planning process.

We agree with the proposed maximum three year duration.

14. *Are the powers available at each grade appropriate for the level of scrutiny given?*

For Grade 1, no – see previous response. We broadly agree with the division between Grades 2 and 3, although we set out below some proposed changes to the requirements for Grade 3.

However, we not believe the proposals have resolved how to give effect to the stated intention that any powers which do not reflect the will and preference of the adult should only be considered at Grade 3. The decision in a guardianship case concerns who is authorised to take decisions, not what the decisions are. The decisions are often taken at a later date, and may not be fully considered at the time of appointment.

The same issue arises with the proposal to require a medical report at G2 or G3 if changes result in significant restrictions on liberty. We are also not sure why a medical report is appropriate in respect of aspects of a care regime.

It may be the intention that guardianship applications will be more tailored to the current situation of the adult and authorise specific named interventions or placement, but this would risk requiring further applications should the adult's situation change in future.

Nor do the proposals make clear how the judicial body is to be made aware of the will and preference of the adult, in cases where the adult has not sought to be represented. We believe this should be explicitly addressed in the social work/MHO report.

15. *We are suggesting that there is a financial threshold for Grade 1 guardianships to be set by regulations. Do you have views on what level this should be set at? For example the Public Guardian requires that financial guardians have to seek financial advice on the management of the adult's estate where the level is above £50,000. Would this be an appropriate level, or should it be higher or lower?*

We believe that Grade 1 should only grant sufficient powers to manage basic finances similar to those authorised by the current Access to Funds regime.

We suggest that the detail can be left to regulations rather than the primary legislation. Regulations should not focus only on the level of funds but the complexity of activity required to manage the adult's funds.

16. *We are proposing that at every grade of application, if a party to the application requests a hearing, one should take place. Do you agree with this? Please give reasons for your answer.*

Yes. We also believe it should be more common, if not universal, for the judicial body at the Grade 3 level, to meet the adult.

In situations where a case has been referred to a hearing, it should be possible for it to focus only on those areas which have led to the hearing, rather than have to prove all the facts of the case. As a practical example, if there is no dispute about the medical evidence of the person's level of impairment, a doctor should not have to be called to give evidence.

17. *We have listed the parties that the court rules say should receive a copy of the application. One of these is 'any other person directed by the Sheriff'. What level of interest do you think should be required to be an interested party in a case?*

Significant and current involvement with the adult.

18. *We have categorised grade 3 cases as those where there is some disagreement between interested parties about the application. There are some cases where all parties agree, however there is a severe restriction on the adult's liberty. For instance very isolated and low stimulus care settings for people with autism, or regular use of restraint and seclusion for people with challenging behaviour. Do you think it is enough to rely on the decision of the Sheriff/tribunal at grade 2 (including a decision to refer to grade 3) or should these cases automatically be at grade 3?*

We do not agree that grade 3 is only for cases where there is disagreement. Certain particularly intrusive powers should be specified as requiring a hearing at grade 3, although it may be acceptable for the powers to be authorised on a temporary basis at a paper hearing, pending the full determination. This includes the kind of powers cited in the paper.

Other examples might be power to forcibly return an adult, power to restrict contact with relatives or people with whom the adult may wish to have a relationship, power to search for or confiscate otherwise legal items such as alcohol, and powers to monitor or restrict social media.

Not all of this need be specified in primary legislation – the provisions could be added to or amended by regulations or by the judicial body in the light of experience.

In addition, there should be a broad discretion of the judicial body to raise the case to grade 3 whenever they feel it is appropriate.

19. *Please add any further comments you may have on the graded guardianship proposals.*

No question has been asked on the proposal at pages 45-46 to extend the category of those appointed as guardians to include organisations. We do not rule this out completely, but it raises a number of very serious issues of principle. We have concerns about private organisations who are providing or charging for care also being guardians because of the conflicts of interest, and we are unclear what roles are envisaged for the Care Inspectorate and Mental Welfare Commission.

20. *Do you think our proposals make movement up and down the grades sufficiently straightforward and accessible? Please give reasons for your answer.*

Generally yes. However, if our suggestion that a reformulated Grade 1 should be registered with the tribunal rather than the OPG is accepted, this might further assist with ease of movement.

21. *Do you agree with our proposal to amalgamate intervention orders into graded guardianships? Please give reasons for your answers.*

On balance, yes. Often there is a lack of clarity about whether to apply for an Intervention Order or Guardianship Order, and we recognise the concerns about Intervention Orders

which may run for significant periods of time. We agree there should be equivalent scrutiny for both. However, we do not always know how Intervention Orders are used, so more examination of current practice may be needed.

22. *Do you agree with the proposal to repeal Access to Funds provisions in favour of graded guardianship? Please give reasons for your answer.*

Yes. The current system is little used, and should be part of a redesigned framework for guardianship.

23. *Do you agree with the proposal to repeal the Management of Residents' Finances scheme?*

    23.1 If so, do you agree with our approach to amalgamate Management of Residents' Finances into Graded Guardianship?

    Please give reasons for your answer.

Yes. Again, this system has not been used to the anticipated extent and should be part of a redesigned framework. But more detailed work will be needed, particularly to consider issues of conflict of interest. As above, we have serious concerns about the suggestion that care homes should have guardianship powers in order to collect their own fees, and this requires further scrutiny.

Chapter Eight – Forum for guardians

24. Do you think that using OPG is the right level of authorisation for simpler guardianship cases at grade 1? Please give reasons for your answer.

As above, we do not believe administrative authorisation is appropriate for the wide range of powers proposed at G1. We support a simple process of registration supported by evidence for the powers necessary to support the adult in decision making on medical and welfare issues, and perhaps for some simple financial powers. However, our preferred model would be for the judicial body to authorise G1 appointments via an administrative process with judicial supervision where indicated. This would be better in ECHR terms, would facilitate cases moving up and down the grades, and would reduce potential conflicts for the OPG in a dual role of both approving people and then regulating them.

25. Which of the following options do you think would be the appropriate approach for cases under the AWI legislation?

a. Office of the Public Guardian considering grade 1 applications, a Sheriff in chambers considering grade 2 applications on the basis of documents received, then a Sheriff conducting a hearing for grade 3 applications.

Or

b. Office of the Public Guardian considering grade 1 applications, with a legal member of the Mental Health Tribunal for Scotland considering grade 2 applications on the basis of the documents received, then a 3 member Mental Health Tribunal hearing grade 3 applications.

Please give reasons for your answer.

See our comments above regarding G1 applications. As to the appropriate forum, we favour the tribunal, for reasons more fully set out in *'Scotland's Mental Health and Capacity Law: the Case for Reform'*, namely

- The 'one-stop' approach for mental health and incapacity cases would help develop consistent approach to common issues, reduce potential conflict between forums on areas of overlapping jurisdiction (e.g. treatment for mental disorder in community settings, use of restraint and return to hospital, new powers proposed in Chapter 12), and assist with the ultimate goal of an integrated legal regime
- Tribunals are generally more informal and accessible, with specialist expertise and training
- We want to see greater involvement of the adult in hearings, and this would be hard to achieve where AWI cases are part of general court business
- The tribunal can adopt a flexible approach to suit the case, deploying between one and three members and with shrieval members for particularly complex or significant decisions
- The national framework allows for development of common approaches across Scotland and for cases of significance to influence practice in other hearings

- The tribunal is better placed to act in the role of periodic review and some degree of supervision of cases – issues generally will not be legal disputes but applying the principles of the Act to complex and dynamic circumstances.

26. *Please also give your views on the level of scrutiny suggested for each grade of guardianship application.*

See responses above, particularly that we think the tribunal rather than the OPG should scrutinise Grade 1.

27. *If you have any further comments on the proposals for the forum, please add them here.*

Although we favour the tribunal, we suspect that either a tribunal model or a more UNCPRD compliant sheriff court is likely to be more expensive than the current processing of cases in sheriff courts, unless the overall reforms reduce the number of cases which require full judicial hearing.

Chapter Nine – Supervision and support for guardians

28. Is there a need to change the way guardianships are supervised?

28.1 If your answer is yes, please give your views on our proposal to develop a model of joint working between the OPG, Mental Welfare Commission and local authorities to take forward changes in supervision of guardianships.

Yes, although many of the changes may be around practice and resourcing, rather than legislation. There are a number of issues which we discuss below:

How much supervision should there be?
Supervision could and should be improved – the current level of supervision is much less than at the commencement of AWI.

We cannot go back to that level of supervision for all cases. Many private guardians need little or no active supervision. The Act requires local authorities to allocate supervisors in every case in a way which does not reflect priorities of social work allocation or needs of guardians. Most guardians we have spoken to say they rarely if ever see their supervisor, but few feel this is important.

We refer again to the guiding principles in our Law Reform report – most people are honest and want to do well, so 'supervision' needs to be proportionate and directed at support rather than monitoring, unless there is reason to be concerned.

Risk based approach?
We agree with a risk-based approach, subject to improved support and guidance being available to all who want it. As set out above, we support a substantial recasting of powers granted at G1 which in those cases could greatly reduce the need for formal supervision.

At G2/3, we agree that the social worker writing the report for those grades should consider the need for active supervision based on specified criteria, with the level of supervision set by the court/tribunal. However, the system needs to recognise the dynamic nature of guardianship – supervising bodies need to be able to increase or reduce the amount of supervision to reflect changes in circumstances.

Who should supervise?
We already work closely with OPG but would support more formalised steps to share information. Subject to resourcing, MWC would wish to continue visiting at least as many people subject to guardianship as we do now (around 350 a year) and a more formalised risk-based approach would assist with targeting. This could be combined with thematic visits to identify issues arising for particular groups.

We believe it is important to retain a local authority role in supervision of guardian, because of the connection to the authority's responsibility to assess care needs and the Adult Support and Protection function.

There may need to be more to be done in cases where there is concern that the local authority role as welfare guardian or supervisor, and possibly even the MHO role, may be unduly influenced by the council's own policies or priorities, or a difficult relationship with the family. The MWC can and does intervene in such cases, but it can be difficult to know how to balance our role against the oversight of the court.

In order to provide greater reassurance that MHOs always have the appropriate skills and independence, we believe more needs to be done to develop their standing and role, for example reinvigorating the MHO network and reviewing the guidance for MHOs.

Powers of attorney

While it may be impractical to expect the same degree of supervision for the thousands of welfare attorneys, we believe there should be a greater degree of consistency between the two forms of proxy decision maker.

28.2 If you consider an alternative approach would be preferable, please comment in full.

An argument could be made for reform of the supervisory regime to bring OPG and MWC together into a single supervisory body. This would require a substantial review in its own right. Consideration of this option might be appropriate if and when proposals are developed for a unified regime for adults with incapacity, mental health and adult support and protection.

Particularly if the forum moves to a tribunal, we would be interested in exploring the idea of a streamlined system of supervision which would allow concerns to be reviewed by the supervisory bodies (OPG, MWC) with a reporting relationship to the tribunal, who could then determine if action was needed.

Absent that, most improvements are likely to be non-legislative – about better co-ordination and better resourcing, including resourcing to provide support and advice to current/prospective guardians, attorneys or supporters.

Not discussed is the substantial overlap with Adult Support and Protection – that would benefit from review.

29. What sort of advice and support should be provided for guardians?

We outline this in our document *Supervising and Supporting Welfare Guardians*[5]. Much of the material is old and formats may be outdated. It would be helpful to provide detailed online advice and guidance in an interactive, user-friendly format.

30. Do you have views on who might be best placed to provide this support and advice?

Please give reasons for your answers

[5] https://www.mwcscot.org.uk/media/51862/Supporting__Welfare_guardians.pdf

Most private welfare guardians (who need support or supervision) do not need advice or support regarding their role as welfare guardian. They need advice and support on how to obtain resources and best care for the adult for whom they are the guardian. Ongoing advice and support of this nature must be available through their local authority or signposted by them.

Some guardians would benefit from advice and support about their role as guardian. If for instance, they are putting their own needs and wishes before that of the adult, or wanted to exercise powers in areas where the adult could adequately make choices for themselves, it would be beneficial for someone locally in the structured role of supervisor to be able to step in and guide them on how to follow the principles. This requires skill and time to build up a relationship, which may be best done by a local authority social worker.

In complex cases, the Commission is well placed to provide advice to local authorities, guardians, the adult, and care providers.

There is also an important role for advocacy to support the adult and in some cases to support the guardian in respect of their dealings with public agencies.

There would be value in some form of peer support for welfare guardians. This would probably require some initial funding and organisational support at the national level.

If resourced, the MWC would be happy to take on responsibility for or assist with developing more online support and guidance materials for guardians.

31. *Do you think there is a need to provide support for attorneys to assist them in carrying out their role?*

    31.1 If you answered yes, what sort of support do you think would be helpful?

Yes. In general, they would benefit from the same support as guardians. Indeed, since an attorney may take powers many years after they were appointed, and they may have had little advice at that time, more support may be needed to ensure they understand their role and how best to assist the adult.

Chapter Ten – Order for cessation of residential placement, short term placement order

32. Do you agree that an order for the cessation of a residential placement or restrictive arrangements is required in the AWI legislation?

32.1 If so does the proposal cover all the necessary matters?

Yes, for the reasons set out in our response to the *Consultation on the SLC report on Adults with Incapacity.*

Additional matters which should be addressed include:

- Who can apply for the order. We assume the adult, and any person with an interest
- The interaction with s291 of the 2003 Act. In particular, s291 only applies where a person is being treated in hospital 'for mental disorder'. Since the new proposal only applies to registered care settings, this would seem to leave a gap where the adult is in hospital receiving treatment for a physical condition. We believe the adult should be able to apply for detention in hospital (which has not been properly authorised by the new procedure proposed at Chapter 12) to be ended
- Measures authorised by the Adult Support and Protection Act (and possibly other legislation, such as public health legislation) may also need to be excluded from the scope of the new power
- It is not clear why this proposal only applies in care homes and 'adult placement services'. Although it may be unlikely that de facto detention will happen in other settings, it is not impossible.
- Whether the court/tribunal can prevent significant restrictions of liberty which are not currently in place but may happen in future (e.g. some forms of restraint)
- There may need to be provision for how often applications can be made in a specified period, or power for the court/tribunal to specify a time limit before a further application can be made, to prevent multiple or vexatious applications
- The court/tribunal should be able to specify what alternative measures (which may include restrictions of liberty) would be authorised, or require a guardianship application to be submitted within a specified period
- Non means-tested legal aid should be available (although we would accept a merits test being applied).

We suggest there should be a single statutory procedure to challenge unauthorised detention/significant restriction of liberty, merging s291 and this proposal. The MWC should be able to refer a case of potential de facto detention to the judicial body for consideration.

The process should be at least as simple and quick as the s291 process – which involves a downloadable form, with a hearing within 5 days.

The bullet points suggest that a condition of making the proposed order is that there is no capacity on the part of the adult to consent. We do not believe incapacity should need to be established. It should be possible for someone who may have some degree of capacity to challenge restrictions of liberty under which they have been placed. See our response to the Consultation on the SLC report for further details.

33. Do you agree that there is a need for a short-term placement order within the AWI legislation?

Yes. We have long argued for some form or emergency power in relation to welfare decisions where it would take too long for an AWI application to be put together with all supporting evidence and be heard by the sheriff.

33.1 If you agree, does the above approach seem correct or are there alternative steps we should take? Please comment as appropriate.

Consideration should be given to an alternative approach involving an application to the judicial body for an emergency order. The order could be made at a paper hearing if the judicial body were satisfied with the evidence provided. We suspect this would not take any longer than convening a full case conference with MHO attendance and arriving at a decision. This would also ensure there has been some independent oversight of the decision, which will in many cases become a permanent change, and that the decision is genuinely being taken for the benefit of the adult, and not to address other issues, such as pressures on beds. It would also make it clear precisely who is taking the decision, which may not be obvious in a case conference.

The points below apply both to the proposal and our suggested alternative.

It is not clear who is to arrange the independent medical assessment, or what is meant by 'independent' in this context. If one is appropriate, this might be a role for Commission appointed designated medical practitioners, although we are not sure that a doctor is the professional best placed to assess that restrictions of liberty are necessary in an emergency. The key issues are proper risk assessment, and taking any urgent decision in the context of an appropriate plan for the longer term.

It is essential that independent advocacy is fully involved in the process, including participation in any meetings where the move may be authorised. The adult and informal carers or close relatives should also be entitled to participate in these meetings.

The third bullet on p61 suggests that this power is only felt necessary where a *Cheshire West* deprivation of liberty is in prospect. Further consideration may need to be given to other measures which may amount to a significant restriction of liberty, if that concept is retained.

We presume that this procedure could not be used to overcome the refusal of a guardian or attorney to consent to a placement, but this needs to be set out.

Our experience of the transfer provisions in the Mental Health (Care and Treatment) Act suggests that great care needs to be taken regarding time limits for appeals. It is generally desirable that a move should not take place until any objection has been heard but not that an urgent move to which there is no objection should be held up pending a non-existent appeal.

Further consideration is needed as to any overlap with Adult Support and Protection powers.

34. Do you consider that there remains a need for section 13ZA of the Social Work (Scotland) Act 1968 in light of the proposed changes to the AWI legislation?

On balance, yes.

34.1 If you answered yes, should the section remain in its current form or are changes required to, for example, restrict its use to the provision of care services with the exception of residential accommodation? Please give reasons for your answers.

It is not clear why it is felt that s13ZA may no longer be needed or why residential accommodation should be excluded. The new proposals are designed to address situations where there is a significant restriction of liberty. Section 13ZA is not intended to cover deprivation of liberty, but simply to make clear that informal care arrangements which do not amount to a deprivation of liberty may be provided by a local authority, notwithstanding the inability of the adult to consent to them. The new procedures would not, then, seem to replace s13ZA.

This section reflects a principle which, if anything, we believe needs greater emphasis in the legislation – that it should not normally be necessary to receive judicial authorisation in order to provide care and support for an adult with impaired decision-making ability, whether as a relative, informal or paid carer or statutory body. Abolishing s13ZA risks creating an impression that formal authorisation is always necessary.

However, we have come across poor practice in the use of s13ZA – for example where local authorities use it to justify a placement which is not supported by all interested parties. We would like to discuss what greater safeguards may be appropriate – whether stronger requirements to adhere to the principles of the legislation and guidance, better reporting and auditing, or stronger powers for the MWC to oversee the use of these provisions.

Chapter Eleven – Advance directives

35. *Should there be clear legislative provision for advance directives in Scotland or should we continue to rely on common law and the principles of the AWI Act to ensure peoples' views are taken account of?*

The extent to which advance directives should be binding raises many complex and controversial issues, so it is perhaps unsurprising that the decision was taken in 2000 to leave this to the common law. It is difficult in primary legislation fully to capture the factors which may make it appropriate, for example, to override an advance directive but, on balance, we believe it is time for this to be addressed in primary legislation.

Reasons for legislation include:

- The common law is not clear. Although guidance may have been developed, it is difficult for doctors to know how far they can rely on this, and for those wishing to make an advance directive to know what effect it will have and what it needs to say
- There has been minimal development of case law in Scotland, suggesting that it is not appropriate to leave the courts to establish a coherent framework which fits the current ethical consensus.
- The inclusion of provision regarding Advance Decisions to Refuse Treatment in the Mental Capacity Act suggests that it is possible to legislate in this area
- The strong emphasis in current policy on empowering patients, Realistic Medicine and anticipatory care planning - a legal framework for advance directives would support this

Also, we believe it is problematic to suggest we should rely on common law and the principles of AWI – if a decision is taken under common law, it is presumably not an intervention under AWI so the principles would not apply.

36. *If we do make legislative provision for advance directives, is the AWI Act the appropriate place?*
Please give reasons for your answers.

Yes. Which legislative vehicle should be used is a second order question but generally it makes sense to be part of general framework for decision making for impaired or incapable adults. This would bring in the principles of AWI, and potentially some of the existing Part 5 framework could be applied.

Our only caveat is that some provision may need to be made in respect of children – it will need to be clear whether a capable child can make such a directive.

More ambitiously, this could be an opportunity to begin to develop a coherent anticipatory care framework, linking power of attorney, treatment decisions, and connections to advance statements and named persons in the Mental Health (Care and Treatment) Act.

Chapter Twelve – Adjustments to authorisation for medical treatment

37. Do you agree that the existing s.47 should be enhanced and integrated into a single form?

Yes.

We set out below a detailed proposal, which draws on but is somewhat different from the model outlined. However, we stress that this is one which we have not consulted on externally. Whichever model is developed, it is vital that there is extensive consultation, including with medical professionals who do not specialise in mental disorder but may have large numbers of patients who are incapable – including practitioners in emergency medicine, intensive care, old age and palliative care.

Our proposal

There should be a first part of the s47 certificate for treatment, and a second part for detention in hospital for treatment for a physical condition. We refer to these as s47 Part 1 and Part 2 below.

In principle, S47(7)(c) should continue to apply. S47(7)(c) seeks to ensure that the AWI cannot be used for treatment of mental disorder against the will of the patient. The Mental Health Act should be used for this. However, it is often difficult to distinguish between the two in cases such as delirium, and further work is needed on how to manage this.

The consultation's proposed grounds for the patient's detention in hospital are that the decision is in accordance with the principles of the AWI. This means the measures must be necessary for the treatment or assessment to be carried out and must be the least restrictive way of ensuring that it is undertaken, and that past and present views have been considered, so far as possible.

The doctor should certify that grounds are met for the patient's detention in hospital to receive one or more of the medical treatment(s) authorised on the s47 certificate. These should include:

- that the medical treatment is necessary
- if the adult did not receive this in hospital there would be a significant risk to their health
- there is no less restrictive alternative for the provision of the treatment.

The s47 Part 2 certificate could be completed by a FY1 doctor, subject to adoption of the further certification/review processes suggested below.

A possible addition could be for detention for treatment for physical disorder to be authorised by advanced nurse practitioners in some hospitals. Training and qualification for this could be added to the training course for completion of s47 certificates by non-medical practitioners.

The doctor who is granting the Part 2 certificate should consult with relatives and others in line with the principles. The certificate should not hold authority if the doctor does not consult a welfare proxy with powers to make decisions about medical treatment if they know of the existence of the proxy and it would have been practicable for them to do consult them. If it is not practicable for doctor to consult any welfare proxy before granting the certificate, they should do so as soon as practicable afterwards.

Access to advocacy for the patient and, where necessary, the relatives, should be available in all cases.

There should be a second medical opinion/certification for the s47 Part 2 within 7 days of the initial doctor's granting of this. This second doctor should have been fully registered for at least 3 years. The second doctor should also consult relatives and others in accordance with the principles and any welfare proxy unless impracticable. The second doctor need not consult relevant people other than welfare proxies if they are clearly documented to be in full agreement with the patient's detention.

We think that this routine second medical opinion/certification could obviate the need for a s50-type review process in the event of a welfare proxy being in disagreement with the patient being detained in hospital under s47 for the provision of medical treatment. (However, for disagreements with proposed treatment itself, s50 and s52 still apply.)

If the second medical opinion doctor does not agree with the grounds for ongoing detention under the s47 Part 2 certificate, the authority for this will cease.

We agree with the proposal that the adult and any welfare proxy should have the right to appeal against their detention, as well as the nearest relative and any other person who can demonstrate an interest.

The medical practitioner primarily responsible for the adult's treatment should, "from time to time", consider whether the patient remains incapable in relation to a decision as to whether or not to go out of the hospital; and whether the conditions for their detention in hospital continue to apply.

Between day 21-28 following the patient's initial detention under s47 Part 2, a mandatory review should be undertaken with consultations as previously. If the doctor issues a Part 2 re-certification, there should be a second medical opinion/certification for the s47 Part 2 within 7 days. Mandatory reviews should take place continuously with these timescales.

There should be automatic judicial review at some point if detention continues for an extended period – perhaps 3 months, although this requires consultation and modelling.

If the conditions for the patient's detention in hospital under s47 Part 2 cease to be met, the doctor should revoke the Part 2 certificate.

The doctor could certify something along the lines of:

- the treatment that required to be provided in hospital has finished
- the treatment the patient is receiving now is of a type or extent that could be provided in the community for this patient with suitable accommodation and support/care.

However, the patient may still be incapable in relation to a decision as to whether or not to go out of the hospital; and it may not be safe for them to leave hospital until a process of finding suitable accommodation or putting arrangements in place in their own home is complete.

A patient who is in this position should not remain detained under the s47 Part 2 certification outlined above. They should move to a different status, with the medical practitioner primarily responsible certifying grounds for this, i.e.

- The patient is incapable in relation to a decision as to whether or not to go out of the hospital

- a process of finding suitable accommodation or putting arrangements in place in their own home is necessary
- While that process continues, there would be a significant risk to the health, safety or welfare of the patient if they were not detained in hospital.

The decision to keep the patient in hospital must be in line with the Principles, and the availability and use of short term placements should be considered.

This further certification might also be applied for some patients who had not actually been subject to a s47 part 2 certificate, but who became unwilling to remain in hospital during admission.

When this certification has been made, safeguards for this situation could be triggered. These might include:

- MHO assessment
- Ability to apply for an end date
- Further appeal right by patient and other appropriate people
- Power by MWC to refer case to tribunal
- Automatic judicial review after a specified period to consider whether a recorded matter should be made and/or an end date set.

38. *Do you think that there should be provision to authorise the removal of a person to hospital for the treatment of a physical illness or diagnostic tests?*

    Please explain your answer.

On balance, yes.

The current authority to remove an adult with incapacity to hospital for treatment of physical illness that is unrelated to mental disorder, where the patient resists or objects, is:

- Where urgent treatment is required, an application for a removal order under section 293 of the Mental Health (Care and Treatment) Act
- In an emergency, common law authority to treat under principle of necessity and use of reasonable persuasion and restraint to allow transfer to hospital.

The MWC suggest in our guidance *Right to Treat*[6] that an application for a removal order should be considered if treatment is required urgently, within 7 days. If the patient can wait for the treatment for longer than that, an application for a welfare intervention order or a welfare guardianship should be considered.

Our view is that an application for a s293 removal order should remain the normal route for obtaining authority to remove an incapable adult to hospital for assessment/treatment of physical disorder where they resist or object. An urgent application can be made to a justice of the peace where the making of an application to the sheriff is impracticable (s294).

The issue concerns the use of the common law in situations where this is impracticable. Situations can arise where a doctor or paramedic is faced with an acutely physically unwell person who needs urgent stabilisation but resists being admitted to hospital. We understand that practice can differ between health professionals as to when the common law can be used and how – for example, what force can be used and by whom.

[6] https://www.mwcscot.org.uk/media/51822/Right%20to%20Treat.pdf

We therefore suggest that it would be appropriate to codify the current common law position to provide clear guidance in such situations. This could be through a provision in Part 5 of the AWI Act for authority to remove a patient to hospital where this is urgently necessary and there is insufficient time to apply for a removal order.

We believe a certificate to authorise the adult's removal to hospital would need to be separate from the s47 certificate that is completed to authorise the treatment in hospital. It would not seem appropriate for a community doctor to fill in a s47 certificate to authorise ongoing assessment and treatment in hospital when they will not be the medical practitioner primarily responsible for the patient's assessment and treatment after their arrival in hospital.

We consider that a doctor present should be able to authorise the patient's removal to hospital if the following conditions are met:

- The patient is refusing to go to hospital and is or appears incapable of making this decision
- It is necessary as a matter of urgency to remove them to hospital for medical treatment for physical disorder
- Making an application for a removal order would involve a delay that would be likely to cause a significant risk to the health of the patient and/or deterioration in their condition

If a doctor is not present, ambulance staff should be able to authorise the patient's removal to hospital if they consider that the above grounds are met, and that:

- Arranging for a doctor to attend to assess the patient would involve a delay that would be likely to cause a significant risk to the health of the patient and/or deterioration in their condition

The certificate could be sent to MWC using a process similar to Mental Health Act Place of Safety detention, including immediate review on admission.

If such a power is not codified, as a minimum there should be clear published guidance in the statutory Code of Practice as to how to proceed under the common law.

39. Do you agree that a 2nd opinion (medical practitioner) should be involved in the authorisation process?

39.1 If yes, should they only become involved where the family dispute the need for detention?

Yes, although a different 2nd opinion doctor from the model suggested. See above for details.

40. Do you agree that there should be a review process every 28 days to ensure that the patient still needs to be detained under the new provisions? How many reviews do you think would be reasonable?

Yes, with details as above. We think this should continue with periodic reviews as outlined for as long as the patient requires medical treatment in hospital for physical disorder.

We have proposed moving to a different authority for detention if this requires to be continued after completion of treatment that clearly requires to be given in hospital. This should flag the need for additional safeguards/judicial review from that stage.

41. *Do you think the certificate should provide for an end date which allows an adult to leave the hospital after treatment for a physical illness has ended?*

We set out above how we think the authority should end, following review. We also think the judicial body should be able to make recorded matters or, in exceptional circumstances, set an actual end date.

42. *In chapter 6 we have asked if we should give consideration to extending the range of professionals who can carry out capacity assessments for the purpose of guardianship orders.*

43. *Section 47 currently authorises medical practitioners, dental practitioners, ophthalmic opticians or registered nurses who are primarily responsible for medical treatment of the kind in question to certify that an adult is incapable in relation to a decision about the medical treatment in question. It also provides for regulations to prescribe other individuals who may be authorised to certify an adult incapable under this section.*

    Do you think we should give consideration to extending further the range of professionals who can carry out capacity assessments for the purposes of authorising medical treatment? Please give reasons for your answers.

We believe appropriately qualified psychologists should be able to issue s47 certificates. A professional can only issue a s47 certificate in respect of treatments for which they are primarily responsible. Apart from psychologists, we do not think extending the list of non-medical professionals who can qualify to issue a s47 certificate is indicated, other than perhaps for chiropodists who perform minor surgery.

Chapter Thirteen - Research

44. *Where there is no appropriate guardian or nearest relative, should we move to a position where two doctors (perhaps the adult with incapacity's own GP and another doctor, at least one of whom must be independent of the trial) may authorise their participation, still only on the proviso that involvement in the trial stops immediately should the adult with incapacity show any sign of unwillingness or distress?*

Perhaps. We do not have a fundamental difficulty with this proposal but we believe the research provisions at s51 should only be altered on the basis of clear evidence of benefit.

We can see two possible justifications for this change

- That it would allow some incapable research subjects who might benefit from the treatment to participate
- That it would broaden the potential pool of research subjects.

The first argument is more persuasive, although we are not aware of actual cases where people with mental impairments have not benefited from treatment which would have helped them.

We would need to be persuaded by clear evidence that the requirement to obtain the consent of guardians or nearest relatives has impeded valuable research by narrowing the pool of subjects.

45. *When drafting their power of attorney should individuals be encouraged to articulate whether they would wish to be involved in health research?*

Yes, although this would not appear to be a matter for legislation.

46. *Should there be provision for participation in emergency research where appropriate (e.g. if the adult with incapacity has suffered from a stroke and there is a trial running which would be likely to lead to a better outcome for the patient than standard care)?*

Perhaps. Again, we have no fundamental objection, but the justifications in the paper do not appear to be fully worked through, and we are not clear what would change.

Although the paper is not clear, we suspect that the discussion on 'emergency research' is not about people who are already incapable (because of e.g. a learning disability for dementia) but reflects a concern about the possible restrictions on research into the condition which has caused the incapacity – e.g. a stroke or heart attack.

We think it could be acceptable, in such cases, for the requirement to obtain consent from the nearest relative to be waived. But we do not know whether it is proposed that other criteria, e.g. that the research involves only minimal foreseeable risk, might also be removed or watered down. We would not agree to this without further evidence of benefit.

47. *Should authorisation be broadened to allow studies to include both adults with incapacity and adults with capacity in certain circumstances? (e.g. an adult with incapacity who has an existing condition not related to their incapacity may respond differently to different types of care or treatments to an adult with capacity)*

Perhaps, if the circumstances are specified more clearly. In the case of people whose response may be different to those with capacity, we suspect that they could already be included in research which could be justified under s51(1)(a). The fact of the differential response means that the research being carried out on the incapable adult is not the same research as is being carried out on capable adults.

48. *Should clinical trials of non-medicinal products be approached in the same way as clinical trials of medicinal products?*

We do not understand the distinction, which does not appear in the Act. Section 51 covers 'surgical, medical, nursing, dental or psychological research', which appears sufficiently wide in the context of Part 5.

49. *Should there be a second committee in Scotland who are able to share the workload and allow for appeals to be heard respectively by the other committee?*

We have no strong view, but do not currently see the need for this. We would have thought it perfectly possible for the statutory Ethics Committee to organise itself so that it can deal appropriately with the business it has, and if necessary create structures to allow for review of decisions.

We have found it extremely difficult to find any information about the membership, contact details or work of the statutory Ethics Committee. It would be helpful to provide that it should publish an annual report on its work.

50. *Should part 5 of the Act be made less restrictive?*

We do not understand what this question means.

Chapter Fourteen - Miscellaneous

51. Are there any other matters within the Adults with Incapacity legislation that you feel would benefit from review or change? Please give reasons for any suggestions.

We make a number of specific suggestions below, but we also stress that the current proposals are already radical and significant, and require much more detailed development before legislation can be brought forward. Reconciling the demands of *Cheshire West* with the UNCRPD and, at the same time, updating legislation which is beginning to show its age, is a massive and complex task, which requires a thorough and inclusive policy development process involving key stakeholders, which we'd be glad to participate in.

In that process, it will be important to recognise that there are many specific issues and problems relevant to particular groups which have not been fully considered. To pick just two examples, Part 5 of the Act does not always work well in relation to palliative care, and there are many difficulties in operating the guardianship powers effectively for people with alcohol related brain damage, whose capacity and risk may fluctuate greatly in a short space of time.

The consultation does not contain any modelling of the impact of reforms on courts, doctors, MHOs and so on. That requires careful consideration, since workload implications will be very significant.

Our response to the Consultation on the SLC report on Adults with Incapacity identified a number of issues that we believe should be reviewed. The main issues not covered in the current consultation are

- Consolidating the appointment of a welfare attorney with other procedures, such as appointing a named person or making an advance statement under the Mental Health Act, to make it easier for people to plan for future incapacity or illness. The removal of the default named person by the Mental Health (Scotland) Act 2015 has increased the desirability of this
- Jurisdictional issues, particularly cross-border recognition of guardianship and powers of attorney, clarifying the complex interaction of residence requirements (where AWI applies a different test from the rules regarding which local authority should fund care) and making it possible to apply for guardianship in advance of a move to Scotland
- The duties of the MWC under AWI – in addition to the issues raised by the proposed reforms (e.g. the potential for a broader visiting, support or supervisory role), we believe it would be helpful if we had a similar responsibility as under the 2003 Act to monitor the operation of the Act and to promote its principles.

There are a number of issues about medical treatment under Part 5 which would benefit from review, for example

- The interaction between Part 5, the Mental Health Act and the common law regarding treatment for physical conditions with a connection to mental disorder (e.g. delirium, suspected brain tumours, uncontrolled diabetes)

- Whether the s50 procedure for an independent second opinion applies to cases where the doctor wishes to withdraw or not to give treatment, and the welfare attorney or guardian disagrees
- There is a specific issue regarding allowing bone marrow to be donated by an incapable adult – this has been done in at least one case, but the legislative basis is problematic.

The consultation leaves unresolved the extent to which informal decision making without a legal process should continue. We believe it should, but it may be necessary to consider some equivalent to s5 of the Mental Capacity Act or s9 of the equivalent Act in Northern Ireland, which provides some degree of legal protection for those who do so, provided they have acted in accordance with the principles.

There is a lack of clarity around the use of guardianship and intervention orders to make or amend testamentary provisions, with the Code of Practice being inconsistent with some judicial decisions.

We believe DSS appointeeship must be integrated into the new graded guardianship system. The current arrangements lack appropriate safeguards and are highly susceptible to abuse.

Although we use the term guardianship throughout, we would repeat the point made in *Scotland's mental health and capacity law: the case for reform* that this term is outdated and should be replaced.

Finally, we remain of the view that the current consultation should form part of a comprehensive review of the entire legislative framework for non-consensual care and treatment.