

**Adults with Incapacity (Scotland) Act 2000 – Proposals for Reform**

**Response of Scottish Human Rights Commission**

The Scottish Human Rights Commission was established by The Scottish Commission for Human Rights Act 2006, and formed in 2008. The Commission is the national human rights institution for Scotland and is independent of the Scottish Government and Parliament in the exercise of its functions. The Commission has a general duty to promote human rights and a series of specific powers to protect human rights for everyone in Scotland.

**Our approach**

The Commission welcomes the opportunity to respond to the proposals for reform. The Commission has long expressed concerns regarding the rising levels of non-consensual interventions in the affairs of individuals with “mental disorder”[[1]](#footnote-1), via mental health and incapacity legislation, accompanied by safeguards that have not proved effective. We have repeatedly called for a review of the framework for non-consensual care and treatment, to reflect the principle of supported decision-making. The Commission has highlighted the following areas priorities for action[[2]](#footnote-2):

* “*Set out a road map for reform of the full legislative framework (the Mental Health (Care & Treatment)(Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007), with the participation of people with lived experience*
* *Ensure supported decision-making is at the heart of Adults with Incapacity reform already underway*
* *Coordinate the existing/proposed reviews in line with the Convention on the Rights of Persons with Disabilities (CRPD), with the aim of achieving supported decision-making.*
* *Devote resources to exploring supported decision-making in practice*
* *Implement the five actions proposed by the Special Rapporteur on the Right to Health.”*

The Commission is committed to the idea of a reform that delivers rights-based legislation. While there has been much debate about, and some tension between, international human rights standards, we consider it is possible to discern an international consensus that we must make concerted efforts to move away from substitute decision-making and towards supported decision-making. We take this as our guiding principle and we have approached the consultation from this perspective. We note that this is in harmony with the Scottish Government’s own intentions[[3]](#footnote-3), however, there are a number of proposals which we believe pull in the opposite direction. We aim to point out areas where we feel the proposals move further towards substitute decision-making, with suggestions for how they could be reframed.

Fundamentally, we believe the legislation must be framed as a supportive piece of legislation, which exists to provide support to individuals whose capacity may be limited, rather than to remove such capacity from them. This can, at times, require what might be considered “100% support”, based on the “best interpretation of will and preferences”[[4]](#footnote-4) but it is crucial that it is always conceived as support, to move away from an acceptance that some bright line exists whereafter a person’s legal capacity may be restricted by legislation.

It is fundamental to a shift towards supported decision-making that, in all instances, effort is directed towards enabling the individual to express their “will and preferences” and make a decision before any other type of intervention is considered. This must be supported by meaningful and robust obligations. We will highlight throughout this response where we consider they should be applied. In particular, independent advocacy must be recognised for its crucial role in providing supported decision-making[[5]](#footnote-5).

We consider that many of these proposals require significant further development, involving both people with lived experience of their capacity being in question[[6]](#footnote-6), and experts in the field. While it remains challenging to construct a perfect system in compliance with human rights standards, there are both international examples which provide us with a strong starting point and many well-informed experts who have made efforts to answer the difficult questions which arise, both in law and in practice. The present reform is a crucial opportunity to synthesise these good practice examples into a world-leading piece of rights-based legislation, as the Adults with Incapacity (Scotland) Act 2000 (AWI) once was. However, if not carefully considered, it carries with it significant risk of diluting safeguards and opening further routes to interference with the human rights of those who will be subject to it. We urge great caution in ensuring this is not an unintended consequence of any reform proposals.

**The legal framework**

The Scotland Act 1998 requires thatall legislation of the Scottish Parliament must be compatible with ECHR rights.[[7]](#footnote-7) It also requires that Scottish Ministers must observe and implement the UK’s other international obligations, which includes obligations under international human rights treaties the UK has ratified.[[8]](#footnote-8) In the context of this reform, particular importance is rightly placed on The Convention on the Rights of Disability, which has been ratified by the UK.

Alongside the Equality and Human Rights Commission, we are part of the UK Independent Mechanism that was established by the UK under Article 33(2) of the UN Convention on the Rights of Persons of Disabilities (CRPD) to promote, protect and monitor implementation of the Convention.

In the UK’s first review, the Committee on the Rights of Persons with Disabilities made a number of concluding observations emphasising the need to abolish substitute decision-making practices and build supported decision-making in legislation, policy and practice.[[9]](#footnote-9)

We acknowledge that there is some degree of tension between the obligations imposed by ECHR and CRPD with regard to incapacity laws, and important legal questions remain to be addressed in relation to these proposals. We do not attempt to provide a definitive answer to these in every case. Our comments reflect our interpretation of human rights standards at present, however, we believe further collaborative work would be required to ensure any tricky areas are resolved as far as possible.

**CHAPTER THREE – Restrictions on liberty**

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

We agree that the proposals must take into account both how a person lives and where a person lives. We highlighted, in our response to the Scottish Law Commission Report on Adults with Incapacity[[10]](#footnote-10), the potential for Article 8 ECHR and, in some circumstances, Article 3 ECHR to be engaged by restrictive care arrangements and we recommended that a broad view of deprivation of liberty be taken to encompass not just the authorisation of deprivation of liberty but the appropriateness of care itself.

First and foremost, we consider it essential that there is a focus on early discussion with the individual, with a view to maximising their capacity, seeking their informed consent and, thereby, avoiding a deprivation of liberty. We agree with the position set out that, if an adult expresses their wish to be in a place that involves significant restriction of liberty, this can provide valid consent for the purposes of Article 5 ECHR. However, in order for this to form a meaningful stage in the process, we consider that specific emphasis and detail would be required, in primary or secondary legislation, to detail the obligations on those proposing the arrangements. This should cover specific steps which must be evidenced to have taken place before an authorisation of a significant restriction on liberty will be granted.

The English Law Commission’s proposals on deprivation of liberty[[11]](#footnote-11) suggest a robust list of steps that must be taken and recorded in order to maximise the exercise of the adult’s capacity and respect their will and preference. These could be adapted to the Scottish context to bring much more rigour to the requirement. They are:

1. the steps taken to establish that the person lacks capacity;
2. the steps taken to help the person to make their own decision;
3. why it is believed that the person lacks capacity;
4. the steps taken to establish that the act is in the person’s best interests [in Scottish terms, “to the person’s benefit”];
5. a description of the person’s wishes, feelings, beliefs or values ascertained wishes and feelings for the purposes of the [best interests] determination and, if the decision conflicts with them, an explanation of the reason for the decision;
6. that any duty to provide an advocate has been complied with; and
7. that the act would not be contrary to an advance decision.

**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.**

The English Law Commission consulted on a wider list of factors to identify restrictive care and treatment due to concern that the notion of a “significant restriction of liberty” may be drawn more narrowly than the definition of a deprivation of liberty in the *Cheshire West[[12]](#footnote-12)* judgment. These factors were intended to develop a concept wider than deprivation of liberty, which also takes into account the Article 8 ECHR rights of individuals. Those not currently covered by the proposals, but necessary to capture a broader ambit of rights are:

* the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
* any care and treatment that the person objects to (verbally or physically);
* significant restrictions over the person’s diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).[[13]](#footnote-13)

While the English Law Commission has now taken an approach which does not seek to define the factors of a deprivation of liberty, we believe this approach has much to recommend it in the context of the Scottish proposals. We consider that it is important to identify these elements as these are undoubtedly matters which would require a higher degree of scrutiny than the administrative scrutiny anticipated for Grade 1 guardianships. Our reservations about Grade 1 guardianships are expressed below and, if any of the above circumstances were applicable, we consider it particularly inadequate for guardianship to be authorised as an administrative matter.

We also consider that the use of technology as a means of control should be included, alongside other types of restraints or barriers.

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

We consider that what constitutes an “apparent objection” requires careful consideration. While the *Bournewood* decision[[14]](#footnote-14) makes clear that compliance does not amount to consent, there may be circumstances in which an individual should be able to signal their assent or lack of assent, although this would need to be accompanied by supportive safeguards to ensure their assent is genuine. This may require further development as part of the role of a supported decision-maker (see proposals in Chapter 7).

**CHAPTER FOUR – Principles of Adults with Incapacity legislation**

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

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

We strongly agree that the principles require amendment to reflect Article 12 CRPD. We believe this reform is an opportunity to reframe AWI legislation as a supportive, rather than restrictive, piece of legislation and an amendment to the principles would provide a strong underpinning. We strongly support a new principle which places emphasis on the obligation to provide support and it is important that the principle captures the essence of Article 12 obligations. A distillation of Article 12 has been neatly summarised by Dr Peter Bartlett as

*“The idea is that one never entirely loses legal authority to make decisions; instead, supports for decision-making become ever stronger, as functional ability decreases”[[15]](#footnote-15)*

This is a useful touchstone to bear in mind when constructing a new principle. The proposed principle still assumes a cut-off point, whereafter “support” fails and an intervention steps in. We consider that the legislation should construct all the measures offered under the Act as a form of support, albeit one increasing to the intensive support of a guardianship-type measure in appropriate circumstances. We develop this approach in response to Chapter Seven. Additionally, we have concerns about the term “without success”. “Success” could subjectively be interpreted as making a decision deemed appropriate by others, as opposed to simply making a decision and this allows leeway for a paternalistic approach.

Accordingly, we suggest the following basis for an alternative principle:

*“All practical help and support to enable the adult to exercise their legal capacity must be given[[16]](#footnote-16). No one shall make a decision on behalf of the adult unless it can be demonstrated that all practical help and support has not led to the adult making a decision and the will and preferences of the adult are not known”*

It is well known that the principles are not consistently applied in practice. We consider therefore that the duties attached to them, and the scrutiny of the performance of those duties, require to be more robust. We believe that this principle requires to be backed up by an attributable duty and to require evidence of its being performed. We support the recommendation of The Essex Autonomy Project that “*Statutory provisions regarding support in the exercise of legal capacity must be attributable. For example, statutes that state only that support should be provided must be supplemented with clear guidance about who bears the responsibility for providing that support*”[[17]](#footnote-17).

**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?**

The CRPD Committee’s General Comment No.1 (2014) is very clear that regimes must respect the person’s autonomy, will and preference[[18]](#footnote-18). The precedence this must take is echoed by the European Court of Human Rights (ECtHr) in *A-MV v Finland*[[19]](#footnote-19).The current AWI principles do not place any primacy on the will and preference of the individual as the adult’s wishes and feelings are only one of a number of principles and, even then, only require to be “taken account of”.

We consider that the principle proposed by the Essex Autonomy Project – that there should be a rebuttable presumption that effect should be given to the person’s reasonably ascertainable will and preferences, subject to the constraints of possibility and non-criminality, rebuttable only if it is shown to be a proportional and necessary means of effectively protecting the full range of the person’s rights, freedoms and interests – should be reflected in the amended principles. It would help to cement the foundation of the amended legislation in respect for legal capacity, while taking account of the permitted grounds for interference with Article 8 ECHR.

Again, we consider that this principle must be accompanied by an attributable duty to undertake all practicable steps to determine the will and preferences of the person (in line with Recommendation 2 of the Essex Autonomy Project).

**CHAPTER FIVE – Powers of attorney and official supporter**

**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?**

**If so, do you consider that the proposal for advance consent provisions will address the issue?**

Yes, clear safeguards are required in relation to potential deprivations of liberty and accordingly the present uncertainty regarding the use of powers of attorney should be remedied. ECtHR caselaw*[[20]](#footnote-20)* highlights the need for sufficient safeguards against arbitrariness, including access to a judicial procedure capable of determining the lawfulness of the individual’s detention, even where consent is provided by an authorised person, and periodic compulsory examination for the purpose of assessing whether an individual needs to remain in detention[[21]](#footnote-21). The proposals are unclear as to the requirement for regular review of arrangements as the example seems to suggest that this is a condition that people would have to actively choose to include in their Power of Attorney. Regular review should be an automatic requirement.

We do, however, agree, that individuals should be able to make advance decisions in relation to arrangements which may amount to a deprivation of liberty, as an exercise of their legal capacity. We agree that a significant degree of specificity would require to be stipulated in order for such advance consent to be valid in potentially very distressing circumstances. It would also be essential that individuals truly understood what they were consenting to. This would require in-depth discussion with any person drawing up a Power of Attorney and the criteria should be designed in such a way as to ensure this takes place. A list of prescribed wording may tend to allow standard form Powers of Attorney to be used without considered thought as to their meaning. A programme of education for solicitors practicing in this area and for individuals considering Powers of Attorney would be advisable.

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

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

**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?**

We are very supportive of the creation of a role which gives clear authority to support the individual in making decisions and in having those decisions legally recognised. This is in line with CRPD General Comment No.1 which states *“Legal recognition of the support person(s) formally chosen by a person must be available and accessible, and the State has an obligation to facilitate the creation of support…This must include a mechanism for third parties to verify the identity of a support person as well as a mechanism for third parties to challenge the action of a support person if they believe that the support person is not acting based on the will and preference of the person concerned”[[22]](#footnote-22)*

We consider that there is a need for a more involved supported decision-making role in place of Grade 1 guardianship, which we explore in response to Chapter 7, however, we also see merit in the creation of an ‘official supporter’ who assists the adult to make the decision but has no authority beyond that. We think official recognition is important to facilitate the exercise of legal capacity in the broad range of areas to which it relates e.g. financial transactions[[23]](#footnote-23), access to justice.

In terms of the means of appointment, the Irish Assisted Decision-Making (Capacity) Act 2015 provides a similar model, called a ‘Decision-Making Assistant’, appointed by way of a Decision-Making Assistance Agreement[[24]](#footnote-24). We consider this provides a strong model for the appointment process.

We believe terminology can help to shift the emphasis towards a supportive piece of legislation. Accordingly, we consider that the term ‘official supporter’ is appropriate.

**CHAPTER SIX – Capacity assessments**

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

The concept of capacity assessments is highly contested from a CRPD perspective[[25]](#footnote-25), in particular, whether it is possible to discern a bright line whereafter a person can be deemed incapable of making certain decisions. It is essential to understand the power that accompanies such assessments opening, as they might, the route to significant restriction or removal of legal capacity[[26]](#footnote-26). Extreme caution should be exercised in widening this power and, its corollary, the misuse of power.

As a general point, we acknowledge that there are circumstances in which it may be necessary to intervene in an individual’s affairs for their protection or for the protection of others and, indeed, that this may be required in order to protect certain of their rights, such as the right to life or the protection from inhuman and degrading treatment. However, the challenge is for the route by which such intervention is arrived at to be one which does not discriminate against disabled people.

General Comment No.1 requires that “the provision of support to exercise legal capacity should not hinge on mental capacity assessments; new, non-discriminatory indicators of support needs are required in the provision of support to exercise legal capacity”[[27]](#footnote-27). One route to achieving non-discriminatory routes into the legislation is to shift from testing the functional capacity of the individual to testing the robustness of the supports offered[[28]](#footnote-28), meaning “*any test of a person’s ability to exercise their legal agency is actually a test of whether the supports provided to the person are adequate and appropriate to the task in hand. If not, they should be altered until will and preference can be expressed, or it becomes apparent that this is not possible*”[[29]](#footnote-29).

This is a relatively new and untested interpretation but one that we consider may have promise. In any event, we consider that significantly more work needs to be done to develop the appropriate tests which will ensure that people are provided with support when they need it, but are not unduly deprived of their legal capacity. We welcome the work being carried out to develop consistent standards across law and medicine on the assessment of capacity in contributing to this end. However, until more consistent, non-discriminatory practice has been developed, we would urge against widening the category of those able to make capacity assessments. We are concerned that, at present, this risks increasing the avenues for intervention in an adult’s affairs, which works against a move towards supported decision-making.

It may be that certain categories of practitioners are appropriately placed to carry out capacity assessments, such as psychologists. We understand that the role of psychologists is being considered by the review of learning disability and autism in the Mental Health (Care & Treatment)(Scotland) Act 2003 and we consider that it would be sensible to use those findings to inform this question, along with awaiting findings regarding the definition of capacity.

Capacity assessments currently play a pivotal role in determining an individual’s enjoyment of a range of their human rights. As regards the other professionals who are able to authorise section 47 certificates, we cannot see where it would be appropriate for dental practitioners, ophthalmic opticians, or registered nurses to be authorised to carry out capacity assessments for guardianship orders, if this is indeed what is being proposed.

**CHAPTER SEVEN – Graded guardianship**

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

We think there is potential in the idea of creating gradations of support (or intervention, as presently expressed), however, we think the proposed grades need significant reworking to achieve any significant shift towards supported decision-making and, still, to ensure adequate safeguards.

As we have outlined above, we believe that reformed legislation should be reframed as a supportive piece of legislation, making significant moves away from substitute decision-making. We believe therefore that the institution and the concept of guardianship need to be reframed towards a support model. While there has been much debate about the CRPD Committee’s interpretation of Article 12 and its potential conflict with the views of other human rights bodies, we believe that a system can be constructed which, as far as possible, aims to satisfy the demands of the varying views.

We appreciate that there is a desire to reduce the resource burden of the current system and we believe that resources could more usefully be employed towards providing genuine support than on the demands of the system. It is worth bearing in mind that, the more successful a range of support measures are, the less recourse to legislation may be required. We are concerned, however, that reducing the investment of resources would, in some of the current proposals, result in unacceptably low scrutiny which would fail to protect individuals’ rights. Our principal concerns lie in relation to Grade 1 guardianship which we consider grants powers far too wide-reaching to be considered an “administrative decision”.

We believe the proposals require much greater development, involving a range of stakeholders, and that this is a priority amongst the matters consulted on. We suggest that the grades could be reworked along the following lines

* Grade 1: reformulated as a supported decision-making/co-decision-making model
* Grades 2 & 3: broadly as set out in the proposals but constructed as a form of facilitated decision-making, subject to our further comments below

**Grade 1**

Currently, the step up from an official supporter would be a Grade 1 Guardian, however, we think that there is scope for something in between the two which is a more formal supported decision-making role.

The issue, as we see it, is that all Grades of guardianship are forms of substitute decision-making which remove a person’s legal capacity and vest it in someone else. This is where the discriminatory denial of capacity becomes acute from a CRPD perspective[[30]](#footnote-30). In reality, guardianship in Scotland is often intended as a supportive measure which assists a person to carry out affairs in relation to which their capacity is limited. In this sense, we consider that a binary vesting of capacity (in either the individual or someone else) can and should be avoided. Rather, mechanisms should be created which allow an appointed person to sit alongside the individual to support them in the exercise of their capacity. This would also provide more appropriately for individuals with fluctuating capacity.

Grade 1 provides for a Guardian to be appointed to assist a person in a wide range of essentially simple and uncontroversial ways. It is predicated on the lack of objection of the individual (or anyone else). Accordingly, we believe this could be reconstructed as a supported decision-making model. The appointed person would not therefore have the power to override the decision of the individual, however, this would not be necessary as any controversial decisions should be dealt with by way of Grade 2 Guardianship. This has some crossover with the role of a Continuing Attorney in that both persons can exercise legal authority simultaneously, however, it would also cover welfare matters and would not necessarily need to be set up by the individual.

The characteristics of this model would be

* the individual could appoint such a person or someone with an interest could apply to be appointed
* no one could be appointed against the wishes of the individual
* the individual would be able to end the appointment[[31]](#footnote-31)
* the appointed person would have a duty to ascertain the individual’s will and preferences as far as possible
* the appointed person could not act against the wishes of the individual
* legal authority would be shared between the individual and the appointed person
* the appointed person could help the individual to make a decision and to implement it. For example, an individual might be able to decide where they wish to live or that they want to have care but may have more difficulty taking the necessary steps to enact that, where the appointed person could assist by e.g. signing tenancy agreements, dealing with social work, setting up direct debits.

Following on from our comments on deprivation of liberty[[32]](#footnote-32), there might be scope for the appointed person to perform a check that the person’s wishes were being interpreted in a faithful way and given effect to.

This is similar to what has been suggested by the Mental Welfare Commission[[33]](#footnote-33) in their ‘registered supporter’ model and also has much in common with the ‘registered decision-making supporter’ proposed by People First[[34]](#footnote-34). These models would require further development and synthesis, however, we believe this is a crucial element to get right in the reform.

**Grades 2 and 3**

We broadly agree with the reasons for matters being considered at these Grades. We believe that all significant interventions in the affairs of the adult should be subject to judicial scrutiny. This includes

* any significant restrictions of liberty
* some circumstances of care which may engage Articles 3 or 8 ECHR
* significant financial control over the individual (regardless of amount)
* decisions which conflict with the will and preference of the individual

At Grade 2, the appointment could still involve legal authority being shared between the individual and the appointed person as, again, there can be no disagreement with the adult. However, the level of scrutiny required is higher by virtue of the seriousness of the impact on the individual’s rights.

We agree that Grade 3 is appropriate for any matters of contention where a decision will need to be made as to which person is best placed to make a decision which respects the rights, will and preference of the individual and for certain situations of heightened vulnerability (see below).

**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.**

We believe that the process for application for Grade 1 guardianship would need to be revised in line with a reformulation of the model. However, we consider that, the steps currently set out would be onerous for individuals to carry out without the aid of legal advice. Steps such as seeking a local authority report, an incapacity certificate, and intimating the application within what we presume would be prescribed timescales (although this is not explained in the proposals) are matters that already cause delays in guardianship applications and there is a risk that this could lead to a greater resource burden. For example, if forms are not completed accurately, or timelines are not complied with by local authorities or medical practitioners, this may result in applications having to be returned or re-intimated or fresh reports being prepared.

We also consider that serious thought and advice will be required to ensure that applicants only seek those powers strictly required. How would individuals be enabled to understand the need to restrict the powers sought to those only absolutely necessary? The current proposals lend themselves to a tick-box exercise where a wide range of powers may be sought. This is of particular concern given the low level of scrutiny proposed for such applications.

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

**Grade 1**

We consider that the powers listed under Grade 1 are significantly too far-reaching for administrative oversight. As we understand it, the only limits regarding the powers themselves, as opposed to the level of disagreement, are the amount of property and a significant restriction on liberty. This leaves a very broad range of powers under Grade 1.

Many of the powers have significant implications for the Article 8 ECHR rights of the individual (e.g. regarding care and treatment, daily activities) and, if these powers are to be removed from the adult, a higher standard of scrutiny is required.

In particular, we do not consider the following powers suitable for Grade 1 guardianship:

* to consent to any medical treatment not specifically disallowed by the Act or procedure or therapy of whatever nature and provide access for that, or refuse such consent
* to decide alone, or with others, on the level of care which the adult may require

Article 12(4) CRPD requires regular review of measures relating to the exercise of legal capacity by a competent, independent and impartial authority or judicial body. Article 8 ECHR requires that interferences must be in accordance with the law, which must guarantee proper safeguards against arbitrariness including access to a remedy whereby the individual can require a court to rule on the lawfulness, including proportionality, of the interference, or to have it discontinued[[35]](#footnote-35). We do not consider that administrative scrutiny provides the requisite standard of review.

A significant role for this level of scrutiny would be to identify if an application should properly be dealt with at a higher grade where it, for example, involves a significant restriction on liberty. The proposed administrative review does not allow for adequate scrutiny for this to be identified as it does not involve interrogating the substantive nature of the application, merely checking “whether the application meets the requirements in the legislation”[[36]](#footnote-36).

If Grade 1 guardianship was reformulated as a supported decision-making model, the standard of scrutiny required might be lower. We have grave concerns if an appointment capable of overriding the individual’s will and preference is subject to only administrative review. To allow these to be granted with so low a standard of scrutiny surely goes against a move towards supported decision-making. We do not believe that such a problem needs to be created and we believe there is scope for Grade 1 to be reformulated as a supported decision-making model.

**Grade 2**

The level of scrutiny proposed here is, in effect, what happens in many guardianship cases at present, as hearings are often brief and largely based on the papers. Accordingly, we agree that a decision could be made on the papers so long as that decision was made with meaningful scrutiny by an appropriately qualified judicial authority. A legal panel member or Sheriff in chambers would be required to identify if there were substantive matters that warranted consideration and to propose a course of action to remedy them.

**Grade 3**

We agree that any contentious matters should be determined by a full hearing of a judicial authority. It may be that parties don’t necessarily object to the appointment in itself but rather wish to raise issues regarding the specifics, such as the powers required, the duration of the order or the support which could be or has been offered to the individual. In order to ensure that the least restrictive decision is made, these issues should be capable of being canvassed without hindrance.

We also believe there should be a requirement in all these cases that the judicial authority must meet the adult to whom the application relates, including if this requires a visit to the adult.

**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?**

In order to set any threshold, we think the level of power vested in the appointed decision-maker must be considered. We are not convinced that a financial cut-off point is a good barometer of power. If an appointed person has control over the entirety of a person’s finances, the potential for them to control the individual is significant, whether the amount is small or large.

**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.**

We agree that a hearing should be available to all those who request it. We cannot see any alternative route whereby parties can be heard and in-depth consideration be given to their issues[[37]](#footnote-37). This process should be easily accessible for any matters that require further consideration even if they do not constitute “objections” to the appointment of the applicant.

We are pleased that the adult will be able to request a hearing at any stage, however, we think considerably more is required to ensure the process is more centred on the support and the participation of the individual. A hearing in response to an application before the court or tribunal is too late in the process to provide meaningful support to the adult. We also query whether participating in a full hearing before a judicial authority can be considered a participative approach and we believe the onus should not lie principally on the adult to seek their participation.

As we have already highlighted, there should be obligations to involve the adult at early stages, in discussing the matter at hand, in determining any support that should be provided to them, all with a view to maximising their autonomy and reducing the need for interventions. This should take place before a specific route of intervention has been determined and we believe that an attributable duty to provide support must be designed into the process.

**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 consider that the increased vulnerability of individuals in these situations requires a higher degree or scrutiny and should automatically be considered at Grade 3.

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

We agree that the uncertainties regarding supervision of Intervention Orders should be addressed and we do not think they will be required if time-limited, specific guardianship orders are put in place.

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

**Do you agree with the proposal to repeal the Management of Residents’ Finances scheme?**

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

We agree that there is scope for all types of necessary interventions to be amalgamated into a revised form of graded interventions. We have significant concerns about extending the category of those who may be appointed to include third sector organisations, solicitors and care providers. We are concerned about the potential for conflicts of interest or concentrations of power. Many of the restrictions on who can be appointed as guardian exist for a reason. For example, the barrier on spending a residents’ funds on items or services which are provided by the establishment acts against conflicts of interest where a care home could pay themselves funds.

In order to provide for those who do not have anyone appropriate in their lives to act as an appointed person, there are models of state provision of supporters which we believe are worth exploring. These include the establishment of a panel of “Decision-Making Representatives” capable of being nominated by the courts to assist a person[[38]](#footnote-38).

We consider that the following characteristics are necessary to allow individuals to be appointed as guardians

* no involvement in the provision of care to the adult
* necessary skills and training. Training could be provided by the oversight body
* oversight by a state authority. The state’s responsibility is engaged where there is known to be an interference in the adult’s Article 8 ECHR rights[[39]](#footnote-39). Where welfare matters are concerned, the OPG would not be the most appropriate body to determine the suitability of those seeking appointment.

**CHAPTER EIGHT – Forum for guardians**

**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.**

No. For reasons, see above at Chapter Seven

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

**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**

**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.**

We do not have a particular view on whether the Sheriff Court or the Mental Health Tribunal is the appropriate forum for these matters and we can see advantages in both. We consider that current Sheriff Court practice would need to evolve significantly in order to meet the needs of those subject to the legislation, however, we think either this or the development of the Mental Health Tribunal could achieve the same ends.

The factors that we consider to be most important to achieve in either forum are:

* **Facilitating the meaningful involvement of the adult**, with sufficiently flexible approaches to do so: As we have highlighted above, we believe there should be a requirement in all these cases that the judicial authority must meet the adult to whom the application relates, including if this requires a visit to the adult. Article 13 CRPD requires that “procedural accommodations” are provided to facilitate the effective role of participants with disabilities and we agree that the focus on flexible options for the participation of the adult are increasingly required. We understand that the procedural rules in Germany’s courts require personal contact with the adult which, in practice, encourages the frequent participation of the adult.
* **Specialism**: To date, many of the most useful developments in caselaw have been seen in Sheriffdoms with dedicated AWI Sheriffs. Considerable guidance can also be found by interpreting decisions of the Court of Protection in England. We believe that the development of strong practice can be significantly advanced by the interpretation of the principles in caselaw regarding Scotland’s own legislation.
* **Training**: Article 13 CRPD requires “appropriate training” in order to ensure effective access to justice and we agree that it will be essential for all judicial decision-makers to receive comprehensive training in relation to CRPD (in addition to the other matters identified)[[40]](#footnote-40). They will require to develop a robust understanding of supported decision-making given that it is, after all, a developing and sometimes untested field.

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

See above at Chapter Seven.

**CHAPTER NINE – Supervision and support for guardians**

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

**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.**

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

We agree that there is a need to change the way guardianships are supervised so that supervision becomes more meaningful and sustainable. We consider that a risk-based system has potential, however, in order for this to act as an adequate safeguard, the factors by which risk is assessed must be robust. The standard required by CRPD is that “*the safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests*”[[41]](#footnote-41) which would suggest that higher degrees of intervention (Grades 2 and 3) would require higher levels of supervision.

The proposals do not set out what the levels of supervision at Levels 1 and 2 will be but the robust assessment of risk is all the more important if supervision for such cases is low or non-existent. It is difficult to comment on these proposals until the criteria for risk and the levels of supervision are elaborated further, however, as we have highlighted above, we believe that it is important to consider concentrations of power, howsoever arising, even where small estates are being managed. It is also important to consider the role of conflicts of interest – given that the capacity of local authorities is under pressure when supervision is required, we can envisage a conflict of interest in them determining whether supervision is required.

We do agree that it would be beneficial to consider financial and welfare matters together and we support a model of joint working between the OPG, MWC and local authorities.

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

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

We believe that advice and support for both guardians and attorneys is crucial. This should focus on developing an understanding of their role in supported decision-making, how to apply CRPD principles and AWI principles. Since Article 12 represents a paradigm shift, it is crucial that this shift takes place in communities and day-to-day interactions, rather than being confined to legal processes. General Comment No.1 is clear about the pivotal role that legal capacity plays in accessing other rights and a cultural understanding of the paradigm shift must be built. This should extend to all those providing support for decision-making (e.g. Official Supporters, informal supporters) as the real mark of success would be if adults were being supported to make decisions and exercise their legal capacity on a daily basis without recourse to legislation.

The models highlighted in ‘*Supported Decision-Making: Learning from Australia’* [[42]](#footnote-42) evidence the importance of building the knowledge and skills of family members and friends as an effective way to support and sustain decision-making ability. We believe there is potential in developing such models in a Scottish context.

It is also important to provide advice and support for adults who may require supported decision-making as, in terms of General Comment No.1, “*State parties have an obligation to provide training for persons receiving support so that they can decide when less support is needed or when they no longer require support in the exercise of their legal capacity”[[43]](#footnote-43).*

**CHAPTER TEN – Order for cessation of residential placement, short term placement order**

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

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

Yes. This proposal provides a direct protection against de facto detention which provides an important safeguard where there is someone in a position to raise a challenge.

The persons entitled to apply for such an order require clarification. The adult themselves should be able to apply for an order. In that case, the wording around consent should be clarified. The words “in respect of which there is no capacity on the part of the adult to consent” should be replaced by “in respect of which the adult has not consented”, and make clear that this includes those who are merely compliant but may not have capacity to consent.

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

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

It is difficult to ascertain how long a guardianship application might take under the proposals, however, it seems clear that the process will leave a gap for matters of an emergency nature and that this is a failing of the current system. We would prefer that a particular order, with its own safeguards, is established, instead of reducing safeguards in the regular guardianship procedure. Accordingly, we support the creation of a short term placement order.

In the first instance, however, there should be concerted attempts to enable the adult to exercise their legal capacity in relation to this decision and this should be reflected in the criteria for the granting of an order. Failing to do so results in the establishment of yet another route for substitute decision-making and thus moves in the wrong direction. We have set out earlier our proposals for attributable duties of support and these could be reflected here.

We understand the proposals to mean that an adult can be moved in the face of their opposition only where they do not lodge an official appeal (although this bears clarifying). We support a route of appeal which postpones the move until it has been determined, which would also allow consideration as to how much support has been provided to the adult to make a decision. Article 5(4) ECHR requires both “speedy review” of the lawfulness of detention and continuing review “at regular intervals”, particularly in circumstances where the grounds for detention are susceptible to change over time, such as mental health[[44]](#footnote-44). While such review can take place speedily after the event, prior review and authorisation provides a stronger safeguard against arbitrariness.

**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?**

We do not consider that there remains any need for section 13ZA in light of the proposed changes. In our view, in practice, section 13ZA lacks sufficient safeguards against arbitrary detention and substitute decision-making.

**CHAPTER ELEVEN – Advance directives**

**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?**

Advance planning is an important form of supported decision-making[[45]](#footnote-45). It can also provide an indication of whether a person would consent to a particular measure, which is integral in assessing whether a deprivation of liberty engaging Article 5 ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR).

While the common law does provide scope for the making of an advance directive, we know that, in practice, this is very rarely used and the lack of significant court decisions has been acknowledged. Given the importance of advance planning in protecting an individual’s rights, all structures which can encourage its use should be put in place and we believe legislative provision would be a significant improvement. In addition, the greater the use of advance directives, the fewer situations in which intervention may be required. Placing advance directives on a statutory footing would encourage individuals to consider their wishes in depth and provides clarity for medical practitioners when they come to put them into effect.

**CHAPTER TWELVE – Adjustments to authorisation for medical treatment**

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

The proposals engage both Article 5 and Article 8 and, potentially, Article 3 ECHR. The aspect of preventing the person from leaving the hospital may well give rise to a deprivation of liberty, while the authorisation of medical treatment without their consent engages the right to private and family life and, could, in severe circumstances engage the prohibition of inhuman and degrading treatment.

Non-consensual treatment may, in ECHR terms, be permitted but only where national law provides for such intervention, the intervention is in pursuit of a legitimate aim, appropriate safeguards exist and, where there is a degree of discretion in its implementation, the scope of such discretion is defined.[[46]](#footnote-46) In addition, it appears that the unqualified right to respect for physical and mental integrity in Article 17 CRPD was intended to apply in situations of involuntary detention and treatment.[[47]](#footnote-47) This may arguably strengthen the Article 8(1) ECHR right and thereby provide an additional constraint on unwarranted and excessive treatment[[48]](#footnote-48) that may otherwise be justified under Article 8(2).[[49]](#footnote-49)

The ECtHR has made clear that authorisation to administer non-consensual treatment does not automatically follow from authorisation to detain, instead requiring separate substantive and procedural safeguards[[50]](#footnote-50). We consider that the reverse also applies and separate safeguards should be provided to address the question of detention and the question of treatment. These considerations point to the need for robust safeguards to ensure each of the rights. Accordingly, we agree that there is a need to provide clear and specific procedures for these situations. It is important, however, that these proposals do not widen the scope for restricting the adult’s legal capacity and permitting non-consensual interventions. Combining the existing power with authority to detain the individual, to use force where necessary and to remove the adult to hospital results in much more significant scope for intervention.

Again, we highlight that any procedure must begin with specific steps to support the adult to make a decision and exercise their legal capacity. While the principles of the Act apply, there is no elaboration in sections 47-50 of how a person’s objection to treatment should be dealt with. Section 50 requires that consent be sought from guardians, attorneys or interveners but it does not address the consent of the adult themselves. At present, section 47 certificates can effectively exclude the adult’s views if they are deemed to be incapable. Thoughtful consideration of such issues in the Court of Protection has made clear that capacity cannot be treated as an “off-switch”[[51]](#footnote-51). If this model is to apply, it must be adapted to place primacy on the will and preference of the adult and to work towards their consent, first and foremost.

Similar to our comments above in relation to short term placements, we consider that a short appeal period should be allowed to elapse before treatment can take place.

**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?**

Removing an individual to hospital, possibly with the use of force if “immediately necessary”[[52]](#footnote-52), is a more serious interference with their rights and would be more likely to engage Article 3 ECHR. If this additional step is required, this should be subject to judicial consideration. We understand that, in these circumstances, the MWC currently recommend[[53]](#footnote-53) that an application for a removal order under s.293 Mental Health (Care & Treatment)(Scotland) Act 2003 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 an Intervention Order or a Welfare Guardianship should be considered. We believe that a s.293 removal order should remain the 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 (s.294).

**Do you agree that a 2nd opinion (medical practitioner) should be involved in the authorisation process? If yes, should they only become involved where the family dispute the need for detention?**

Yes. A second opinion provides an important safeguard against arbitrary use. We consider that a second opinion medical practitioner should also become involved where the adult objects to the treatment, whether they are considered to lack capacity to do so or not.

**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?**

We support the proposal for the authorisation to be time-limited. We highlighted above that Article 5(4) ECHR requires both “speedy review” of the lawfulness of detention and continuing review “at regular intervals”, particularly in circumstances where the grounds for detention are susceptible to change over time. We consider, therefore, that there should be an automatic judicial review after the initial period of detention and a period of 28 days would seem to be acceptable in terms of speed. In the period up to 28 days there should be a requirement for regular review by the medical practitioner. The ability to appeal by the adult and their family/proxy/guardian is an essential safeguard and we agree with the proposals in that regard.

**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 agree also that an end date must be fixed and that procedures must be designed to ensure that an adult is not kept in hospital without therapeutic reason, in compliance with the Article 5 ECHR requirement to ensure there remains a continuing necessity for detention[[54]](#footnote-54).

**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.**

As we have outlined at Chapter Six, we do not support the range of professionals being extended. We are particularly concerned about such an extension if the power of those professionals can extend from authorising medical treatment to detaining an adult for treatment. We maintain that only those with a thorough understanding of the “assessment of capacity”, particularly as it develops away from non-discriminatory criteria, should be empowered to wield such power.

**CHAPTER THIRTEEN – Research**

**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?**

**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)?**

**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)**

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

**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?**

**Should part 5 of the act be made less restrictive?**

Our position in relation to all of the above questions is that we believe that the safeguards are as robust as they are for good reason and we would not support any loosening of the restrictions.

Human rights standards place stringent restrictions on the ability to conduct medical research in the absence of consent. Article 7 of the International Covenant on Civil and Political Rights and Article 15 CRPD very clearly stipulate that “…*no one shall be subjected without his or her free consent to medical or scientific experimentation*”. We are quite certain that the CRPD Committee would interpret this as being an absolute ban. If part 5 of the Act is to be made any less restrictive, this should mean less restrictive for the rights of the individual.

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

We believe that any advance consideration of medical matters should be encouraged and, given that attorneys have a consenting role in the procedure as it stands, this should be based on an understanding of the will and preference of the adult in relation to the matter. We find it difficult to imagine how an individual could give informed consent for research about which they know nothing at the time. Human rights standards set out by the Council of Europe explain the detailed information required to constitute informed consent[[55]](#footnote-55). Advance consideration would be unlikely to be able to meet this standard, however, it could enable adults to state if they do not wish to be involved in research and this should be determinative as “unwillingness to participate in the research”[[56]](#footnote-56).

**CHAPTER FOURTEEN – Miscellaneous issues**

**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.**

With a view to fundamentally reframing the legislation as a supportive measure, we believe that the institution of guardianship must be renamed, the term having become loaded with many negative and paternalistic connotations. The title of the legislation itself should also have a focus on support rather than on deficits (i.e. “incapacity”). The recent Irish legislation made this shift, to the Assisted Decision-Making (Capacity) Act 2015, and we recommend something along these lines, or use of the term Supported Decision-Making.

We repeat our call for a comprehensive review of the whole legislative framework regarding non-consensual care and treatment. In the meantime, we would like to see a road map for reform of the framework in the short to medium term and with the involvement of people with lived experience and informed experts in both law and practice.

1. For example, see ‘*Disability rights in Scotland, Supplementary submission to inform the CRPD List of Issues on the UK*’, (SHRC & EHRC, 2017) <http://www.scottishhumanrights.com/media/1557/crpdfeb2017scotlandsupplement.docx> [↑](#footnote-ref-1)
2. Consideration of Petition PE1667: Calling for a review of Scottish mental health and incapacity legislation, 5 December 2017 <http://www.scottishhumanrights.com/media/1743/pe1667-re-mental-health-and-incapacity-legislation-december-2017-002.doc> [↑](#footnote-ref-2)
3. “What we are seeking to achieve is an over-arching support mechanism which will maximise the autonomy and exercise of legal capacity for persons with impaired capacity so that genuine non-discriminatory respect is afforded for an individual’s rights, will and preferences.” p.11 of consultation [↑](#footnote-ref-3)
4. General Comment No.1 (2014) of the Committee on the Rights of Persons with Disabilities, at para.21 [↑](#footnote-ref-4)
5. See Recommendations 3 and 4 of ‘*Three Jurisdictions Report: Towards Compliance with CRPD Art.12 in Capacity/Incapacity Legislation across the UK’*, Essex Autonomy Project (2016) [↑](#footnote-ref-5)
6. Article 4 (3) CRPD requires that disabled people and their representative organisations are involved in the development and implementation of legislation and policies that affect them [↑](#footnote-ref-6)
7. ss29(2)(d) and s.57 Scotland Act 1988 and s.6 Human Rights Act 1998. [↑](#footnote-ref-7)
8. Para 7(2) Schedule 5 Scotland Act 1998 [↑](#footnote-ref-8)
9. **Article 12, Equal recognition before the law**: “The Committee recommends that the State party, in close consultation with organizations of persons with disabilities, including those representing persons from black and minority ethnic groups and in line with the Committee’s general comment No. 1 (2014) on equal recognition before the law, abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws. It urges the State party to step up efforts to foster research, data and good practices in the area of, and speed up the development of, supported decision-making regimes…” (para.31)

**Article 13, Access to justice**: “The Committee recommends that the State party, in close collaboration with organizations of persons with disabilities:

 (a) Develop and implement capacity-building programmes among the judiciary and law enforcement personnel, including judges, prosecutors, police officers and prison staff, about the rights of persons with disabilities;

 (b) Design and implement a decision-making regime with guidelines and appropriate resources, focusing on respecting the will and preferences of persons with disabilities, particularly persons with intellectual and/or psychosocial disabilities, in court proceedings;” (para. 33)

**Article 14, Liberty and security of the person**: “The Committee recommends that the State party:

 (a) Repeal legislation and practices that authorize non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment;” (para. 35)

**Article 17, Protecting the integrity of the person**: “The Committee recommends that the State party repeal all types of legislation, regulations and practices allowing any form of forced intervention or surgery, and ensure that the right to free, prior and informed consent to treatment is upheld and that supported decision-making mechanisms and strengthened safeguards are provided…” (para.41)

Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland, 3 October 2017 [↑](#footnote-ref-9)
10. <http://www.scottishhumanrights.com/media/1265/consultresponseawi.doc> [↑](#footnote-ref-10)
11. ‘Mental Capacity and Deprivation of Liberty’, Law Commission (2017) at p.167 [↑](#footnote-ref-11)
12. *Cheshire West and Chester Council v P* [2014] UKSC 19 [↑](#footnote-ref-12)
13. ‘Mental Capacity and Deprivation of Liberty: A Consultation Paper’, Law Commission (2015), at p.68 [↑](#footnote-ref-13)
14. *HL v United Kingdom* (45508/99) [2004] ECHR 471 [↑](#footnote-ref-14)
15. Bartlett, P., "Reforming the Deprivation of Liberty Safeguards (DOLS): What Is It Exactly that We Want?", (2014) 20(3) Web JCLI [↑](#footnote-ref-15)
16. In line with Recommendation 5 of the Essex Autonomy Project “The scope of statutory requirements regarding the provision of support should be expanded to encompass support *for the exercise of legal capacity*, not simply support *for communication* (as in AWIA s1(6)) or support *for decision-making capacity* (as in MCA s1(3))” [↑](#footnote-ref-16)
17. Recommendation 6, Essex Autonomy Project [↑](#footnote-ref-17)
18. para.26 [↑](#footnote-ref-18)
19. “*The starting point, based on the current international standards, was that the will and preferences of a person with disabilities should take precedence over other considerations when it came to decisions affecting that person”* , Application no. 53251/13 [2017] at para. 67 [↑](#footnote-ref-19)
20. *Červenka v. The Czech Republic,* Application no.62507/12 [2016], *KC v Poland*, Application no.31199/12 [2014] [↑](#footnote-ref-20)
21. *KC v Poland*, ibid at para.70 [↑](#footnote-ref-21)
22. para.29(d) [↑](#footnote-ref-22)
23. Article 12 (5) CRPD [↑](#footnote-ref-23)
24. Part 3 <http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/pdf> [↑](#footnote-ref-24)
25. “*The concept of mental capacity is highly controversial in and of itself. It is not, as it is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity*.”, para. 14 General Comment No.1 [↑](#footnote-ref-25)
26. See, for example, paras. 21-26, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 28 March 2017 [↑](#footnote-ref-26)
27. para. 29(i) [↑](#footnote-ref-27)
28. For discussion see ‘*Navigating the ‘Flashing Amber Lights’ of the Right to Legal Capacity in the United Nations Convention on the Rights of Persons with Disabilities: Responding to Major Concerns’*, Gooding, P., Human Rights Law Review, 2015, 15, 45-71 [↑](#footnote-ref-28)
29. Ibid at p.60 [↑](#footnote-ref-29)
30. para.27 General Comment No.1 [↑](#footnote-ref-30)
31. para. 29(g) General Comment No.1 [↑](#footnote-ref-31)
32. See above at p.5 [↑](#footnote-ref-32)
33. ‘*Scotland’s Mental Health and Capacity Law: the Case for Reform’*, Centre for Mental Health and Capacity Law & Mental Welfare Commission (May 2017) [↑](#footnote-ref-33)
34. ‘Supported Decision-Making: A Framework’, People First (Scotland) <http://peoplefirstscotland.org/files/2017/03/Framework-Final.compressed.pdf> [↑](#footnote-ref-34)
35. X v Finland [↑](#footnote-ref-35)
36. p.51 of consultation [↑](#footnote-ref-36)
37. As required by *X v Finland*, at para. 90 [↑](#footnote-ref-37)
38. In Ireland’s Assisted Decision-Making (Capacity) Act 2015 [↑](#footnote-ref-38)
39. *X and Y v. the Netherlands* (8978/80) [1985];*Storck v Germany* (36022/97) [2005] [↑](#footnote-ref-39)
40. See also concluding observation in relation to Article 13: “The Committee recommends that the State party, in close collaboration with organizations of persons with disabilities: (a) Develop and implement capacity-building programmes among the judiciary and law enforcement personnel, including judges, prosecutors, police officers and prison staff, about the rights of persons with disabilities;” [↑](#footnote-ref-40)
41. Article 12(4) CRPD [↑](#footnote-ref-41)
42. ‘*Supported Decision-making: Learning from Australia’*, Killeen, J. (2016), available at <https://www.wcmt.org.uk/sites/default/files/report-documents/Killeen%20J%20Report%202016%20Final.pdf> [↑](#footnote-ref-42)
43. para. 24 [↑](#footnote-ref-43)
44. *Herczegfalvy v Austria* (1992) A 244, 15 EHRR 437 [↑](#footnote-ref-44)
45. para.17 General Comment No.1 [↑](#footnote-ref-45)
46. *Silver v United Kingdom* (5947/72) [1983], paras 88 and 90. [↑](#footnote-ref-46)
47. See, for example, United Nations, *Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its Seventh Session* (UN Doc A/AC265/2006/2, 13 Feb 2006). [↑](#footnote-ref-47)
48. B McSherry, “Protecting the integrity of the person: developing limitations on involuntary treatment” in B McSherry (ed), *International Trends in Mental Health Laws* (2008) 111 at 112-119*;* J Stavert “United Nations Convention on the Rights of Persons with Disabilities: possible implications for Scotland for persons with mental disorder” (2009) 47 *Scottish Human Rights Journal* 2. [↑](#footnote-ref-48)
49. However, the Court has admittedly not arrived at this conclusion yet and missed such an opportunity in *DD v Lithuania*. [↑](#footnote-ref-49)
50. *X v Finland*, Application no. 34806/04 [2012] [↑](#footnote-ref-50)
51. *Wye Valley NHS Trust v B* [2015] EWCOP 60 at para.11 [↑](#footnote-ref-51)
52. s.47(7)(a) AWI [↑](#footnote-ref-52)
53. ‘*Right to Treat?*’ MWC (2011) [↑](#footnote-ref-53)
54. *Herczegfalvy v Austria* (1992) A 244, 15 EHRR 437, *KC v Poland*, (31199/12) [2014] [↑](#footnote-ref-54)
55. “Before being asked to consent to participate in a research project, the persons concerned shall be specifically informed, according to the nature and purpose of the research:

of the nature, extent and duration of the procedures involved, in particular, details of any burden imposed by the research project;

of available preventive, diagnostic and therapeutic procedures;

of the arrangements for responding to adverse events or the concerns of research participants;

of arrangements to ensure respect for private life and ensure the confidentiality of personal data;

of arrangements for access to information relevant to the participant arising from the research and to its overall results;

of the arrangements for fair compensation in the case of damage;

of any foreseen potential further uses, including commercial uses, of the research results, data or biological materials;

of the source of funding of the research project.”

Article 13, Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research. While, the UK is not a signatory to this Convention, it sets out the minimum human rights standards considered acceptable across Europe. [↑](#footnote-ref-55)
56. s.51(3)(b) AWIA [↑](#footnote-ref-56)