Law Society of Scotland

Consultation Response

Scottish Mental Health Law Review

May 2022

Introduction

The Law Society of Scotland is the professional body for over 12,000 Scottish solicitors.

We are a regulator that sets and enforces standards for the solicitor profession which helps people in need and supports business in Scotland, the UK and overseas. We support solicitors and drive change to ensure Scotland has a strong, successful and diverse legal profession. We represent our members and wider society when speaking out on human rights and the rule of law. We also seek to influence changes to legislation and the operation of our justice system as part of our work towards a fairer and more just society.

Our Mental Health and Disability sub-committee, with contributions from our Criminal Law committee to our response on Chapter 3 of the consultation document, welcomes the opportunity to consider and respond to the Scottish Mental Health Law Review consultation.[1] The sub-committee has the following comments to put forward for consideration.

In the context of our deliberations, conflicts (and what might be perceived as conflicts) affecting individual members of participating committees were the subject of declarations by those members and appropriate management in the fully cooperative processes within and between committees leading to preparation of this response.

Executive Summary

Our General Comments

We refer to previous engagement and our previous relevant consultation responses, dating back to 2012. We highlight the need for comprehensive reform across all areas covered by relevant legislation, including the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000, the Adult Support and Protection (Scotland) Act 2007, and those provisions which are located outwith the main areas of legislation, including provisions for administration of social security benefits, and for interventions under section 13ZA of the Social Work (Scotland) Act 1968. We emphasis the need for reforms to be designed to meet all needs for support for the exercise of legal capacity and effective enjoyment of all rights "on the same basis as others" in terms of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), including to act, transact, make decisions, and generally safeguard, exercise and have the full benefit of their rights and interests. We call for the abolition of "mental disorder" or similar gateway terminology based on diagnostic criteria, in order to achieve compliance with UNCRPD and a human rights approach.

We highlight our priorities for implementation, including:

- A regime to govern deprivations of liberty in terms of Article 5 of ECHR

[1] https://consult.gov.scot/mental-health-law-secretariat/scottish-mental-health-law-review/

- The resources needed to ensure recruitment, training and retention of adequate numbers of mental health officers ("MHOs")
- Steps to ensure that there is no form of means-testing for any form of Legal Aid in relation to any proceeding concerning welfare matters, to ensure that funding in individual cases should be adequate to allow solicitors to comply fully and properly with their professional obligations to understand what clients want and to take their instructions, and to ensure full access to justice, including access to legal services, for all people with relevant needs, and representation in all relevant proceedings, to comply with applicable human rights requirements[2].
- That a unified tribunal be established to have principal jurisdiction under the 2000, 2003 and 2007 Acts, so that experience of a one-door approach can be followed sequentially by alignment, and then consideration of fusion, as indicated in the last paragraph of this Executive Summary.
- Support for current initiatives towards the development of mediation services in relation to all matters of actual or potential conflict within any aspect of all relevant areas of law

We recommend that the Final Report address the need for adequate resourcing, and careful planning of implementation, of reformed law, without which there is a serious risk of substantial failures in practice to achieve intended outcomes.

Introduction and Background

There are uncertainties and inconsistencies in this chapter which we recommend should be eliminated in the Final Report. We recommend for the Final Report adoption of inclusive terminology such as "(all) people with relevant needs" and "(all) relevant areas of law" as suggested in our General Comments, and that in those and other respects narrow rather than inclusive terminology should be employed only where that is clearly appropriate and necessary.

What is the purpose of the law?

The focus of this chapter is on public law principles and duties, and we recommend that this is clarified in any final proposals. We recommend that the proposed purpose of the law should be extended to apply to all people with impairments of relevant capabilities, however caused, and should include facilitating the effective exercise of legal capacity by all people who are capable of that if provided with necessary support, and for those who are not fully capable of acting and deciding for themselves, but doing so in full compliance with relevant human rights instruments. Subject to these points, we are broadly supportive of the proposals set out in this Chapter. However, complementing these essentially public law principles should be retention and enhancement of existing principles applicable to private law aspects of the relevant statutes, updated to comply with the recommendations of the Three Jurisdictions Report[3] and our previous recommendations. All principles enshrined in law should be made effective by attributable duties and available remedies.

Supported decision making

The suggested definition of supported decision-making in the first sentence of this Chapter is too narrow, and we recommend that the broad concept of exercise of legal capacity must be adopted in the Review's final recommendations. The principle of greater support for autonomy must not be limited only to people

[2] These have been clearly stated in the very recent case of *Kovacevic v Croatia*, accessed since this response was otherwise drafted.

[3] One half of the membership of the core research group for this UK-wide project comprised members of our Mental Health and Disability Sub-Committee, all but one of them still current members.

using health and care services or applied only within those services. One of the critical areas for provision of support for the exercise of legal capacity is in meaningful access to legal services and to justice. Subject to these comments, we welcome the recommendations for a wide-ranging supported decision making scheme. We support a broad definition of the potential scope of advance directives, and have published a separate report setting out our recommendations for reform in this area.[4] A wide ranging supported decision making scheme must address the need for publicity, accessibility of relevant information, and education about the importance of accessing it.

The role and rights of carers

We recommend a holistic overview approach to engagement between the cared-for person, unpaid carers, and other supporters with all services. We suggest that such holistic management can appropriately and efficiently be achieved by the concept of an “enveloper” with functions relating to co-ordination, information-sharing, and ensuring effective and efficient delivery of services. Information should be shared, subject to minimum necessary limits. Carer awareness training should be mandatory, and should not be limited to staff in any one particular service.

Human rights enablement – a new approach to assessment

We welcome and support both the basic concepts of human rights enablement (“HRE”), as described in this Chapter, and of an autonomous decision-making test in Chapter 6. They should be at the core of our way forward in Scotland in relation to all relevant areas of law. However, as described in the consultation document, both are seriously undeveloped. The concept of HRE set out in this chapter needs to be extended across all rights relevant to all individuals within the scope of the Review, and to how they are to be made real in law as being enforceable rights with corelative duties which are all clearly attributed, with clear and accessible remedies. This must, if need be, include unhindered access to legal services, and to an authoritative and independent judicial or quasi-judicial body. Introduction of an HRE framework would require further clarity regarding how the proposals would work in practice, including accountability, flexibility and a full implementation strategy. The availability of a review and appeal process is an essential part of ensuring accountability, and the final stage would be legal review by a judicial body. There should always be independent support and representation for an individual seeking to review or appeal an HRE. Consideration should be given to creating a role similar to that of the Official Solicitor.

Autonomous decision making test

We welcome and support the principle of an autonomous decision-making test, which should apply to any form of intervention under any of the relevant legislation, and should cover all aspects of the ability to exercise autonomy and self-determination, not limited to decision-making. We highlight a need for standardised mandatory training for all persons involved in applying and ADM test. The suggested ADM test will be based on a framework of the human rights principles. The aspects of ‘maximum benefit’ principle and the principle of 'reciprocity' in the delivery of identified interventions should continue to be reflected in the application of the ADM test. There should be an escalation system to challenge the

[4] 22-05-19-adwg-report-final.pdf (lawscot.org.uk)

application of the test, and there should always be an ultimate right of access to an independent judicial or quasi-judicial process.

Reduction of coercion

We recommend that proposals for reduction of coercion should address any non-consensual intervention of any kind, as well as analogous situations, such as where available choices are unduly limited to choices that suit providers rather than that may suit the individual. The safeguards for medical treatment in Part 16 of the 2003 Act should be strengthened, and wherever possible such provisions should apply as widely as possible, and not be limited to particular services such as medical treatment. The role of the Mental Welfare Commission should be strengthened and extended to all non-voluntary interventions within the broad overall remit of Mental Welfare Commission, with appropriate resourcing.

Accountability

We highlight that issues of accountability are relevant to all areas of law and practice within the remit of the Review. It is essential that people know their rights and have access to clear and accessible methods of challenge where their rights are violated. All rights must have corresponding attributable and readily ascertainable duties. We agree with the proposals to give the Mental Health Tribunal increased powers to order that specific care or support be provided, and recommend that an equivalent process should be introduced under AWI procedure. However, there is a gap in enabling people who lack capacity to seek redress for recorded matters which are not fulfilled. We recommend the creation of a role in Scotland equivalent to the Official Solicitor in England, applicable across civil process in Scotland. The right to appeal against unjustified restrictions should apply to all situations of non-voluntary intervention, including those under AWI legislation. We support the proposal for a 'remedy panel' in principle, but further clarity is required as to the distinction and interaction between a complaints process, and any legal process capable of delivering a legally effective remedy. We consider that mediation may be a useful tool in resolving certain complaints. We support the principle of collective advocacy groups raising court actions, but note the requirement for effective funding and access to legal advice, guidance and support for groups who wish to take this step. A right of redress to the Courts should always remain available. We agree with the proposals to develop and promote advocacy - both collective and individual. However, without a corresponding proposal to develop and promote legal services available to individuals we have real concerns regarding how individuals and groups will be able to access justice. We support proposals to make the scrutiny landscape more effective. We support the proposals to extend the Commission's role and call for the Commission always to be resourced with in-house legal expertise.

Children and young people

The current 2003 Act principle for children is still needed, and should be extended to include the wider principle of respecting all of the rights of the child under the UNCRC along with the UNCRPD. Statutory duties should be extended to Scottish Ministers and health and care agencies, should be clearly attributable, and should be accompanied by a right to redress for the child and their parents. Detention of children and young people should be approved by a mental health officer. Access to CAMH services should be available up to and including the child's 18th birthday. We support the proposals relating to relative and families. We would agree that children's voices require to be considered in order to inform any decision-making process, which should always be person specific. Engaging the young person's

participation is a crucial part of the process. Rights to advocacy should be strengthened. We endorse the recommendations of the Rome Review quoted in the consultation paper. We consider that the Mental Health Tribunal is currently best placed to deal with the mental health law cases for children currently. We agree that mental health legislation should incorporate separate provisions for children and young persons. Recent case law on the inter-relationship of guardianship and continued application of child law provisions should be considered and should be explicitly applied/disapplied in the Review's recommendations.

Adults with Incapacity proposals

We are disappointed that the consultation document discloses little real development of necessary work on the adults with incapacity regime over the four years since conclusion of the 2018 consultation. We refer to all of our previous submissions on adults with incapacity reform. We recommend that the Final Report should include a comprehensive statement of necessary reforms and should stress the urgency of proceeding with them.

On Guardianship, we recommend that the Final Report should take account of recent and current emerging issues in this area, particularly in recent and current litigation. We welcome the move away from the previous 'graded guardianship' proposals - about which we have previously raised concerns - but are concerns that the proposed "decision-making framework" may create confusion. We call for additional safeguards, and clear information for individuals and organisations. We recommend that the role of co-decision maker be retained and developed to allow flexibility. We make recommendations regarding the proposed 'streamlined application process', and in particular note that the use of a pro forma encourages a tick box approach which is fundamentally inappropriate. It is important that any proposals for emergency application emphasise the need to retain but accelerate the operation of necessary safeguards, and we suggest an alternative approach.

Intervention orders (IOs) should be retained. It is important to recognise that there are two distinct types. The use of intervention orders in which the court itself takes the required action should be enhanced, and should be mandatory in situations such as making a Will for the adult. We give some examples of situations where the other type of intervention order, where the court delegates to an appointee, is appropriate and should continue to be available, perhaps with some degree of fine-tuning of procedural requirements.

On Powers of Attorney, we refer again to our previous consultation responses. We support measures to increase awareness of powers of attorney, and to provide further guidance and support to attorneys and granters.

On Part 5 Medical Treatment and Research, we refer to our recent paper on Advance choices and medical decision-making in intensive care situations. We support extending the exclusions in section 47(7) to exclude anything that could be authorised under the 2003 Act, and anything that would require authorisation under any current deprivation of liberty scheme (including the current basic requirement to comply with Article 5 of ECHR) or any other provision of the 2000 Act. We are not aware of any evidence to support changes to the dispute resolution procedure in section 50, as it has hardly ever needed to be initiated.

Law Society of Scotland

Deprivation of Liberty

There is an urgent need to introduce necessary provision for authorisations of deprivations of liberty. We offer a note of the current position in law, and the main issues. We welcome, and commend, the work done by the Review in relation to this issue, and the thought given to an appropriate regime. We refer to our previous consultation responses. We agree that the supported decision making model, and emphasis on respect for the rights, will and preference of the adult, is an important safeguard for the adult. We stress that there is a need for regular review, and note again the need for independent legal advice and the potential for the creation of a role akin to that of the Official Solicitor. We consider it essential that deprivation of liberty is authorised by a judicial body, through a process adapted to reflect support for autonomy and supported decision making, but note the potential significant burden on families in some circumstances of renewing the order as often as every six months, as opposed to the essential human rights requirement for regular review. Regular review by the relevant local authority may be preferable. We highlight the need for appropriate procedural safeguard, and for the adult, or a person acting on their behalf, to have access to independent legal advice. We agree that urgent orders may be required in very limited circumstances, but that any order should be initially granted only for a period of 7 days, with a properly intimated hearing held no later than the seventh day, but because the initial intervention can in effect be pre-emptive, all essential human rights-based requirements should nevertheless be complied with. More information is required as to how an urgent order depriving liberty will differ from, or operate in conjunction with, the proposed emergency appointment of a decision-making representative. It is essential that urgent orders are included in an overall scheme for authorisation of deprivation of liberty, and that the scheme is implemented as soon as possible.

We recommend that there should be a clear requirement on a court or tribunal to facilitate the personal participation of the adult, to supplement this where necessary, to record how this has been done, and in the absence of participation, to record the reasons and to record the steps nevertheless taken to ascertain the ‘will and preferences’ of the adult. These requirements should be among those that are mandatory in all circumstances, including for urgent orders. We note that any new system must be properly resourced, including the education and training of relevant participants. Public awareness of the issues concerned must be raised by appropriate, easily comprehensible publicity. Advice and guidance must be made widely available, in all appropriate formats.

Mental disorder

We reiterate our view, noted above, that the term “mental disorder”, or any similar barrier to accessing ways of meeting the particular needs of any and all people with relevant needs, is incompatible with a human rights-based approach and should be excluded from relevant legislation.

Fusion or aligned legislation

We reiterate our call for a unified forum for judicial or quasi-judicial purposes, facilitating a ‘one door’ approach. This should be the priority, prior to consideration of fusion or aligned legislation. The creation of unified forum would allow for the development of experience of the need for alignment, in the first instance, and thereafter the re-evaluation of the appropriateness of fully fused legislation in light of experience following upon those preceding steps.

General Comments

Previous engagement

The work of the Scottish Mental Health Law Review ("the Review") is embedded in, but independent of, a broader process of review and consultation by Scottish Government which, though following upon earlier developments, could be said to have commenced with Scottish Government's consultation on the UN CRPD Draft Delivery Plan 2016-2020 and on the Scottish Law Commission ('SLC') 2014 Report on Adults with Incapacity, to which we responded in December 2015 and March 2016 respectively. Our further relevant submissions are listed in Annex A, mentioned below.

We commend and are grateful for the considerable opportunities which we have had for engagement with both those leading relevant work of Scottish Government from early 2016, and with the Review Team up to and including during the current consultation period. We have been encouraged throughout to respond comprehensively, and continue to do so.

The need for comprehensive reform

Whereas the principal focus of the 2016 and 2018 consultations was upon the AWI regime and we sought to maintain a broader overview on the whole area of relevant legislation, the Terms of Reference of the Review place substantial emphasis on mental health law, and in relation to the Review (and concurrent work by Scottish Government) we, as well as participating fully within the main focus of the Review, have continued to stress the need for comprehensive review and reform. Much of the forward-looking work and thought by the Review Team reflected in the present consultation document is expressed in the consultation document principally by reference to mental health law and people subject to provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") by reason of mental disorder, but would more appropriately apply across areas covered by all relevant legislation, and in relation to all people subject to or who might become subject to any of the main areas of legislation, including in particular the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") and the Adult Support and Protection (Scotland) Act 2007 ("the 2007 Act") as well as the 2003 Act. For simplicity of reference, we use in this response the comprehensive terminology "(all) people with relevant needs" and "(all) relevant areas of law", respectively. We recommend that this terminology, or similarly comprehensive terminology, be adopted throughout the Final Report, except only where references unavoidably apply to people with limited categories of needs, or to some limited area of law, and are demonstrably inappropriate for application beyond those limits.

We recommend that the Final Report makes it clear that its proposals should be applied to all relevant areas of law, including those which happen to be awkwardly located in legislation other than the Acts of 2000, 2003 and 2007. Examples are provisions for administration of social security benefits, and for interventions under section 13ZA of the Social Work (Scotland) Act 1968, both of which we consider may fail to meet required human rights standards, including but not limited to availability of rights to redress. They should also be designed to meet all needs for support for the exercise of legal capacity and effective enjoyment of all rights "on the same basis as others" in terms of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), including to act, transact, make decisions, and generally safeguard, exercise and have the full benefit of their rights and interests.

We are disappointed that the current consultation period is inadequately short, in view of the lengthy and detailed nature of the consultation proposals. We acknowledge and record that it has been explained to us that the current consultation does not seek to cover all areas of ongoing work by the Review, which will continue during and beyond the consultation period. Moreover, it has been explained that the Final Report will represent only a step along the way towards reformed legislation, so that, for example, it will not contain drafts of suggested legislation. It will however be a most important and highly influential part of the wider and longer process, and we recommend that the Final Report should contain guidance and recommendations as to the further process thereafter. Some of those points are addressed in this general section of our response. We accordingly suggest that the Final Report should include a recommendation to Scottish Government that promptly upon issue of the Final Report, a more adequate period of consultation upon it be initiated, in particular to minimise further delay in addressing significant needs for reform identified several years ago, and still not yet addressed.

To serve the objective of making adequate human rights-compliant provision for all people with relevant needs, all of the recommendations in all of the output of documents listed in Annex A should be included in the Final Report.

Abolition of "mental disorder" or similar gateway terminology based on diagnostic criteria

The Review's Terms of Reference could be described as covering (a) mental health legislation and people with a mental disorder; and (b) all three Acts and all people subject to them; together with (c) broad discretion to the Chair to 'make such other recommendations as the Chair considers appropriate'. It is noted, however, that the consultation document is frequently limited as both the areas of law addressed and as to the people whose needs require to be catered for within the broad scope of all relevant legislation. While such an approach might be consistent to the frequent limitations in the Terms of Reference to mental health legislation only, or to people subject to relevant legislation by reason of mental disorder, such limitations would not enable the Review to fulfil the broader aspects of its remit. AWI legislation is not limited to people with mental disorders, and (for example in Part 2 of the 2000 Act) extends to people with no current impairments of their capabilities, who seek to provide for possible impairment in the future. The principal purpose of the 2007 Act is to meet the needs of people at risk, whether or not arising from mental disorder or impairments of their capabilities, in terms of the 2000 and 2003 Acts. Moreover, such limitations require to be set aside in order to fulfil the important elements of the Terms of Reference seeking recommendations for compliance with European Convention on Human Rights (ECHR) and UN CRPD, and regarding possible convergence of all three pieces of legislation, as well as the requirement to consider areas of previous and ongoing work specified in the Terms of Reference. We recommend that the Final Report should re-emphasise and recommend the need for the law reform process going forward to encompass all areas of relevant law, and all people whose needs it seeks to address, in a comprehensive and holistic manner.

The potential tensions identified above are, in our view, artificial. They are predicated upon the term 'mental disorder', and upon that term, or the same concept in other words, continuing to be used in definitive manner. In our view, the difficulty relates not to the terminology, but to the use of such a concept at all. Concepts of disability have developed from a medicalised approach to an approach focused on social context, but both those approaches seek to treat people with disabilities as to some degree 'apart'.

UN CRPD and a human rights approach stress that all people should have the same rights and status, regardless of the nature and extent of any disabilities. The approach to deliver that must be a human rights approach. To achieve that, we strongly support the principles of human rights enablement and an autonomous decision-making test described in Chapters 5 and 6 of the consultation document. Even if these concepts, and the development of them, were the only output of the Review, that output would still be significant and commendable in shaping the way forward for meeting the needs of all people, throughout their lives, in a human rights-compliant manner, in accordance with fundamental principles of justice and the rule of law. That requires a broadening of the proposals to cover all relevant areas of law and all people who might be or become within the scope of any of them.

That approach also requires abolition of the term 'mental disorder', or of any similar concept which puts some people into a category. That absolutely does not mean that healthcare needs, including mental healthcare needs, should not be identified and addressed, and that people with such needs may require special provision within the scope of a holistic regime. That, however, applies to all potential areas of need, some of which will continue to require special provision and procedures to ensure that needs are met in a human rights-compliant manner, having regard in particular to relevant provisions of UN CRPD and provisions such as Articles 5, 6 and 8 of ECHR.

The term 'mental disorder', or any similar concept, nevertheless hinders rather than helps in achieving those objectives. That has long been recognised in the context of Scots law, and has helped to shape positive development, but has not been adequately applied. Thus the 2000 Act refers to 'adults', unqualified except for specifying that these are people over the age of 16. Where particular provisions or procedures under the 2000 Act are engaged in relation to them, they are engaged because particular criteria apply to them, not because they have been put into some general differentiating category. They remain adult people, like everyone else. The hazards of putting people into special categories were emphasised at least as long ago as 1993:

'Laws everywhere are based on assumptions – a norm – which do not fit everyone, in every situation. So special rules of law are needed for some people, in some situations. The category of 'the norm' forces the creation of other categories, outwith the norm. The difficulty is caused by the boundary put round the category described as the norm. It is a boundary reinforced with strands of ignorance and fear, outdated but persistent. People outside the boundary may be deprived, unnecessarily, of participation in what is normal. People inside the boundary may be disqualified from receiving special help and special provision, even though they may need it.

'In society, there is no need for such a boundary. There should simply be a recognition that some people, in some situations, need special help or special provision. The law must define criteria. It will do so with greater precision if the emphasis is upon identifying needs; rather than having to label people as outside the boundary of the norm, before special needs can be assessed and met. This approach requires

reorientation of some legal concepts, and care in application. But it has the potential to humanise legal systems for the benefit of all, particularly those who perceive the law as threatening, rather than helpful.'[5]

The very existence of a term such as 'mental disorder' has the negative and discriminatory effect described above. In practice, it fosters an attitude that anyone with that label attached is different, not like the rest of us, so that treatment that is essentially discriminatory, and in violation of at least some rights, can be justified by no reason other than the attachment of such a differentiating label. If the ideals of a human rights approach, and the aspirations of UN CRPD, are to be realised in Scotland, such labelling must be abandoned. As in the above quotation, the focus should be upon identifying needs, defining how they can most appropriately be met, and meeting them, with full recognition of, and compliance with, the full rights of all people, with the counterpart of attributable duties to ensure that their rights are met, and that all people have real access to effective remedies if they are not. The Review's concepts of human rights enablement and an autonomous decision-making test, including other broad objectives identified in the consultation document, offer a way to achieve such an outcome. But it must be achieved without boxing some people in under particular categories, or the provisions in isolation of any one area of legislation.

Our previous consultation responses

Particular items in our output to date are listed in Annex A. They should be read cumulatively, building progressively with developments and experience, later documents to be read as superseding earlier ones only if and to the extent that any contradictions are identified. It has been helpfully explained to us on behalf of the Review Team that the consultation document is targeted, and does not seek to cover the range of broader issues addressed, cumulatively, by our output in Annex A. We therefore do not repeat any of it here except to the extent specifically relevant to the task of responding to matters addressed in a targeted consultation with short consultation period.

We nevertheless recommend that the broader picture, encompassing at least by reference all that is addressed by the output in Annex A, be encompassed in the Final Report, as stated above.

We also recommend that a fully coordinated and comprehensive approach to all areas of law be recommended for processes beyond submission of the Final Report through to preparation of reforming legislation.

Our priorities for implementation

We recommend that the Final Report addresses matters of relative urgency, timescale and sequence. In the course of engagement with the Review Team as narrated above, we have been encouraged to identify matters as priorities to be addressed and implemented in the short term within the broader law reform process referred to at the outset of these general comments. We would identify the following such matters:

(1) So long after the final decision of the European Court of Human Rights in the 'Bournewood case' in October 2004[6] , and some 13 years after a regime to govern deprivations of liberty in terms of Article 5 of

[5] See page 198 of 'A New View' by Adrian D Ward. Adrian Ward is the Convener of our Mental Health and Disability Sub-Committee.

[6] *HL v UK*, [2004] 40 EHRR 761

Law Society of Scotland

ECHR came into force in England & Wales, it is regrettable and damaging that Scotland still has no appropriate provision at all, notwithstanding that the whole current process of review of the law commenced with the intention of legislating following upon the Scottish Law Commission's 2014 Report[7] on the subject. By the very fact of failing to make provision, Scottish Government may continue to be in violation of Article 5. We are concerned that serious contraventions of the rights of elderly and disabled people may have occurred before and during the pandemic, particularly in processes of unlawful transfer of such people from hospitals to care homes, or unlawful retention of them in hospital, and a wider issue of failures even to recognise actual and potential deprivations of liberty. Documents in Annex A record and report such potential breaches of human rights and of law. We recommend that the Final Report should urge immediate remedy of this serious deficit of provision.

(2) That Scottish Government commit to ending the current discriminatory under-provision of the resources necessary to enable all people in Scotland with relevant needs to enjoy the range of rights assured to them by UN CRPD "on the same basis as others". As an immediate priority, Scottish Government should take immediate action to enable compliance with fundamental human rights requirements in relation to mental health and adults with incapacity proceedings by providing local authorities with the resources needed to ensure recruitment, training and retention of adequate numbers of mental health officers ("MHOs"), the numbers actually discharging MHO functions having reduced over a period in which demand (including demand resulting from legislative changes) has more than doubled.

(3) Scottish Government should take immediate and effective steps to comply with previous undertakings, including those given in conjunction with introduction of the 2000 Act, to ensure that there is no form of means-testing, direct or indirect, for any form of Legal Aid (including Advice and Assistance) in relation to any proceedings concerning welfare matters or welfare powers; and to ensure that funding in individual cases should be adequate to allow solicitors to comply fully and properly with their professional obligations to understand what clients want and to take their instructions, so as to be able adequately to represent the client's position in accordance with the client's will in the matter (or best interpretation thereof). Beyond the specific question of provision of adequate Legal Aid, there should be a commitment from Scottish Government to ensure full access to justice, including access to legal services, for all people with relevant needs.

(4) We would also recommend early implementation of the recommendation originally made, with full reasoning, in section 4.1 of our 2016 Response on AWI, that a unified tribunal be established to have principal jurisdiction under the 2000, 2003 and 2007 Acts. This is a separate matter from questions of fusion of legislation, or aligned legislation, addressed in Chapter 13 of the consultation document. Establishment of a unified tribunal should either precede or at latest coincide with alignment of legislation, and should in any event precede any decisions about fusion. Best would be if it could be introduced at an early date, so that further consideration of both alignment and fusion might be informed by experience of a single tribunal operating to uniform standards across the country, and with any disposals under any three of the relevant Acts available in any matter brought before it under any of them. The matter is urgent

[7] Scottish Law Commission Report No 240 on Adults with Incapacity (October 2014)

because lack of those features at present has a range of disadvantages and detriments, above all to the rights and interests of people affected by such procedures.

(5) Scottish Government should commit to supporting current initiatives towards the development of mediation services in relation to all matters of actual or potential conflict within any aspect of all relevant areas of law.

Finally, we recommend that the Final Report address the need for careful planning of implementation of reformed law, without which there is a serious risk of substantial failures in practice to achieve intended outcomes. A suitable model was the creation of the implementation steering group for the 2000 Act. The work of that group led to the review of experience which in turn led to necessary adjustments to the 2000 Act included in the 2007 Act. Reformed legislation across all three relevant areas is likely to require some adjustment in the light of experience in practice.

The structure of our response

In view of the short consultation period allowed, and – in the context narrated above – the limited and targeted focus of the consultation, our main more general comments are contained in this ‘General Comments’ section of our response. The consultation document itself invites comments, suggestions or thoughts on each substantive chapter of the consultation, together with a number of consultation questions for each chapter. We have addressed each substantive chapter of the consultation below.

We have also provided a more detailed page-by-page analysis of the consultation document in Annex B. This should be read alongside and as supplementary to our general comments and our responses to the consultation questions.

This response draws on and is informed by the experience of our members, and further information and practical examples of the issues we raise can be provided on request.

Chapter 1: Introduction and Background

Our general comments on this chapter

This chapter contains uncertainties and inconsistencies which, we recommend, be eliminated in the Final Report. There are references to “legislation”, implying limitation to matters of relevant areas of law within the Acts of 2000, 2003 and 2007. Even within the combined scope of the three principal relevant areas of law, there are unexplained limitations. For example, under “Impact of Covid 19”, the reference to “mental health and incapacity issues” is not compatible with the limitation to “systems of mental health support and care”, and neither is compatible with the broader aspects of the remit to address all three areas of law. As regards the people whose needs are addressed, there are unexplained differentiations of terminology, such as people with “mental health conditions”, people with “mental disorders”, people with “mental health

conditions of whatever type", when it would appear that most if not all of these references should be to what we have termed "all people with relevant needs", rather than those within only a small sector of the Review's broader remit. There are other apparently inappropriate, and in any event confusing, narrowings of provisions. In some cases the inconsistency is obvious, as with the very narrow definition of "compulsion" followed by a reference to all three areas of legislation across which that narrow definition is inappropriate. Sometimes there are references to "compulsion", and elsewhere to "coercion", without explaining what is intended to be the difference. On page 7 there is a limitation to "a non-discriminatory basis for involuntary treatment", whereas to achieve a holistic approach to human rights compliance all types of involuntary interventions should be encompassed in any proposals. We recommend for the Final Report adoption of inclusive terminology such as "(all) people with relevant needs" and "(all) relevant areas of law" as suggested in our General Comments, and that in those and other respects narrow rather than inclusive terminology should be employed only where that is clearly appropriate and necessary.

Here and elsewhere, see also our comments on "decision-making" in relation to Chapter 3, but applicable also to other chapters.

Chapter 2: What is the purpose of the law?

Our general comments on this chapter

It emerges only gradually from reading this chapter, and is not explicitly explained, that its purpose is limited to a focus on public law principles and duties (as opposed to the private law issues principally addressed by the 2000, 2003 and 2007 Acts) and assurance of economic, social and cultural rights. This should be clarified in any final proposals.

Our response to the consultation questions

2.1 What are your views on the purpose and principles that we are proposing?

The definition of "the purpose of the law" in the second paragraph of this chapter, albeit limited in terms of the first paragraph to "the purpose and principles of mental health and capacity law" with adult support and protection law for some unexplained reason excluded, is plainly wrong. The definition reads: "We believe the purpose of the law should be to ensure that all the human rights of people with mental disorder are respected, protected and fulfilled". Even without including people at risk in terms of the 2007 Act (who should be included), the coverage should be along the lines of people with impairments of relevant capabilities, however caused, not limited to those for whom the cause is a mental disorder. The purpose

should be facilitating the effective exercise of legal capacity (a) by all people who are capable of that if they are provided with necessary support, and (b) for (rather than by) those who are not fully capable of acting and deciding for themselves, which must be done in full compliance with relevant human rights instruments.

Beyond the above points, and those mentioned in response to some of the questions below, we are broadly supportive of the Review's proposals in this chapter, if read as limited to the particular objectives noted in the questions below.

It is essential that reformed legislation contains no less than the principles in existing legislation, made more effective and human rights-compliant in accordance with the recommendations in the Three Jurisdictions Report.[8] All principles enshrined in law should be made effective by attributable duties and available remedies.

Subject to the above, we would suggest that consideration be given to clarifying the following points in relation to the principles proposed, and to adopting unified and inclusive terminology and language, as suggested above.

- "Respect for autonomy": The limitation to decisions only is regressive in the context of Scots law and of CRPD. Scots law addresses the full range of capability for juridical acts, and CRPD does not refer to decision-making at all: it refers to support for the exercise of legal capacity, clearly having the same meaning as relating to all juridical acts.
- "Non-discrimination and equality": It would be helpful to explain how these can be balanced against requirements for respect for diversity.
- "Respect for carers": these proposals are to be particularly commended. Experience indicates that the most valuable right for carers would be that they be consulted where appropriate, included in review and decision-making meetings and discussions, and provided with (without having to hunt and battle for it) full information to allow meaningful involvement, including in the foregoing ways. There should however be safeguards. Their rights should be their own rights, not "guardianship by the back door" under which they would purportedly speak for the adult – as opposed to being a useful and often primary source of information required to achieve shared understanding of the adult's wishes and feelings, will and preferences. The safeguards in Article 12.3 of CRPD should be observed in relation to their role, insofar as relevant to it, particularly – for example – in relation to issues such as conflict of interest.

2.2 What do you think about the approach that we are proposing for Scottish Government to meet core minimum obligations for economic, social and cultural rights in this area?

[8] Essex Autonomy Project, Three Jurisdictions Report: Towards Compliance with CRPD Art 12 in Capacity/Incapacity Legislation across the UK, 6 June 2016, available at:https://autonomy.essex.ac.uk/wp-content/uploads/2017/01/EAP-3J-Final-Report-2016.pdf

“Core minimum obligations” should not, within the scope of the Review’s remit, be limited to either “the mental health context” or “mental health services”. Nor should such obligations apply only to those with mental disorders.

The duties placed on public bodies require to be attributable, with the counterpart of rights conferred on the individual, and with accessible remedies to enforce compliance. Law must not be purely aspirational or declaratory.

2.3 What are your views on our suggestions for reforming sections 25 to 27 of the 2003 Act?

We have no further comments.

2.4 Do you have suggestions on how law could be reformed to address stigma, discrimination, and issues with attitudes towards mental disability?

It is doubtful whether the law alone can achieve these objectives. Having explicit provision can help, by focusing attention on particular issues. However, such duties will only be effective where they are accompanied by effective performance by government and public authorities.

2.5 Do you have suggestions on how the law could lead to prevention, and how the law could address the social determinants of mental health?

We have no further comments.

2.6 What are your views on our proposals on adequate income, housing and independent living, inclusion in society, and accessible information?

We have no further comments.

2.7 Are there other economic, social or cultural rights which you feel are particularly relevant to mental health?

We have no further comments.

2.8 Do you have views on the system-wide changes which we think are needed?

We have no further comments.

2.9 What do you think law reform can do to achieve culture change in mental disability services?

We have no further comments.

Chapter 3: Supported decision making

Our general comments on this chapter

It is sometimes suggested that "supported decision-making" is used as convenient shorthand for the requirement for support for the exercise of legal capacity. It is not clear whether the Review adopts this shorthand. If so, that should be made clear at the outset of any final proposals.

There is a substantial difference between concepts of decision-making (not mentioned anywhere in UN CRPD) and "exercise of legal capacity" (the core relevant concept in UN CRPD). That broader concept accurately coincides with the development of Scots law over the last 40 years, is consistent with the references to both acting and decision-making in section 1(6) of the 2000 Act, and avoids the lengthy debates – largely irrelevant to Scotland – between the supposed respective merits of "substitute decision-making" and "supported decision-making", neither of them mentioned in UN CRPD, which the travaux préparatoires demonstrate was drafted to be neutral in that respect, neither encouraging nor prohibiting so-called "supported decision-making". The criticisms of "substitute decision-making" which have caused much debate elsewhere are predicated upon a "best interests" approach, adopted in England & Wales in their Mental Capacity Act 2005, but rejected in Scotland in 1995[9] and not relevant in Scotland. To revert to issues of decision-making only, as opposed to the support required by Article 12.3 of UN CRPD for the broad concept of exercise of legal capacity, would in a Scottish context be unacceptably regressive. The suggested definition of supported decision-making in the first sentence of Chapter 3 is too narrow, and the broad concept of exercise of legal capacity must be adopted in the Review's final recommendations.

The principle of greater support for autonomy must not be limited only to people using health and care services or applied only within those services. It should apply to all people and to exercise by all of them of their legal capacity anywhere across the whole spectrum of the law (put otherwise, to all juridical acts).

[9] See paragraph 2.50 of Scottish Law Commission Report No 141 on "Incapable Adults".

One of the critical areas for provision of support for the exercise of legal capacity is in meaningful access to legal services and to justice, and appropriate safeguards in all procedures of a judicial character to maximise the participation of the adult, and the effectiveness and basic fairness of that participation, including maximising the possibility for the adult to contribute meaningfully and for the adult's will and preferences to be competently articulated on the adult's behalf, including any situation in which the adult does not fully endorse the views of anyone with a safeguarding rather than strictly representational role. As regards facilitation of the adult's participation, so as (for example) to comply with the requirements of Article 6 of ECHR, provisions in Scotland are better developed in relation to some but not all tribunal proceedings, and in relation to criminal law proceedings, than they are in relation to civil law proceedings, where generally (and despite the commendable efforts of many judges and others with quasi-judicial roles), procedure has not been brought up to date to meet current human rights standards and best practice.[10]

Our response to the consultation questions

3.1 What are your thoughts on our recommendations for a wide ranging supported decision making scheme?

Subject to our comments above, we welcome the recommendations for a wide ranging supported decision making scheme. The scheme must be capable of identifying and accommodating variations (including short-term variations) in capabilities, and the vast range of needs and circumstances which may apply. The "norm" must be to enable individuals to make decisions, not to "participate" in decisions by others or in which others have roles at the level of making the decision, as opposed to supporting and enabling the making of a decision.

We support a broad definition of the potential scope of advance directives, and have published a separate report setting out our recommendations for reform in this area.[11]

In the criminal law context, a number of people with mental health disorders, learning disabilities and autism find themselves interacting with the criminal justice system each year. There is certainly scope for greater support for such persons and perhaps representation. Provision of the latter in particular however would require to be carefully considered.

[10] For recent discussion of the relative disadvantages in civil, compared with criminal, proceedings, see the recent article "When I was a child … I reasoned like a child": Harmonising the approach to childhood capacity for criminal wrong-doing and civil fault", Dr Lesley-Ann Barnes Macfarlane, 2022 SLT (News) 67, which describes recent research into the progressive development of the brain beyond childhood into the early years of adulthood, and although focused primarily on the position in child law is equally relevant to adults with impairments of their capabilities.

[11] 22-05-19-adwg-report-final.pdf (lawscot.org.uk)

The Rome Review notes that *“In practice, the intermediary can support the lawyer to understand how the person communicates.”* and *“Access should be available to everyone who is charged with a crime or who is prosecuted for a crime, and who needs support with their communication.”*

This phraseology would imply an intermediary is envisaged as encompassing a more supportive role as opposed to a representative one. It is not clear to what extent, if any, the Review proposes extending specialist support in legal and administrative proceedings beyond criminal proceedings. It would be helpful to have the Review’s comments and recommendations as to wider application. Consideration should also be given to the Article 5 ECHR implications where decision-making proceeds without full and independent representation of the adult.

3.2 What do you consider would be the barriers to this?

See our comments above on the need for a broad concept of exercise for legal capacity.

A wide ranging supported decision making scheme must address the need for publicity, accessibility of relevant information, and education about the importance of accessing it. See comments on implementation in our initial “General Comments”.

There is a significant difference between providing a supportive role and a representative one.

In terms of the former, in the criminal justice context, there are already provisions allowing vulnerable witnesses to utilise the services of a supporter when giving evidence.[12]

From the consultation it appears what is suggested is something more akin to the role of an appropriate adult however as opposed to a vulnerable witness supporter. The following comments have been provided on that basis.

The role of an intermediary would have to be carefully specified in order to avoid conflicting with the duties and responsibilities of other court practitioners.

For example, it is the role of the accused’s solicitor to explain the court process and procedure to them. An intermediary for an accused person would have to complement the role of the defence solicitor as providing conflicting advice to an individual would cause confusion.

Furthermore, if a witness does not understand a question it is the duty of the individual asking the question to clarify what is meant. It is very important the witness only answers the questions asked of them. Having an intermediary clarify a question may be problematic in that their understanding of the question may not align with what the person asking the question intended.

[12] See section 271L of the Criminal Procedure (Scotland) (Act) 1995

Another point to consider (albeit more minor in nature) would be the impact on the running of the court. Summary trials in particular are often fast paced with courts dealing with a high volume of cases on a daily basis. If it is intended that the intermediary would operate in a similar manner to a translator then consideration will have to be given to court loadings in order to allow sufficient time for trials to be heard.

As noted above there a significant differences between playing a supportive role and a representative one. The above comments are directed towards a more supportive role. If it is envisaged that intermediaries are to encapsulate a more representative role then further consultation will be required.

3.3 How do you think the SDM scheme should be taken forward?

In terms of support for witnesses in criminal cases, an independent body could be established with a focus on providing support to those with mental health disorders, autism and learning disabilities. This body could complement the work of Victim Information and Advice, within COPFS, to provide specialised support to those who require it.

Consideration could be given as to whether the organisation would also be able to provide assistance to accused persons.

At the moment supporters in criminal trials are often volunteers from Victim Support however a specialised organisation comprising of individuals trained to assist those with mental health disorders, autism or learning disabilities may be better placed to provide the support envisaged from intermediaries.

Whilst work on developing a National Care Service may provide an opportunity to review a whole system approach to support for decision making, great care should be taken to avoid supplanting private law principles focused on the rights of the individual with a paternalistic public law approach.3.4 How do we mitigate against undue influence or pressure in SDM generally?

The safeguards applicable to the principle of *negotiorum gestio* are a useful source in existing law, which would reasonably provide a starting-point for any recommendations: see the Report of the Law Society project.[13] The safeguards must adequately comply with Article 12.4 of UN CRPD. They should include similar safeguards to those relating both to the creation and the operation of powers of attorney.

3.5 Should there be legal duties on public bodies to secure SDM for people who need it? If so, given that advocacy is a form of SDM, what should be the relationship

[13] 22-05-19-adwg-report-final.pdf (lawscot.org.uk)

between that and the existing duties in respect of advocacy?

See our comments at 3.3, above. Duties on public bodies must be clear and attributable, and must not supplant private law principles focused on the rights of the individual.

3.6 What are your thoughts on the creation of a Centre of Excellence for Supported decision making?

We have no further comments.

Chapter 4: The role and rights of carers

Our general comments on this chapter

Here, in particular, the narrow focus on carers of recipients of mental health services, and even there upon their engagement only with mental health services, is inappropriate. Broadly, in our experience the evidence gathered by the Review on that narrow basis is relevant to all unpaid carers, caring for people with needs across the whole spectrum of the Review's remit, and as regards engagement of services with all services with which the cared-for person is involved or (importantly) ought to be involved but isn't. That extends further to the services with which carers themselves are, or ought to be, involved in consequence of their caring roles. Experience indicates that even where the carer and the person cared for need the support of the same service, there is a risk of engagement with either (or even both) without reference to the other. The cared-for person, and sometimes more than one cared-for person, unpaid carers, other supporters, and all services with which all or any of them are or need to be engaged (including paid care services) require a holistic overview which should be the subject of ongoing management. The needs of some individuals within the broad ambit of that overview can potentially extend to any service. For example, a young carer, even if only involved intermittently in care provision, or even if only more generally involved with the consequences of living in a family or household environment where someone's care needs are a significant element, may require engagement with special aspects of education services.

We suggest that such holistic management can appropriately and efficiently be achieved by the concept of an "enveloper".[14] The enveloper appointed in relation to each "circle of need" can be anyone within any service that is engaged with one or more people within that circle of need, and does not necessarily require to be personally involved heavily in such provision. Rather, the role is a coordinating one with an "open door" to all within that circle of provision and receipt of both paid and unpaid services, including both care

[14] See that concept as developed in the educational field as described at pages 28-30 of "Developing holistic education", Seed, the Falmer Press, 1992.

and support. The function should primarily be one of coordination, information-sharing (subject to necessary limitations, as noted below), and ensuring effective and efficient delivery of services currently engaged, and any which ought to be but which are not, including appropriate involvement of all in processes of information-sharing, planning and decision-making, and listening to but not duplicating the functions of guardians, attorneys, advocates and others. The caveats identified above in relation to supporters apply. The enveloper requires to be able to strike an appropriate balance between avoidable or unproductive conflict, and the dangers of "group think" when that may move away from accurate identification of the will and preferences, wishes and feelings of the cared-for person.

Our response to the consultation questions

4.1 What are your views on mandatory Carer Awareness training for all mental health staff?

Carer awareness training should be mandatory, but not limited to staff in any one particular service. The limitation of carer awareness training to mental health staff only is inappropriately narrow.

4.2 What are your views on information sharing with unpaid carers of all ages?

Generally speaking, all information should be shared subject to minimum necessary limits. There should not be any general limitation to a "need-to-know" basis, as that could in general terms give an impression of defensive exclusion and lack of recognition of roles, and more specifically failure to take account of relevant information which an unpaid carer can provide, and of which services may be unaware until it is provided.

Limitations on sharing should be strictly drawn, limited to situations where there is a clearly identified need not to share, linked to a real and demonstrable concern that such sharing would be harmful to someone somewhere. Even with tight definition of what might be withheld, there should be safeguards to ensure that this is not in fact driven to any extent by the convenience of providers. One of the beneficial potential consequences of having strictly drawn "exclusion rules" is to emphasise the importance of sharing everything for which a decision to exclude cannot be robustly justified.

4.3 If an unpaid carer, what are your views on sharing information with mental health practitioners?

Not applicable to us, though the question should not be limited to sharing with any one relevant service.

4.4 What is needed to ensure mental health services identify and engage with young carers?

Again, this should not be limited to any one service. We have suggested a methodology in our general comments above.

4.5 What are your views on including unpaid carers in discharge planning and processes, as stated in the Carers (Scotland) Act 2016?

The same principles should apply to discharge planning and processes as are suggested above for all relevant planning and decision-making.

4.6 What needs to happen to ensure unpaid carers of all ages are respected and valued?

This can appropriately be achieved, we would suggest, by the methodology suggested in our general comments on this chapter.

Chapter 5: Human rights enablement – a new approach to assessment

Our general comments on this chapter

We welcome and support both the basic concepts of human rights enablement ("HRE"), as described in this Chapter 5, and of an autonomous decision-making test in Chapter 6. They should be at the core of our way forward in Scotland in relation to all relevant areas of law. However, as described in the consultation document, both are seriously undeveloped.

The concept of HRE set out in this chapter needs to be extended across all rights relevant to all individuals within the scope of the Review, and to how (*inter alia* in the context of each of the three Acts) they are to be made real in law as being enforceable rights with corelative duties which are all clearly attributed, with clear and accessible remedies, to ensure in a straightforward manner performance of those duties or – at worst – redress for non-performance. This must, if need be, include unhindered access to legal services and to an authoritative and independent judicial or quasi-judicial body.

The language of this chapter seems to be vaguely aspirational, visualising an imaginary world in which everyone acts for the best, rather than ensuring implementation and non-violation of rights of people in society who are most vulnerable and least able to assert their own position, and who in consequence

Law Society of Scotland

constantly fall to the end of the queue, if not off the end of the queue. The Review's recommendations in this area require to be based upon a robust analysis of the extent to which potential violations, including potential mass violations, of fundamental human rights have come to light in Scotland recently, including (for example) deprivations of liberty in the context of discharging patients from hospitals to care homes before and during the pandemic,[15] and holding them unlawfully in hospitals when there is no longer clinical need to be there[16]. Safeguards for human rights need to be robust.

The unduly weak tenor of this chapter is encapsulated in the use of "enables" in the first line of the last paragraph on page 66. Law must ensure, not enable, both respect for and non-violation of human rights. The distinction should be made between respecting competent exercises of will, and respecting actual or constructed expressions of will and preferences to the extent that decisions cannot be competently made by someone for themselves, despite provision of all required support. There is a clear distinction between rights, including rights attached to a competent expression of will, and will and preferences to be respected in processes of decision-making where (and only where) even with all relevant support the person cannot make competent decisions of their own.

The reference to "irrespective of diagnosis" in the last paragraph on page 66 is irrelevant and potentially unduly limiting. The framework should apply to everyone, differentiating those who can make competent decisions and those who, for any reasons, cannot. Diagnosis of anything is not a reason for assuming incapacity. That misapprehension currently applies frequently in practice. Even under AWI, it is one step, and only one step, which must precede the process of assessing capacity for a particular purpose under that Act.

Our response to the consultation questions

5.1 What are your thoughts on the proposed HRE framework?

See our comments above. We welcome the purpose of the Human Rights Enablement Framework, seeking to put human rights into focus in a practical and tangible ongoing assessment. We wonder, however, whether the terms "framework" and "enablement" will lead to sufficient understanding of the judgement and application of rights-based practice expected of practitioners. Ensuring- as it should be- that human rights practice is the responsibility of all, and not just of the judicial system, is key but is not widely understood. An effective HRE framework must give effect to all individual rights, and must avoid the adoption of a paternalistic approach to the delivery of services.

[15] https://www.lawscot.org.uk/news-and-events/law-society-news/new-report-confirms-alarm-of-scottish-solicitors-over-discharges-to-care-homes/

[16] https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention

We understand the proposed HRE framework is intended as an ongoing process and one of an ongoing consideration for the individual, but suggest an assessment or similar may place clear focus of what is expected of practitioners. One of the key challenges in applying the proposals will be noting and reacting to changes in circumstances necessitating changes in assessment.

5.2 How do you see the framework as proposed working in practice?

We consider better emphasis and focus on the human rights of individuals by way of a HRE is a positive step and provides the potential for real change.

In practice where resources are limited- in particular for Mental Health Officers (MHO's) and in some areas Responsible Medical Officers (RMO's)- we would welcome clarification as to how real change will be achieved. We would suggest that the HRE framework will only be effective in practice if various professionals throughout an individual's journey, or when an impactful event occurs, are made accountable for its application. This may include where professionals seek to limit the will or preference of an individual by a step or compulsive treatment. There should be a coordinator responsible for identifying the appropriate "lead person" in each case. Consideration should be given to the possibility of this being the same person as the "enveloper" suggested in our response to Chapter 4, above.

5.3 What barriers do you see to its operation in practice?

See our general comments and answers above. Introduction of an HRE framework would require a full implementation strategy covering the reformed regime as a whole, following enactment of reforming legislation, overseen by an Implementation Group.

5.4 What are your thoughts on who should initiate an HRE?

As stated above, with limited resources identifying the professional or professionals responsible for the HRE at various points is necessary to achieve the objectives set out. MHOs currently have responsibilities including advising a patient of their rights and seeking to assist in providing support and referrals for advocacy etc. Responsibility for initiating an HRE may be an additional burden if it was the responsibility of just the MHO. A practical approach may be for responsibility to rest with the party seeking to obtain the order or similar, for example an RMO who is a party and applicant when he or she seeks to vary an order etc but in other instances the MHO takes this responsibility. This may necessitate a collective register of HRE plans for each patient but in practice care plans for various actions under current legislation are shared and medical records or multi disciplinary teams collate and record similar types of documents for patients.

A patient should have a right to request an HRE, as well as a right to refuse.

5.5 What are your views on the triggers for an HRE? Is there anything not included which should form a trigger?

We support the list of triggers detailed in the consultation paper and the fact a formal review is suggested after a period of one year. This would bring into scope patients in long term hospital without change or in residential units and care homes without change rather than in less restrictive environments. Often no positive steps are the most concerning for vulnerable patients. We would welcome clarity, however, on what options would be open however to the reviewer in these cases if there was a breach of rights and an inability to progress to less restrictive care and better resources.

5.6 What are your views on the right to request a review and the right of remedy and appeal as proposed?

This is an essential part of ensuring accountability, and of ensuring that the HRE is a fundamental part of practice in this area going forward. Without a route of appeal the process would not strike the balance required to bring about change and improve access to justice and the rights of those involved. We welcome a staged process with a view to seeking to resolve matters at an early stage for the individual if possible and to bringing about early discussion. However we also welcome that the final stage should be legal review by a judicial body given the importance of the HRE.

There should always be independent support and representation for an individual seeking to review or appeal an HRE.

We would emphasise that there is currently a gap in Scotland when someone is not capable of instructing their own representation, or there is no legal proxy appointed to seek the right of remedy and appeal as proposed. We would reiterate our views on creating a role similar to that of the Official Solicitor in Scotland that may go some way to addressing this gap. See our response to Chapter 8.

5.7 Would the body for remedy and appeal differ if the request for a review was in respect of a group of persons rather than an individual?

Group reviews or appeals would have the potential to be complex at the final stage if the process was the same as for an individual. The process could be different, and this would allow the same body to deal with both. We have previously welcomed the Mental Health Tribunal having a wider remit, and providing statutory powers of review for a group HRE and an individual HRE would allow the same body to deal with all HRE.

Group proceedings may create additional issues regarding sharing information. See our general comments on Chapter 4.

Chapter 6: Autonomous decision making test

Our general comments on this chapter

See our general welcome of, and support in principle for, both the concepts of HRE and of an autonomous decision-making test, in our general comments to Chapter 5.

The provisions of this chapter should however apply to any form of intervention under any of the relevant legislation, and should cover all aspects of the ability to exercise autonomy and self-determination, not limited to decision-making.

Our response to the consultation questions

6.1 We seek your views on the current capacity and SIDMA tests. You may wish to use the numbered options in that section above to indicate your preferred position but feel free to offer other suggestions and to expand on your preference.

The current capacity and SIDMA tests are task and decision specific, interlinked with a specific diagnosis. Their application is based on an assumption that decision making and capacity to consent to treatment interventions could be impaired as a direct result of a mental disorder. This approach, however, causes confusion, especially when inconsistencies come into play when understanding and/or applying these tests when ensuring the right person receives the right care, in the right place, at the right time, within the context of making the best use of available resources.

6.2 We seek your views on the concept of the test of autonomous decision making, distinct from a capacity or SIDMA test. We have deliberately not asked specific questions; we wish to leave this open for you to offer any comments on its workability for different categories of persons and to make any suggestions for improvement.

We support a single system of ADM testing replacing capacity and SIDMA tests as suggested by the Review, but envisage similar gaps/challenges to those identified above will surface in its application. These gaps/challenges can be minimised through standardised mandatory training for all staff involved, perhaps similar to child protection training, with annual mandatory updates. There should be specialist training offered to specific groups of healthcare and other professionals who directly apply the test for any purpose across all these principal Acts, recognising and authorising them as someone who is suitable to apply the ADM test. Such an approach would bring the human rights principles into fullest application when

applying the ADM and SDM tests. Currently, the two tests (capacity and SIDMA) are applied within a framework of principles e.g. the overarching principles of each of the Acts. The suggested ADM test will be on a framework of the human rights principles. The aspects of ‘maximum benefit’ principle and the principle of 'reciprocity' in the delivery of identified interventions should continue to be reflected in the application of ADM test. The role of all aspects of advance planning should be taken into account in developing an ADM test.

The gaps and challenges identified by the Review (highlighted in the consultation paper) in the application of the capacity and SIDMA tests under the current legislative framework may still be present in the new ADM test. This includes inconsistency in application due to the lack of appropriate training. It is equally important for both the professionals applying the ADM test, and the professionals providing support and delivering interventions under the ADM (and SDM) framework to be appropriately trained.

6.3 What are your views on the skills and experience required for someone to competently undertake a test of a person’s ability to make an autonomous decision?

See above. On the question of who would apply the ADM test, it should be based on the set of principles – someone who is appropriately trained and who is accountable for the provision of support or delivery of the intervention and who does not have a conflict of interest.

6.4 What are your views on the ADM appeal process?

Within the suggested new ADM test model, there should be an escalation system to challenge the application of the test and, indeed, an automatic review where an explicit measure of what is being delivered (in the form of interventions) and measurement of non-delivered interventions can be carried out. These should be scrutinised as part of the safeguarding procedures. There should certainly always be an ultimate right of access to an independent judicial or quasi-judicial process, which to comply with human rights requirements must be readily accessible in practice, for all.

Chapter 7: Reduction of coercion

Our general comments on this chapter

The initial definition on page 89, and indeed the term “coercion”, are too limited. Proposals for reduction of coercion should address any non-consensual intervention of any kind, as well as analogous situations such

as where available choices are unduly limited, to choices that suit providers rather than that may suit the individual.

Our response to the consultation questions

7.1 Your views on how the Review understands coercion

The limitation to coercion, in the narrow field of mental health law and practice, is inappropriate. The broad issues of non-voluntary intervention require to be addressed. See above.

7.2 What you think about the Review's proposed approach to reducing coercion, including reducing the use of involuntary treatment

See preceding answer. Monitoring and scrutiny must include recognition, and identification in particular cases, of covert factors, including unintended ones. On the one hand, reductions in the need for coercion and of resistance to what is proposed could be said to limit requirements for coercion, but at the same time they could amount to subtle coercion.

7.3 Whether you think that "coercion" or some other word(s) should be used to describe the use of force, the possible use of force, and the experience of coercion

"Coercion" is an inappropriate term, and should be replaced with "non-voluntary intervention".

7.4 Your views on whether law reform could drive changes which could reduce the use of coercion. Changes might include: changes to physical environments; changes to resourcing and better valuing of staff; addressing attitudes and culture; and acceptance, participation and activities on wards, for example.

These should all be matters of good practice, driven by appropriate education, training, supervision and monitoring, regardless of current applicable laws; though law reform can play a helpful role in clearly targeted aspects. Changes should apply in all care settings, and if possible supervision and monitoring of other settings, including private homes, should be alert to inappropriate use of powers authorising non-voluntary intervention, as well as unauthorised non-voluntary interventions.

7.5 Whether you think that safeguards for medical treatment in Part 16 of the Mental

Health Act should be strengthened, including the current responsibilities of the Mental Welfare Commission and 'Designated Medical Practitioner', and ways in which the patient or their supporters might challenge particular interventions.

Yes, but wherever possible such provisions should apply as widely as possible, and not be limited to particular services such as medical treatment.

7.6 Your views on whether the Mental Welfare Commission should have stronger powers to oversee the use of coercive interventions and to identify areas for action.

Yes, but extending to all non-voluntary interventions within the remit of Mental Welfare Commission (and subject to adequate resourcing of the Commission, or failing that to such limitations – including discretionary limitations – as are necessary within available resources).

7.7 Any suggestions that you have for the Review's ongoing work on understanding rising rates of detention and on community-based Compulsory Treatment Orders

In the short remaining time available to the Review, the Review may need to limit this work, important though it is, to ensure a balanced approach across all situations of non-voluntary intervention, to the extent that this has not already been done. Work relating to rising rates of detention could usefully take account of broader issues arising from Article 5 of ECHR.

Chapter 8: Accountability

Our general comments on this chapter

Issues of accountability are relevant to all areas of law and practice within the remit of the Review. It is essential that people know their rights and have access to clear and accessible methods of challenge where their rights are violated. All rights must have corresponding attributable and readily ascertainable duties.

Our response to the consultation questions

8.1 What do you think about our proposals to give the Mental Health Tribunal

increased powers to order that specific care and / or support be provided for a person?

We would agree with the proposal to strengthen the powers of the Mental Health Tribunal for Scotland ("MHTS")- or of any unified forum, see our general comments above- to make 'recorded matters'. We would agree that the Tribunal should be able to require NHS boards, local authorities, and integration authorities to provide such care and support as may be required to avoid the need for an individual's compulsion or ensure that compulsion respects the human rights of the patient. We would also recommend that an equivalent of the "recorded matters" provisions is essential under AWI procedure.

We are concerned however that there are further deficits and barriers in the current mental health tribunal system that require to be reformed in order to ensure the effectiveness of any recorded matter. The RMO can bring a recorded matter back if not complied with, but few do. The remit of what is a recorded matter restricts the statutory Tribunal, and a wider remit could assist. In the case of patients who may lack capacity to instruct a solicitor, it is possible that a recorded matter may not be subject to further scrutiny by MHTS for a two year period in terms of the processes for mandatory review within the 2003 Act. Even in the event that such a patient's interests at a tribunal hearing are represented by a *curator ad litem*, the *curator's* locus ends at the conclusion of the tribunal hearing process in contrast to previous mental health legislation where a *curator* could appeal a decision at first instance. In our view, this does not comply with wider human rights practice. There is in our view a gap in enabling people who lack capacity to seek redress where recorded matters are not fulfilled by health or social work staff.

There is no "Official Solicitor" to litigate on a person's behalf, and the current system relies on family seeking to enter the process, failing which the matter is left in the hands of the tribunal. This is disempowering for any adults who lack capacity to instruct a solicitor in the tribunal process, or require significant support to contact and instruct a solicitor. We consider that there should be a role in Scotland equivalent to the Official Solicitor in England. This role should not be restricted to the mental health tribunal process but across all civil processes in Scotland. There is no official body or individual in Scotland who can independently decide to progress a case on behalf of an adult whether at MHTS or in contemplation of any other civil proceedings. The current MHTS system as well as the civil process generally only allows the appointment of a legal proxy once proceedings are underway e.g. a safeguarder in AWI proceedings or a *curator ad litem* in civil proceedings or the MHTS process. We consider this to be a significant omission, and consider that reform in this area should look to create a role equivalent to the Official Solicitor in England with perhaps a similar role at MHTS.

8.2 What do you think about the ways we want to extend current excessive security appeals to anyone who feels they are being subjected to unjustified levels of restriction?

We agree with the principle that anyone subject to detention should have the right to challenge the level of restrictions while staying in the same place, for example allowing someone to challenge 'blanket'

restrictions on a ward. There might be scope for fine-tuning of requirements in some situations, provided that this does not over-complicate procedures.

The right to appeal against unjustified restrictions should apply to all situations of non-voluntary intervention, including those under AWI legislation.

8.3 What do you think about our ideas for reforming the ways a person can raise a concern or complain about their care and treatment? Do you have any other ideas to make this process more effective and equitable?

We would agree that the ways for someone to be able to challenge their care and treatment need to be more equitable, accessible, co-ordinated and effective, and designed around the needs of the complainant.

We note the proposals for a 'remedy panel' rather than a complaint handling process. Whilst we would support this in principle, it will be important to clarify the distinction between a complaints process and any legal process. We are aware of some people with mental disorder pursuing a complaint via a complaints process when they perhaps should have sought legal redress via the judicial system. Whilst we would not advocate for the judicial process to necessarily always be the appropriate forum to resolve issues and concerns around care and treatment, we consider that it is critical that people are aware of the important distinction between a complaints process and a legal process with an enforceable remedy. Would a remedy panel be able to issue enforceable orders or declarators? Could legal and complaints processes proceed in parallel? The remit of such a panel would need to be clear, with advice given to people on rights and remedies. A clear and effective semi judicial process seeking to adjudicate disputes in this field in an informal process would be highly advantageous as compared to the current judicial review process, where access to justice may be denied due to the process and funding issues, regardless sometimes of merit, or effectively denied by delays ("justice delayed is justice denied").

On the issue of mediation, we consider that this would be a useful tool in resolving certain complaints between for example a person and their care team. In particular when an individual is subject to care and treatment with certain restrictions on their liberty, mediation can provide a mechanism to explore the areas of conflict and resolve them without the need for either a formal complaint or a judicial determination. The mediator being specialist to mental health would be invaluable and ensure a human rights-based approach. See our general comments, above, on mediation generally.

We would agree that more meaningful monitoring and reporting on complaints is needed. We would consider that the Mental Welfare Commission (MWC) would be best placed to take on such a role.

We agree that more bodies should be able to ask courts (or other forums having necessary powers) to review whether the rights of any group or individual are not being met. This proposal however will only be effective with proper access to justice in terms of funding arrangements, which are currently lacking in our view. There will also need to be plans to educate and train groups on awareness of rights and remedies in order to render this effective.

8.4 What are your thoughts on collective advocacy groups raising court actions? What about our idea of creating a way for them to escalate unresolved human rights issues to an identified scrutiny body? Is there an existing organisation you feel should take on that role? Should these proposals also cover individual advocacy organisations?

We would support the principle of collective advocacy groups being able to bring cases to court. Again, this would only be effective with a proper system of funding in place to allow groups access to justice and we entirely agree that this right must be supported by access to legal advice, guidance and support for groups who wish to take this step.

We would agree that there should be an alternative way for collective advocacy groups to be able to escalate human rights issues that remain unresolved and unaddressed by services to another scrutiny body/Commissioner to investigate. A right of redress to the courts (or other forums with appropriate powers) should always remain available.

We would agree that advocacy organisations are well placed to notice patterns in human rights breaches, for example in particular services, and are in this regard well placed to take court action for alleged human rights breaches.

8.5 What are you views on why and how we think collective advocacy should be strengthened?

We agree with the proposals around strengthening independent advocacy. Across the legal sector of mental health and incapacity law it is our experience that positive relationships and collaborations have been formed between advocacy workers and solicitors to promote people's rights in the area of mental health and incapacity law. Independent advocacy plays a critical role in supporting people to access justice at the early stages, amongst other things. We agree with the proposals to develop and promote advocacy- both collective and individual. However, without a corresponding proposal to develop and promote legal services available to individuals we have real concerns regarding how individuals and groups will be able to access justice. Currently, the numbers of solicitors conducting civil legal aid work is reducing with those continuing to offer this service facing significant challenges in providing ongoing legal services to people seeking redress or remedy in matters of their care, treatment or liberty or human rights. Without adequate funding of legal services in this area we have real concerns regarding how people would be able to seek to enforce their rights and seek proper remedy. We consider that a properly resourced advocacy service working in tandem with a properly resourced legal provision will be the most effective way for people to have proper access to justice.

8.6 Do you have any suggestions to make the scrutiny landscape for mental health services more effective?

We agree with the proposals thus far contained within the consultation document.

8.7 What do you think about the ways in which we think the role of the Mental Welfare Commission should be extended? Do you have other ideas?

We support the proposals to extend the Commission's role.

We would add our concern that to our knowledge the MWC has had no legal commissioners, legal officers or legal staff since around 2011 (albeit mitigated while the Chief Executive was a lawyer). We consider that as well as the range of health and social work professionals and people with lived experience, legal staff are a necessary part of this organisation. This will be critical given the proposed extension of powers to initiate legal proceedings to protect the human rights of any person or group covered by relevant areas of law.

Chapter 9: Children and young people

Our general comments on this chapter

We have no general comments on this chapter.

Our response to the consultation questions

9.1 Do you think the current 2003 Act principle for children is still needed? Should it be replaced by a wider principle of respecting all the rights of the child under the UNCRC in any intervention – or something else?

The current 2003 Act principle for children is still required. It should in our view be extended to include the wider principle of respecting all of the rights of the child under the UNCRC along with the UN CRPD. We would agree that the system must reflect the needs of Scotland's children and their journey into adulthood.

9.2 What do you think about having a statutory duty on Scottish Ministers and health and care agencies to provide for children the minimum standards needed to secure the human rights set out in international treaties such as the UNCRC?

A statutory duty is required together with a right of redress for the child and parents regarding what can be done to enforce the statutory duty. It is imperative that the statutory duty is very clearly both attributable and enforceable and that this information is readily available to children and young persons and to their families.

9.3 What are your views on reforming crisis services for children and young people experiencing acute mental distress, and about safeguards for emergency detention?

Most mental health services are designed for adults. We would agree that there should be a requirement that detention is approved by a mental health officer. We would endorse the recommendation that it would not be appropriate for children to be admitted into adult psychiatric wards in any circumstances and that there must be a provision for safe and child centred alternatives.

9.4 What you think about law reform to ensure access to CAMH services up to at least the person's 18th birthday, and to ensure age appropriate services more generally?

Access to CAMH Services is required up to and including the child's 18th birthday together with an obligatory transition period for 6 months beforehand which would allow the CAMHS and Adult Services Teams to properly adopt a collaborative approach to the delivery of required services in a patient focused manner.

9.5 What are your views on our ideas about relatives and families?

We agree that there should be a requirement for health and care authorities to take account of the needs of parents and families to information and support where this will help to support the child, that children who are able to do so should have the right to choose their named person in the same way that adults can, and that where a child is not sufficiently mature or is too unwell to choose a named person, the person with parental rights and responsibilities should remain as named person. However, we recognise that in many such situations the safeguards required by Article 12.4 of UN CRPD need to be particularly robust. Also, concepts such as "not sufficiently mature" are problematic: they require clear definition and clearly assessed and recorded application: for consistency, they could be incorporated within the scope of the autonomous decision-making test (Chapter 6). Where this is not in the best interests of the child, the Tribunal at its own hand or at the request of the MHO, may remove that person, and may also appoint another named person. The Review should be conscious that there may be additional stress however, placed on a child in choosing one parent to act as their named person and in a situation where the child's parents have separated, there may be additional conflict. There should therefore be consideration given to

both parents of the young person being involved in the process, and in these circumstances for there to be two named persons.

9.6 What are your thoughts on how supported decision making, human rights enablement and the autonomous decision making test in chapters 3, 5 and 6 might apply to children and young people?

We would agree that children's voices require to be considered in order to inform any decision making process considered person specific, and engaging the young person's participation is a crucial part of the process. This should apply notwithstanding the position that for a young person under the age of 16, where they are unable to make decisions about treatment, that their parent may consent or refuse such treatment on their behalf.

9.7 What do you think about our proposals on advocacy, and on accountability?

We would agree that the duties in the 2003 Act to secure advocacy should be strengthened to ensure that any child with a mental disorder is made aware of their right to independent advocacy. Family advocacy should also be made available in addition to advocacy for the child, and there should be a duty on Scottish Ministers to ensure that this is made available for the family (in implement of Article 12.3 of UN CRPD).

9.8 What are your views on autism, learning disability and neurodiversity, and the possible law reforms for children and young people?

The Rome Review recommendations as detailed are endorsed. We would also endorse the view that part 16 of the 2003 Act should be strengthened to include specific safeguards where children are subject to restrictive interventions including physical restraint and seclusion or isolation, and that there should be consistent standards and safeguards across residential mental health and care settings.

9.9 What do you think about our proposals on safeguards for treatment, and on services and safeguards to protect the relationships between children and parents?

Not enough is currently being done as required to safeguard these relationships. The MHO would require to liaise with other social work colleagues particularly in Children and Family Teams in order to deliver these safeguards. Parents need to be given specific information when either they are being detained or, their child is being detained, about these particular safeguards. It needs however, to be borne in mind in these complex cases that frequently when the child has a severe mental health issue, that this can be caused or contributed to by family dynamics so there would need to be an acknowledgement that this duty

to mitigate the impact of detention on the relationship between the parent and child, would apply only where it was in the best interests of the person detained and their parent or child.

9.10 At this time, Scotland's mental health law applies to compulsory mental health treatment at all ages. Do you have views on the idea of moving mental health law for children to connect it with other law for children, to apply across health, education and social care?

A move to an all-purpose children's tribunal would be a hugely complex undertaking. All the current jurisdictions have individual specialisms and individual strengths in their current approach. This may be worthy of further exploration, and should be informed by families who have been directly involved in the process. We are not aware of any evidence of families saying that they have been lost in the process to date. The Mental Health Tribunal currently sits in child and adolescent cases with an expert in child and adolescent mental health services and a convenor and general member who have received additional training in child mental health services and the law applicable. Only one case per day is before the Tribunal in these often very challenging cases. We consider that the Mental Health Tribunal is currently best placed to deal with the mental health law cases for children. We do agree that mental health legislation should incorporate separate provisions however, for children and young persons.

For young people (aged 16 – 18), and in particular even people over 18, recent case law on the inter-relationship of guardianship and continued application of child law provisions should be considered and should be explicitly applied/disapplied in the Review's recommendations.

Chapter 10: Adults with Incapacity proposals

Our general comments on this chapter

We note that following the Introduction this chapter falls into three parts, each with its own set of questions. We replicate that structure with some overall general comments here, then in relation to each of those three sections we have some general comments followed by our response to the consultation questions.

We note that the three sections of the consultation refer respectively to "guardianship" (only one of the two topics addressed in Part 6 of the 2000 Act, the other being the significantly different provisions for intervention orders), but with brief reference under that heading to the provisions for access to funds (Part 3 of the 2000 Act) and management of residents' finances (Part 4 of the 2000 Act), without referring at all to other important provisions of Part 3 (such as provisions for obtaining information, and the provisions regarding joint accounts in section 32 of that Act), with minimal comment; "powers of attorney" (addressed in Part 2 of the 2000 Act) and "medical treatment and research" (addressed in Part 5 of the 2000 Act).

Some of the matters addressed under guardianship are at least equally relevant, and in some respects more relevant, to powers of attorney. The consultation document states “We will be taking into account comments submitted to the 2018 AWI consultation so you do not need to repeat earlier opinion, unless you wish to.”, but it appears that this applies only to the “power of attorney” section and not the others. For the avoidance of doubt, all of our previous submissions and other references as listed in Annex A should be taken as fully incorporated in this response, and we would expect the Final Report to address the current state of overall review, and any further views and recommendations of the Review, across all areas of relevant law.

It is a matter of particular concern that, as well as failing to address matters excluded from its coverage in the three listed sections as quoted above, this chapter addresses neither the most important provisions of the 2000 Act, in Part 1 of that Act, nor the various provisions in Part 7, nor the matters addressed in more detail in the Schedules. All of these should be covered in the Final Report.

In particular, we take it, from lack of anything to the contrary in the consultation document, that it is intended that the Final Report will endorse the continuation in their application to all adults with incapacity matters (whether within or outwith the principles and definitions of the 2000 Act) of the principles in section 1 (supplemented by section 3(5A)) of the 2000 Act, subject to improvements and strengthening as recommended in the Three Jurisdictions Report in order to ensure UN CRPD compliance. We also take it that the Final Report will endorse continuation of all other provisions of the 2000 Act, subject to our previous recommendations set out in Annex A (in which the terms of a more recent item should in general be read as superseding anything different in an earlier item).

If that is not the case, then we recommend that there should be immediate further consultation on anything of significance which does not coincide with the foregoing understanding.

Given the urgency of some of the needs for improvement and reform of provisions at present contained in the 2000 Act, as well as the extremely urgent need to address issues of deprivation of liberty separately covered in Chapter 11 of the consultation document (resulting in serious and avoidable harm to many vulnerable people), it is disappointing that the consultation document discloses little real development of necessary work on the adults with incapacity regime over the four years since conclusion of the 2018 consultation (much of the content of those responses having already been submitted in response to the 2016 consultation). The Final Report should include a comprehensive statement of necessary reforms and should stress the urgency of proceeding with them.

Guardianship

Our response below to the consultation questions should be read subject to our previous comments about the inappropriateness of narrowing the existing concept in Scots law of “acting and deciding” to “decision-making” only; that a term such as “capacity supporter” is suggested in preference to the inappropriate term “decision-making supporter”; and that provisions for support, co-decision-making, and other aspects apply as much, if not more, to powers of attorney as to guardianship provision.

The Final Report should take account of recent and current emerging issues in this area, particularly in recent and current litigation.

Our response to the consultation questions

10.1 We seek your views on the new model. For example, what do you see as its advantages? What do you see as its drawbacks? What adjustments, if any, would you suggest?

We welcome the move away from an explicit model of 'graded guardianship'- about which concerns were raised in our 2018 Response. However, the 'tier' model of supporting agent perhaps implies a hierarchy of decision-making authority, when in fact a person appointed under a PoA has the same power to make decisions on behalf of the adult as a guardian under the current model. This is perhaps a presentational issue. We also have concerns regarding the term "decision-making framework". It is unspecific as to who makes decisions for or about whom, creating a risk of confusion which is not present in the current system. More fundamentally, for reasons already explained the narrowing of the current scope of the 2000 Act, from acting and deciding to deciding only, would be regressive and inappropriate. Thus, for example, while for the purposes of this response we have adopted from the consultation document terminology such as "decision-making supporter", an appropriate term would be "capacity supporter".

Subject to the above, the introduction of the decision-making supporter is welcomed as a support for ADM. However, in our view there need to be significant safeguards in place, and clear information to individuals and organisations about this role. It is particularly essential that there is robust oversight and a clear avenue to make a complaint or raise a concern about a supporter to a vulnerable adult (perhaps linked to Adult Support and Protection reform, in the case of local authority concerns). A vulnerable person who is being pressured to nominate someone as their Attorney normally has the safety net of a solicitor who can assess whether undue influence is being exerted before the deed is granted; someone self-nominating a decision maker who then exercises their influence inappropriately does not have the same level of safeguard. There would also need to be resources directed to providing training and information for third parties (e.g. banks and other financial institutions) so that the role of the decision-making supporter is understood and the individual does not have to navigate unnecessary bureaucracy to ensure their supporter can be involved.

It is suggested that if the person cannot make an autonomous decision without support, the supporter can offer a best interpretation. It would therefore also need to be made clear to all concerned that the supporter is not a decision making substitute or representative. Individuals themselves may not fully understand the distinction between a supporter and an attorney; neither may some third-party organisations, leading to decisions being made on behalf of the individual without the supporter having proper authority, which exposes the individual, the supporter and the third party to risk.

If people are offered the option of a 'reduced form of POA' (which is inappropriate language in our view – the supporter is facilitating not substituting decision making) and there is no cost or requirement to take legal advice associated with this new route, they may become more reluctant to seek advice on a POA in the belief this will suffice. In the case of people whose capacity is irreversibly declining this may mean they lose the opportunity to grant a POA later.

10.2 Specifically, what are your views on the role of co-decision maker – and its omission from this model?

The comments about co-decision-making in the consultation document are simply wrong. Such arrangements are normally put in place in a power of attorney document, to allow flexibility for the nominated attorney to act simply as supporter, and then as co-decision-maker, before going into full mode of acting solely for the adult. That is far better than a situation of acting fully or not at all. It is not clear what evidence has been used to inform the consultation proposals. The concept of the co-decision-maker should certainly be retained under powers of attorney, in accordance with current best practice. It may be less appropriate in relation to guardianship. However, on balance it would be wiser not to deprive the court (or tribunal) of the option of including co-decision-making arrangements when granting a guardianship order, if the court or tribunal determined that this would best comply with the requirements of section 1 of the 2000 Act. There is a difficulty that guardianship powers may only be conferred upon evidence of incapacity, in which case co-decision making (as opposed to maximum consultation in accordance with section 1 and UN CRPD principles) would be inappropriate. However, co-decision-making can be appropriate to cover circumstances of partial recovery of capacity; and it can also cover situations where the extent of capacity is uncertain, and operation of co-decision-making would ensure certainty in all dealings with third parties but at the same time maximum respect for such capacity as the adult might have.

10.3 Will the proposed change address the issues currently experienced with guardianship? Please explain your answer.

To some extent. However, the proposed 'streamlined' process is focusing on the wrong part of the process, in our view. The barriers to guardianship occur before the application is made, not after it is lodged with the court (or tribunal) and they arise from the lack of availability of MHO reports (and in some areas, also psychiatrists). The proposed "streamlined" process is not in fact substantially different to the current process in terms of what the court/tribunal does, other than reducing the application to a simplified pro forma (see below). We do not think the proposals will deliver the benefits envisaged. Rather, the focus should be on tackling the nature and extent of the information that has to be submitted to the court or tribunal to enable an informed decision to be made, and finding a balance between safeguarding the person and not placing an undue burden on social work and medical services.

10.4 What are you views about the proposed streamlined application process?

See above. Plus, as set out in the 2018 Response, the use of a ‘pro forma’ encourages a tick-box approach to the specification of powers conferred, which is fundamentally inappropriate. Explicitly framing the powers sought in a guardianship application requires the applicant and their agent to focus properly on what the individual can and cannot do or decide for themselves and on seeking only such authority as is necessary. If this is replaced with a series of check boxes, this period of reflection may be absent and some applications will be granted which substitute the Representative where the adult could have operated in that domain with support. Some individuals are in more complex situations (e.g. incapax intestate executors; people with complex property ownership) which require specific and technical powers to ensure their affairs can be properly dealt with – a pro forma would not deal well with these. The circumstances of each individual and the justification for someone else representing them are unique to them and reducing this to a ‘pro forma’ risks losing sight of that individual’s history and autonomy, and encouraging a blanket view of what decisions are to be made for them.

It is unclear what would be produced by this process in terms of the court/tribunal order. It is important that the representative has an official document they can show third parties which sets out their authorisation in a clear and unambiguous form. In practice they will need to be able to evidence this.

We see nothing in the consultation about the duration of a Representative’s appointment. A mechanism for regular review is clearly required.

10.5 Does the proposed emergency provision in the model address the concerns about the current system?

It is important that any proposals for emergency application emphasise the need to retain but accelerate the operation of necessary safeguards.

The issue with urgent interim orders is not about whether or not the court can fix a hearing, rather that it is not possible to apply for one without the same information as is required for a full order. Some courts already make interim orders on the papers in any event (which presents potential article 6 issues), and so this proposed change would have limited practical benefit.

Streamlining the approach to interim welfare orders also needs to take into account the reality that in many cases, an interim order allowing someone to be moved into residential care and deprived of their liberty is a final order as it is (a) not challenged at the next stage and (b) the person is then considered too vulnerable to move into a different care setting.

Nevertheless we accept that the current approach to interim orders is not providing benefit in all cases of urgency. In our view the focus should be on what is required to make such an application and not on changing how the court or tribunal deals with it. The consultation rightly asks what the ‘papers’ submitted should be. We would suggest that these could be, at minimum:-

- At least one piece of evidence indicating that the person does not have capacity to make the decisions in question (i.e. a capacity report carried out by an appropriate professional);
- An application in some form which sets out clearly what interim powers are sought and why they are required to benefit the adult;
- Copies of any documentation indicating past and present wishes (e.g. a PoA);
- Evidence to the satisfaction of the court (or tribunal) that the terms and purpose of the application have been fully explained to the adult in terms understood by the adult, of the support given to the adult to understand them, and of the response of the adult; that the intention has likewise been intimated to any person with a formal role in relation to the adult, with an opportunity to attend or be represented, or alternatively to make written submissions, at the hearing of the interim application; and robust evidence that all that is "reasonable and practicable" to obtain the views and facilitate the involvement of anyone else within the scope of section 1(4) of the 2000 Act; and
- One or more detailed references, given by appropriate persons (e.g. a social worker, solicitor or other person of professional standing) to confirm that the applicant is in all respects suitable for appointment in terms of section 59 of the 2000 Act, including that the applicant understands the nature of the application, and that the referee is aware of no specific reason why the applicant should not be appointed as interim representative. The above of course apply to the proposed guardian, if different from the applicant. Importantly, the presumption that in all welfare matters the chief social work officer is appropriate should be removed from the legislation. There is evidence, including in the personal experience of our members, of adverse consequences of the conflicts arising when a local authority guardian is also provider of services, as well as of discontinuity in persons appointed to exercise guardianship roles for the chief social work officer. The automatic presumption of suitability may be incompatible with state's obligation under Article 12.4 of UN CRPD to ensure that there are adequate safeguards.

10.6 Should the reframed model allow for the grant of a specific or one-off order (currently called an intervention order)? If so, will the reframed model allow for this?

It is important to distinguish between intervention orders under section 53(5)(a) where the court itself makes the decision, and section 53(5(b) where the court appoints someone else to do so. Section 53(5)(a) intervention orders (IOs) should be retained, possibly enhanced, and made the only route for deciding some matters, such as the terms of a Will for the adult. In the case of section 1(5)(b), these should certainly be retained, if necessary coupled with research into their usage. They are valuable, for example, in partial use of section 58(3) to create an IO in particular matters, and (upon the same application) to grant a guardianship order for others – as when the subject-matter of the IO relates to property abroad, so that only the IO requires to be translated and subjected to any other necessary procedures. The downside of them as currently framed is (a) the same amount of information is required as for a guardianship order and (b) a guardianship order application can result in an intervention order being granted but not vice versa. Applying for welfare guardianship and a financial/property IO currently requires two supporting reports. It could be that formal requirements could be more varied for different purposes, so that (for example) an

intervention order could be treated similarly to an interim order as set out above in terms of requiring less documentation, perhaps with the addition of a separate reference/supporting statement which sets out why the IO is needed (e.g. a statement indicating a house needs to be sold to pay care home fees, together with a copy of the title sheet– this specific point would be subject of course to OPG approval in terms of Schedule 2 if it was the adult's dwellinghouse).

10.7 Should the current access to funds process be subsumed within the new model? If so, will the model allow for this?

The existing provisions for operation of joint accounts should be continued. The existing provisions for obtaining information should be continued, subject to improvement so as to be better and more efficiently integrated in the new model.

10.8 Should the current management of residents' finances process be subsumed within the new model? If so, will the model allow for this?

The evidence available to the Review in relation to the operation of this scheme should be disclosed, and any recommendations should be evidence-based. It would appear that it would be appropriate for current supervisory roles to be continued, obviously with adaptations to follow changes in responsibilities, including the introduction of a National Care Service for Scotland.

10.9 What are your views on a system of supervision?

See our various previous comments, including in relation to the preceding question. More active supervision is most required where the appointee has a conflict of interest because of involvement as a provider of services or performer of statutory obligations (notably in the case of local authority chief social work officers).

Power of Attorney

As per our general comments, above, we refer to our previous consultation responses available at Annex A.

Our response to the consultation questions

10.10 What measures should be taken to increase the awareness of a PoA?

Further development of the "mypowerofattorney" campaign, coupled with the implementation arrangements that we advocate above.

10.11 Key points of guidance that need to be given to attorneys.

This is worthy of a carefully drafted, reader-friendly document, with appropriate balance of succinctness but coverage of all essential points. Currently, it is difficult to envisage how this could be better provided than in "Power of Attorney: All you need to know: Granting it, using it or relying on it".[17] A further document would probably only be required in the context of changes or improvements to the statutory regime for powers of attorney if an appropriate updated edition of Ms McDonald's book were not to be planned.

10.12 What support should be given to attorneys – by whom, when?

This is a matter for more effective provision and, perhaps, better coordination among agencies tasked with providing advice in terms of Part 1 of the 2000 Act, rather than of law reform. Guidance and support for granters is also required. Such advice should include, where appropriate, advice in relation to elements of best modern practice including explicit requirements for the attorney to consult, appointment of a supervising attorney, conferring of capacity support and co-decision-making roles, and granting of a parallel advance directive as additional reinforcement of the granter's instructions, as well as covering situations where an attorney ceases to act for any reason (including removal) without a joint or substitute attorney continuing to act.

10.13 The reporting structure for someone with concerns

In the time available to us, we have been unable to consider and comment in further detail. It would be helpful to have further information regarding the evidence base on which the Review is basing any proposals for reform.

10.14 The investigations structure

[17] Sandra McDonald, Souvenir Press, 2021. Ms McDonald played no part in our making of this recommendation: see the last paragraph of our "Introduction" at the beginning of this document.

In the time available to us, we have been unable to consider and comment in further detail. It would be helpful to have further information regarding the evidence base on which the Review is basing any proposals for reform.

10.15 Authorities being able to supervise an attorney, on cause shown, following a statutory inquiry.

This should be by judicial appointment, with maximum discretion to make an appointment suitable to the particular circumstances, backed up by ensuring that powers and duties of all authorities established by statute facilitate this.

10.16 Attorneys having power to authorise a deprivation of liberty (assuming this power has been granted in the PoA).

See our responses to Chapter 11.

Part 5: Medical Treatment and Research

See our previous comments on the role of appointees in medical matters, and see also our paper on "Advance choices, and medical decision-making in emergency situations" (listed in Annex A).

Our response to the consultation questions

10. 17 What are your thoughts on the provisions within s47(7) on the use within the AWI Act of force and detention, and the relationship with the 2003 Act?

The exclusions in section 47(7) should, for clarity, be extended to exclude anything that could be authorised under the 2003 Act, and anything that would require authorisation under any current deprivation of liberty scheme (including the current basic requirement to comply with Article 5 of ECHR) or any other provision of the 2000 Act.

10.18 Is any change needed to the list of special treatments requiring additional safeguards (section 48) or the procedures by which they are authorised?

It is not within our competence to comment.

10.19 It has been suggested that Transcranial Magnetic Stimulation (TMS) should be added to the list of special treatments requiring additional safeguards in section 48. What are your views?

It is not within our competence to comment.

10.20 Is any change needed to the dispute resolution procedure in section 50?

As far as we are aware, there have been very few cases where section 50 procedure has been triggered and none where it has been carried through to an outcome. Given the minimal use of the procedure, and unless there is evidence of situations where it should have been used and was not, or of issues with accessibility, communication or availability, there would appear to be no evidence of need for change.

Chapter 11: Deprivation of Liberty

Our general comments on this chapter

This chapter should include the issues which have been prominent in recent litigation of authorisation of deprivation of liberty when the person in question is transferred cross-border within the UK.[18] Also, given both the urgency of the need to introduce at long last necessary provision for authorisations of deprivations of liberty, widespread lack of understanding of current requirements under Article 5 of ECHR, and widespread deprivations of liberty that have occurred and continue to occur, we recommend that the Final Report set out the current position in law and the main issues. We offer a note of principal points to be covered in Annex C.

Our response to the consultation questions

[18] See for example *City of Wolverhampton Council v The Lord Advocate*, 2021 CSIH 69; 2022 SLT 1 and *Lambeth Borough and Medway Councils, Petitioners*, [2021] CSIH 59; 2021 SLT 1481. Whilst these cases relate to children, see the commentary in the Mental Capacity Report: Scotland, December 2021 and February 2022, for relevance to adults.

11.1 What are your views on the deprivation of liberty proposals?

As stated in our General Comments on the whole document, above, it remains regrettable that Scotland still has no appropriate provision to address the issue of deprivation of liberty. We welcome, and commend, the work done by the Review in relation to this issue, and the thought given to an appropriate regime. We stress the urgency of addressing this deficit in protection for those deprived of their liberty, as we have done on many previous occasions[19]. We have not repeated those responses to previous consultations at length, but urge their consideration.

11.2 Who do you think should be able to apply for a deprivation of liberty order?

Any person with an interest in the welfare of the adult, interpreted in a broad sense, but with due regard to the concept of "operational independence" between those who are involved in providing relevant care, treatment, or support to the individual in circumstances amounting to a deprivation of liberty and those who are responsible for authorising the deprivation of liberty. For avoidance of doubt, we believe that for this purpose "claiming an interest" is too broad and "having an interest" is too narrow, therefore in place of those two existing criteria in the 2000 Act we recommend further careful consultation on who should be able to apply, linked to the various settings in which adults may be placed before or after granting of the order sought, and the various existing roles in relation to that adult.

11.3 What are your views on the safeguards in the process?

We agree that the supported decision making model, and emphasis on respect for the rights, will and preference of the adult, is an important safeguard for the adult.

Circumstances of choice

The consultation makes reference to situations in which "we" can be satisfied that a person who cannot make an autonomous decision has expressed a will and preference as to their current living arrangements. In those circumstances, it is suggested that further judicial oversight of any deprivation of liberty is not required. The identity of "we" is not specified. Such living arrangements may be overlooked, or not recognised. They may leave the person concerned open to abuse, or subject to expedient assessments in times of straitened resources.

It is essential that any assessment of such living arrangements is carried out by persons properly trained to ascertain the will and preference of the adult, to understand the rights of the adult, and to evaluate whether "assent" is validly being given to their circumstances. We have previously described this as: taking all practicable steps to support the individual to express a view in relation to the circumstances under which care, treatment and/or support are being delivered, with appropriate measures in place to ensure that the

[19] See Annex A, appended

individual is not coerced or otherwise pressured into expressing a view[20]. We have suggested that "there is a presumption that circumstances that amount to a confinement (however this is defined ultimately in legislation) also amount to a deprivation of liberty unless the person or body responsible for those circumstances can establish that the individual concerned is validly consenting"[21]. We have stressed the distinction between acquiescence, and "assent".

We agree that there should be comprehensive (and comprehensible) guidance available in relation to supporting an adult to exercise their will and preference to live in an environment which might otherwise deprive them of their liberty, and in relation to ascertaining that will and preference. We also agree that there should be provision in law giving legal protection to any caregiver who is acting in good faith and in line with the principles of the legislation, as found in the relevant legislation in each of England and Wales, and Northern Ireland. We do think that such a provision should be linked to a rebuttable presumption of validity of a broad concept of assent.

We also think that, in those situations where a person expresses a will and preference to remain in their circumstances, despite an apparent deprivation of liberty, there must still be provision for regular review, to ensure that the will and preference have not changed. This is particularly the case where the adult has limited ability to communicate, and/or limited access to resources to challenge or change their circumstances (see below).

In our response to the Consultation on Adults with Incapacity Reform in April 2018, we considered at length the circumstances in which advance consent might be given to measures which would otherwise amount to a deprivation of liberty[22]. We also commented with approval on the approach adopted by the Law Commission of England and Wales to the statutory recognition of the ability to give advance consent by way of express instrument, and the circumstances in which that advance consent might be understood to have been withdrawn.

We agree that regular review will be required of Powers of Attorney which are used to authorise deprivation of liberty. There is already a mechanism for registration of Powers of Attorney by the Office of the Public Guardian, and we would suggest that provision is made for a requirement to notify the OPG that a deprivation of liberty has been authorised. That will allow an administrative reference by the OPG to either the MWC, or the relevant local authority, to ensure appropriate scrutiny and review. However, as these are clearly personal welfare matters, notification to the local authority might be appropriate where authorisation is by anyone other than the local authority: that is already a good practice requirement in the drafting of powers of attorney under which the attorney is empowered to authorise deprivations of liberty.

We agree that there should be a stand-alone right of review of *de facto* detention available to the adult, or a person acting on their behalf. We would welcome the ability for the MWC to intervene in such circumstances, but we are not clear how, in the case of informal placements as described above, the MWC

[20] Consultation on Adults with Incapacity Reform in April 2018 p10

[21] Consultation on Adults with Incapacity Reform in April 2018 p10

[22] *Ibid* pp10-12

will be aware of the adult, or their living arrangements, unless the circumstances are brought to its attention.

We have previously expressed our qualified support for the creation of the role of "registered supporter".[23] A similar role is proposed in the consultation, under the name "decision making supporter". We stressed the importance of choice by the individual concerned, but also expressed our view that an application might be made to the court or tribunal for appointment of a registered supporter, to a person who cannot be supported to make that appointment themselves. We have stressed the need for registered supporters to have access to all information competently available to the adult, to allow the registered supporter to properly support the individual. We have also recommended the integration of arrangements for registered supporters across a wide range of legislation, including both the civil and criminal justice systems. In order to address potential abuse, there should also be a mechanism to allow an application to the court or tribunal for replacement, or removal, of a registered supporter.

We are open to discussion of alternative routes to access justice, including an equivalent of the English concept of "litigation friend", or the creation of an office with similar duties and responsibilities to the Official Solicitor in England, possibly under the auspices of the MWC.

We stress that, for a stand-alone right of review of *de facto* detention to be meaningful, there must be the opportunity for the adult, or a person acting on their behalf, to have access to independent legal advice. That requires also access to non-means tested legal aid.

Proposed orders

We consider it essential that deprivation of liberty is authorised by a judicial body, through a process adapted to reflect support for autonomy and supported decision making. We agree with the proposal that authorisation of deprivation of liberty by a decision making representative, or intervener, by a court or tribunal should be qualified by the requirement for a human rights evaluation, and we would extend that requirement equally to stand-alone orders. In view of the lack of provision and lack of understanding in Scotland, it may well be appropriate for the Final Report to outline the updated regime in England & Wales. See also our offer to assist further with a note of principal advantages of that regime (not available in Scotland) under "Deprivation of liberty: requirements and issues" above.

We also agree that both standard and urgent orders will be required, and that standard orders may be stand-alone, or incorporated into the decision making representative process. We would suggest that the proposed terms of the authorisation for depriving liberty cover also:

the use of locked doors, including the use of keypads, and in respect of both external and internal doors;

the installation and use of assistive technology, including alarms, sensors, and two-way means of communication; and

[23] *Ibid* pp14-16

Law Society of Scotland

authorising reasonable and proportionate physical intervention to maintain the safety of the adult and those with whom they come into contact, including the use of de-escalation and distraction techniques.

We agree that any authority for deprivation of liberty should be granted only to the extent that it is necessary, and only for as long as needed to achieve the protection required. We also agree that a stand-alone order granted should have a review date, and a short end date, and that authority must be revoked sooner, if the person regains their autonomous decision-making.

We have concern, however, about a restriction as short as six months being placed upon an order granted as part of an application for appointment of a decision making representative. Apart from likely placing such an order at odds with the duration of the appointment, in cases such as those of adult children with multiple and severe disabilities, where autonomous, or supported, decision making is not possible, and will not become possible, it is disproportionate, and wasteful of resources, to require judicial scrutiny of care arrangements every 6 months. Such a course of action will place a significant burden on families to begin a process of renewal, including instructing a solicitor, applying for legal aid, etc., almost as soon as an order has been granted. The process may represent a disproportionate interference with Article 8 rights. What might be preferable would be the resourcing and enforcement of regular review of the adult's circumstances by the relevant local authority, in a way envisaged for Guardianship, but rarely consistently achieved.

It is not clear what is meant in the consultation by the paragraph: "There must be a right of appeal at the time of granting. This is to allow it to be heard quickly to avoid person becoming institutionalised – or the equivalent – before the appeal is heard." In our opinion there must be appropriate procedural safeguards in place before a standard deprivation of liberty order is granted. Those safeguards are:

- any application for an order must be intimated to an adult, and any other relevant person, before a hearing on the order is held;
- the adult, and any other relevant person, must have the opportunity to make representations before any order is granted. This includes a right to advocacy services on the part of the adult;
- where necessary, an appropriate person should be appointed to support the adult, or to safeguard their interests, and to make representations before any order is granted;
- there must be a mechanism for expedited appeal of any decision in relation to an order, to a higher court or tribunal (such as is available within short timescales for appeals against the refusal of bail, or applications to revoke short-term detention certificates);
- any proposed deprivation of liberty which involves changing the adult's living circumstances must not take place until determination of an appeal; and
- there must be a mechanism for judicial review, and variation, recall or revocation, of any order, within the period of the order.

Also essential is the opportunity for the adult, or a person acting on their behalf, to have access to independent legal advice, and to non-means tested legal aid.

Law Society of Scotland

Urgent orders

It is preferable that the procedural safeguards, above, apply equally to urgent orders depriving a person of their liberty. Where the urgency is so acute as to render a sufficient period of intimation potentially harmful, we agree that any order should be initially granted only for a period of 7 days, with a properly intimated hearing held no later than the seventh day. Only after an opportunity has been allowed for representations to be made, should any longer authorisation be granted. The same provisions, in relation to representations, safeguarding, appeal and review should apply equally to urgent orders, as to standard orders.

We note that the consultation paper departs significantly from the proposals for Time-Limited Care Certificates proposed by the Scottish Government in April 2021.[24] We noted the assurances given as part of that process, that the proposals were not intended to address delayed discharges from the perspective of care providers, but were intended to meet the needs of adults. We recommend that any proposals for urgent orders depriving liberty are structured in a way which ensures that those assurances are enshrined in subsequent legislation. We also recommend that urgent orders are available only in limited circumstances, which are strictly defined within any proposed legislation.

More information is required as to how an urgent order depriving liberty will differ from, or operate in conjunction with, the proposed emergency appointment of a decision-making representative. We would have concern if an urgent order were to replace Section 13ZA of the Social Work (Scotland) Act 1968, with the benefit of initial judicial scrutiny, but thereafter no provision for an application for a standard order, or on-going review of deprivation of liberty. It is essential that urgent orders are included in an overall scheme for authorisation of deprivation of liberty, and that the scheme is implemented as soon as possible.

11.4 How can we ensure that there is a real, effective and accessible ability for the adult and / or their representative to challenge the lawfulness of a deprivation of liberty order?

There is at present insufficient requirement to involve the adult directly in proceedings, and to secure their actual participation, in accordance with the "rule of personal presence" developed by the ECtHR in cases such as *Shtukaturov v Russia*[25]. This situation has been exacerbated by measures imposed to limit the spread of Covid-19, and the assessment of the Scottish Courts and Tribunals administration that hearings in respect of 2000 Act cases are "administrative", and should be held only remotely, unless otherwise directed by the court.

In our view, there should be a clear requirement on a court or tribunal to facilitate the personal participation of the adult, to supplement this where necessary, to record how this has been done, and in the absence of participation, to record the reasons and to record the steps nevertheless taken to ascertain the 'will and

[24] Our response to that proposal can be found here:21-05-13-mhdc-awi-bill-proposals-time-limited-care-certificate.pdf (lawscot.org.uk).

[25] (App No 4409/05) (2008) 11 CCL Rep 440

preferences' of the adult. Rules of court in England & Wales have been introduced and are designed to ensure that this is done and recorded. Requiring an adult to participate in remote hearings, which require access to technology and potentially discriminate against those with impairments of communication or comprehension, does not respect the rights of the adult to participate in the process, and reduces their access to justice.

Better information should be provided to adults, in an appropriate format. As discussed above, involvement of a registered or decision-making supporter may increase the ability of the adult to challenge the lawfulness of a deprivation of liberty order. The right to advocacy must be retained, and strengthened. The procedural safeguards referred to above are essential. Also essential is the opportunity for the adult, or a person acting on their behalf, to have access to independent legal advice, and to non-means tested legal aid.

Consideration might be given to imposing on anyone applying for an order authorising a deprivation of liberty, a similar duty as that imposed upon Mental Health Officers in Section 61 the 2003 Act. That duty is to inform a patient of their rights in relation to an application for a Compulsory Treatment Order (including their right to legal representation), to inform them of the availability of independent advocacy services, and to take appropriate steps to ensure that the patient has the opportunity of making use of those services.

11.5 What do you see as potential barriers to its operation?

Any new system must be properly resourced, including the education and training of relevant participants. Public awareness of the issues concerned must be raised by appropriate, easily comprehensible publicity. Advice and guidance must be made widely available, in all appropriate formats.

11.6 What else may you wish to see included?

We repeat our calls for proper consideration of the "one door" creation of a unified tribunal to deal with all aspects of law presently covered by the 2000, 2003 and 2007 Acts. Please see our General Comments on the whole document, above, and on Chapter 13, below.

Chapter 12: Mental Disorder

Our general comments on this chapter

Our response to this chapter is subject to our general comments at the beginning of this response document, and in particular our view that the term "mental disorder", or any similar barrier to accessing

ways of meeting the particular needs of any and all people with relevant needs, is incompatible with a human rights-based approach and should be excluded from relevant legislation.

Our response to the consultation questions

12.1 Should there be a gateway to mental health and capacity law which reflects a diagnostic criterion?

No. See above

See our General Comments on the whole document, above. The term ‘mental disorder’, or of any similar concept which puts some people into a category on the basis of a diagnostic criterion, should be abolished.

12.2 If so, what should that gateway be and what terminology should we use?

See our comments above. If a gateway which reflects a diagnostic criterion is retained, a less pejorative term that values diversity and respects differences should be used and should be the subject of consultation primarily of service users, relatives and carers to embrace the principle of inclusivity referred to the Millan Report and in UNCRPD. “Mental disorder” is the language of deficit. It is clear that those diagnosed with a “mental disorder”, their relatives and carers feel stigmatised by the term. Terminology in legislation has evolved over time.[26] The Review’s approach must be driven by compliance with both the ECHR and the UNCRPD. Urgent steps should be taken to implement the recommendations of the Rome Review.

Chapter 13: Fusion or aligned legislation

Our general comments on this chapter

On this chapter generally, there needs to be recognition of two separate issues: the need for a unified forum for judicial or quasi-judicial purposes, and the possibility of unified legislation. We have advocated

[26] The Lunacy (Scotland) Acts 1857 to 1866 refer to a ”lunatic” (i.e. one with a “mental disorder”) as “every person certified by two medical persons to be a lunatic , and insane person, an idiot, or any person of unsound mind”. There was even a lower class of “pauper lunatics”. For youngsters with autism or learning disabilities read, under the Lunacy (Scotland) Act 1862, “imbecile children”, who were cared for solely by charities, who the General Board of the Commissioners in Lunacy for Scotland would issue licences but not fund. A change in the term “mental disorder” was thoroughly examined and alternatives canvassed from a wide spectrum stakeholders, in the Millan Report, pages 26/27, paragraphs 11/22. The conclusion at that time was that the phase should remain.

the need for a unified forum throughout this law reform process, from 2016. The case for a tribunal model of unified forum was developed on pages 13 - 21 of our March 2016 response to Scottish Government Consultation on the Scottish Law Commission's Report on Adults with Incapacity. It must be remembered that one of the reasons for allocating the AWI jurisdiction to the sheriff court was to achieve a "one door" approach in that at that time the sheriff court had jurisdiction in mental health matters. In fact, that "one door" had not bedded in before mental health was transferred to the MHTS. On alignment or fusion, the sequence should be to establish as a priority a unified forum, in our view a tribunal system akin to MHTS. With that in operation, experience would be developed of the need for alignment, which almost certainly would be required where appropriate. Following on from that, consideration could be given to whether there was a need for fully fused legislation. That could only be assessed with experience of all three Acts being operated together in the same forum.

Please note also our General Comments at the beginning of this response, including that an appropriate sequence should be immediate steps to establish a unified tribunal to exercise jurisdiction under the Acts of 2000, 2003 and 2007, and then a process of alignment where appropriate for reasons of consistency or otherwise, and then a re-evaluation of the appropriateness of fully fused legislation in light of experience following upon those preceding steps.

Our response to the consultation questions

13.1 Given the changes being proposed by the Review, do you think a single piece of legislation for mental health, incapacity and adult protection law is the best way forward? Please provide explanation for your answer.

We think that in time a single piece of legislation may be the best way forward as the law going forward requires to encompass all areas of relevant law, and all the people whose needs it seeks to address, in a comprehensive and holistic manner. Current experience shows that people can need and benefit from different parts of the current different legislative regimes at the same time. Professionals need to be aware and consider the powers of all three areas of law but not everyone dealing with adults who are unable to make autonomous decisions have awareness of the full range of the law and powers available. Deprivation of liberty questions and issues relating to coercion can apply with Mental Health Act orders and orders under Adults with Incapacity legislation. Different chapters of legislation could deal with different aspects and different powers sought while respecting the same principles and supported decision making, and thus providing consistency and non-discrimination.

However, the Northern Ireland experience shows that fusion can take time and reform should not be delayed pending the creation and drafting of one piece of legislation.

We therefore confirm our view, expressed above, that alignment of legislation is the preferred option initially and would allow time to see if fusion is necessary or optimal.

13.2 You may consider that two or three pieces of law would be preferred, each dealing with specific issues across mental health, incapacity and adult protection law. If so please tell us, giving an explanation for your answer.

As stated above we believe that alignment is the best immediate route for the reform of law relating to mental health, incapacity and support. It would allow for common principles to be adopted, recognise supported decision making and would allow for the human rights approach suggested above in a consistent way across all three areas of law. It would also allow adults, their families and professionals to consider and see (more easily) what powers or orders might best suit the particular circumstances allowing for a more combined and cohesive outcome.

This would require a single judicial forum to consider applications under all areas of legislation which we have consistently been in favour of. This would promote further consistency in application of principles, oversight of an adult's whole situation, and ability to suggest other remedies.

13. 3 What do you think about our suggestion of aligned legislation? Which aspects of the law should be aligned and which should be left within standalone law?

See our response to 13.2 above. We would suggest that all three pieces of current legislation could be aligned in the first instance and then evaluated before moving to any fusion of legislation.

13.4 Finally please tell us if you consider a single judicial forum should deal with all mental health, incapacity and adult protection cases, and

- **If that forum should be the Sheriff court or a tribunal**
- **If there should be a single forum only in the event of fused legislation, or if a single forum is your preferred way forward regardless of wider changes to the legislation**
- **If you consider aligned legislation is preferred, should a single judicial forum be part of that alignment?**

As stated above at 13.2 and in our general remarks we are in favour of single judicial forum to deal with all cases dealing with mental health, incapacity and adult protection cases. Although there can be cases that only need or deal with one area of law, there are a significant number of cases where at least mental health law and AWI issues arise, and in ASP cases AWI issues are also often discussed and considered. It is crucial that, from a human rights basis and equality basis, the judicial member looking at the issues is aware of all the powers and implications of all aspects of the available legislation. Since the inception of the Mental Health Tribunal more patients and their families have attended Tribunals and participated than when mental health cases were heard in the Sheriff Court. We would submit that a Tribunal setting is more

Law Society of Scotland

user friendly, and a more appropriate physical forum than a court building where vulnerable adults can be left in corridors feeling exposed and more vulnerable or intimated.

We would strongly argue that a single judicial forum should be implemented as early as possible regardless of wider changes to the legislation, but should coincide with any reform being implemented.

A single judicial forum is essential for aligned legislation but could provide further benefits to adults and families if it is implemented in advance of any reform as well as assisting the process of wider reform.

It would also have the other advantages identified in our 2016 response, including that it would be conducive to improved quality, consistency, speed and efficiency of procedures and decision-making.

Annex A

Our previous relevant consultation responses

- Note by ADW (as convener of MHDC) for the Mental Welfare Commission for Scotland on authorising significant interventions for adults who lack capacity (11th February 2004) (available at Annex B of the Law Society of Scotland's Consultation Response on Adults with Incapacity Reform (April 2018))
- Early deliberations on graded guardianship: Initial comments by Adrian D. Ward, Convener, Mental Health and Disability Committee, Law Society of Scotland (12th July 2012) (available at Annex C of the Law Society of Scotland's Consultation Response on Adults with Incapacity Reform (April 2018))
- Law Society of Scotland Response to Scottish Government Consultation on the UN CRPD Draft Delivery Plan 2016-2020 (January 2016)
- Law Society of Scotland Consultation Response to Scottish Government Consultation on the Scottish Law Commission's Report on Adults with Incapacity (March 2016) (available at Annex D of the Law Society of Scotland's Consultation Response on Adults with Incapacity Reform (April 2018))
- Law Society of Scotland Consultation Response on Adults with Incapacity Reform (April 2018)
- Law Society of Scotland Consultation Response to the Independent Review of Learning Disability and Autism in the Mental Health Act (November 2018)
- Law Society of Scotland Written Evidence on "Views and experiences of Mental Health Law in Scotland" (May 2020)
- Law Society of Scotland response to the Scottish Parliament Equalities and Human Rights Committee Inquiry on the Impact of COVID-19 (26 May 2020)
- Law Society of Scotland Consultation Response on Mental Welfare Commission Advisory Committee Equalities Outcomes (20th November 2020)
- Law Society of Scotland Written Evidence to the Independent Review of Adult Social Care (December 2020)
- Law Society of Scotland consultation response on Recommendations for reform of the Adults with Incapacity (Scotland) Act 2000 (April 2021)
- Law Society of Scotland Consultation Response on SMHLR Adults with Incapacity Position Paper: Matters for Inclusion (May 2021)
- Law Society of Scotland Consultation Response on Proposal for Time Limited Care Certificate (May 2021)
- Law Society of Scotland Consultation Response on Proposals for "technical" amendments to the Adults with Incapacity (Scotland) Act 2000 (May 2021)

- Law Society of Scotland paper on Advance choices, and medical decision-making in intensive care situations (May 2022)

Our relevant news items and blogs

- Evidence required to show lockdown hospital discharges were lawful (17 November 2020)
- New report confirms alarm of Scottish solicitors over discharges to care homes (20 May 2021)
- Our 2021 priorities: Incapacity, mental health and adult care and protection, Adrian D Ward MBE LL.B (19 April 2021)

Annex B

Numbering throughout this annex refers to page numbering in the consultation document.

Chapter 2

31. "Respect for autonomy": The limitation to decisions only is regressive in the context of Scots law and of CRPD. Scots law addresses the full range of capability for juridical acts, and CRPD does not refer to decision-making at all: it refers to support for the exercise of legal capacity, clearly having the same meaning as relating to all juridical acts.

"Non-discrimination and equality": It would be helpful to explain how these can be balanced against requirements for respect for diversity.

32. The last paragraph is to be particularly commended. Experience indicates that the most valuable right for carers would be that they be consulted where appropriate, included in review and decision-making meetings and discussions, and provided with (without having to hunt and battle for it) full information to allow meaningful involvement, including in the foregoing ways. There should however be safeguards. Their rights should be their own rights, not "guardianship by the back door" under which they would purportedly speak for the adult – as opposed to being a useful and often primary source of information required to achieve shared understanding of the adult's wishes and feelings, will and preferences. The safeguards in Article 12.3 of CRPD should be observed in relation to their role, insofar as relevant to it, particularly – for example – in relation to issues such as conflict of interest.

33. The suggested comparison between "compulsion" and "those being treated with consent" is a non sequitur. Compulsion should be addressed as non-consensual interventions across the range of the Review's remit, and here compared with people receiving any relevant provision or services voluntarily with those receiving them in the context of non-consensual intervention.

Does the reference to MHTS mean that the Review has concluded that MHTS should be the forum for procedures under all three Acts? The references to universal design and reasonable adjustments could usefully stress that for all purposes universal design is more appropriate, because it is inclusive, whereas reasonable adjustments are always discriminatory, and in principle there should only be resort to reasonable adjustments where needs cannot be met by universal design. Also, the concepts are not limited to physical arrangements: they should be applied, for example, to matters such as judicial or quasi-judicial procedures, voting registration and voting rights, and many others.

34. Statements of requirements of relevant international Conventions should be balanced with assessment of the extent of compliance in Scotland. Has that been done?

35. It would be useful for the Review to spell out how the proposals which the Task Force for Human Rights Leadership are developing can, within the scope of the Review's remit, be translated into effective rather than purely aspirational or declaratory law.

36. Similarly, to recommend that duties be placed on bodies such as those identified does not of itself fulfil the Review's remit. The duties require to be attributable, with the counterpart of rights conferred on the individual, with accessible remedies to enforce compliance.

"Core minimum obligations" should not, within the scope of the Review's remit, be limited to either "the mental health context" or "mental health services".

37. There seems to be an inappropriate dichotomy between the reference to "physical health" at the first bullet-point, and the limitations to the Scottish Mental Health Strategy and people with mental disorder further down.

38. Likewise, limitations to "people with mental disorder" and to "mental health support" (which is clearly too limited to realise the "right to health") are inappropriate.

Chapter 3

45. The statement in the third paragraph should be qualified by stating the inconsistency with the Convention itself, and the requirement upon states to comply with the Convention where its requirements differ from the opinions of the Committee. As to the terms and purpose of the Convention, see the Three Jurisdictions Report.

    "Often described as supported decision-making": That is acceptable only if it is clarified (firstly) that this "shorthand" is used throughout the work of the Review (if such be the case), and (secondly) clear acknowledgement that "supported decision-making" is only one component of "support for the exercise of legal capacity".

    The last paragraph is fundamentally incorrect. The purpose of support for the exercise of legal capacity is to facilitate valid juridical acts by the individual, which is nothing to do with simply expressing views. Does this represent a seriously regressive approach by the Review towards treating individuals as the recipients of services and the objects of decisions by service providers, rather than as people with full rights to self-determination, supplemented only by appropriate mechanisms where despite provision of support they cannot achieve valid juridical acts in such matters themselves? This seems to reflect back as to whether the Review is adopting a fundamentally public law, or fundamentally private law, approach.

47. To what extent do the bullet-points advocate more than exists in existing law? Recommendations in the Final Report should cover combinations of these elements as well as each in isolation.

    The coverage of "a whole range of ways of operating, some of which are well-established and some of which are newer" commendably reflects the dynamic nature of current work in this area. The ultimate

recommendations of the Review must attempt to encompass continuation of such dynamic developments for the period of at least a generation which generally separates reviews of relevant law.

This characterisation of "acting" is inappropriately narrow, particularly as – even in relation to decision-making – it is characterised as following upon a decision having been made, with the unfortunate connotation that it may have been made among choices formulated by others. "Acting" means acting to identify where one's own rights need to be safeguarded or exercised, and what needs to be done to achieve that, which may or may not thereafter lead to a need to formulate and make decisions. In relation to the last paragraph, the complete difference between "effective decision-making" on the one hand, and expressing "preferences, wishes and desires" (in particular in areas where the person's ability to make decisions is limited) on the other, must be stressed; as should the wider contexts, beyond "decision-making", in which preferences etc. should be taken into account (on the one hand) and legal capacity may require to be exercised (on the other hand). It should also be stressed that impairments of capabilities may be short-term or medium-term, rather than permanent. Here or elsewhere, there is an unfortunate tendency for the presumption of capacity that applies prior to the first intervention to become a presumption of incapacity thereafter.

48. Likewise, variations (often short-term) must be fully identified and addressed. In some situations, such as delirium, very substantial impairments and distortions of capabilities can be reversed remarkably quickly by provision of appropriate treatments.

Under "When is supported decision-making needed?", the vast range of needs and circumstances should be stressed. At one end, there is probably no-one who has never needed such support at some time for some purpose. At the other, the reference to enabling a person "to participate fully in decisions about their life" is limiting and regressively paternalistic. The "norm" must be to enable them to make decisions, not to "participate" in decisions by others or in which others have roles at the level of making the decision, as opposed to supporting and enabling the making of a decision.

Under "Range of support to be offered", the limitation to mental health settings is inappropriate. As regards health settings generally, the reference should be to all types of healthcare planning, and of course the principles should be applied across all areas of the Review's remit.

49. The "little used" comment applies not only in the narrow areas of mental health, and healthcare generally, but across the board.

On the last bullet-point on this page, the Final Report should address the considerable need, even under existing provision, for accessibility of relevant information, and education about the importance of accessing it.

50. The definition offered of "advance directives" is inappropriately limited, and incorrect. See definitions in Council of Europe Recommendation (2009)11. On the question of uncertainty under existing law, we

Law Society of Scotland

hope that the Review may find helpful the Report on the Law Society of Scotland's project on *inter alia* advance choices.[27]

51. Simplistic references here and elsewhere to "rights, will and preferences" could inappropriately be read as treating these as a single entity. In reality, there can be (and often are) substantial conflicts among these elements, and among different preferences (it being significant that that term is expressed in the plural in CRPD). Understanding these terms, how they inter-relate, how they can conflict, and how conflicts can be resolved is a major topic in itself, which one trusts will have been addressed by the Review with outcomes to be explained in the Final Report.

    It should perhaps be noted that mental health advance statements were excepted from the work of the Law Society project on the basis that it would be appropriate for them to be addressed by the Review.

52. On the operation of advocacy services more narrowly than intended, it would be helpful to know whether the Review has been able to identify the underlying reasons, including the extent to which additional provisions in law are required, or the extent to which compliance with existing law needs to be achieved.

53. It should be explained that the appropriate adult scheme applies only in criminal law procedures. It would be helpful to have the Review's comments and recommendations as to wider application.

    3rd paragraph: The limitation to people who have mental disorder seems to be particularly inappropriate here. If diversions to mental health disposal are to be mentioned, then likewise should be other diversions, such as to guardianship under AWI.

    As regards the lack of representation, it would be helpful if the Review could develop this point further in the context of compliance, or non-compliance, with Article 5 ECHR; and if the Review could assert a general principle that for human rights compliance any adult who can even in the most generalised way explain wishes, views, relevant experiences and so on (regardless of anyone else's assessment of the validity and relevance of these) to a lawyer should have legal representation to present those, and anything else that appears to represent the adult's position, in those proceedings. That is particularly important where a safeguarder, curator ad litem or similar intends to express views which do not wholly coincide with those of the adult. There must be clear and robust justification for any situation in which any decision-making, judicial or otherwise, proceeds without full and adequate independent representation of the adult.

54. It would be helpful in relation to this section generally if the Review could explain the extent to which it is suggesting improvements beyond those achievable by best practice under existing law. Again, the absolute need for the adult's own representation should be stressed.

55. The "significant drop in the number of named persons appearing" should be quantified and analysed.

    It would be helpful to have elaboration of the comments in the penultimate paragraph.

[27] https://www.lawscot.org.uk/news-and-events/law-society-news/advance-choices-and-medical-decision-making/

56. While McManus referred to "anyone with an interest", existing law distinguishes "persons claiming an interest" and "persons having an interest". Will this distinction be relevant under the Review's recommendations? If so, the Review should address the issues raised in recent cases about the meaning of these terms, and should make recommendations for clarification. Alternatively, the Review should recommend some different, replacement concept(s), with clear and precise definitions.

    As regards the last paragraph, the Final Report should take account of the role of the adult's own representative, which is particularly important whenever there is any divergence between the view of any of those named, and the apparent will and/or preferences of the adult.

57. In relation to "undue influence", the concept of acting as well as making decisions is of particular importance: see for example the comments by Mental Welfare Commission in the Mr and Mrs D Report on the ability to act so as to recognise the exercise of undue influence.

    In the penultimate paragraph, benefit to the person exercising undue influence is not a primary consideration. Exercise of the undue influence may not benefit the influencer at all, but it may be (and often is) nevertheless undue.

    Regarding the last paragraph, the safeguards applicable to the principle of *negotiorum gestio* are a useful source in existing law, which would reasonably provide a starting-point for any recommendations: see the Report of the Law Society project.

58. Other factors should be added to the "examples", such as degrees of confidence and assertiveness, and the effects of historical conditioning such as those resulting from institutionalization, abuse, and other factors.

    Requirements to facilitate implementation of "SDM": These include education, publicity, and all other aspects of implementation, such as were coordinated following introduction of the 2000 Act by the Implementation Steering Group. See comments on implementation in our initial "General Comments".

    SDM is not limited to enabling "people with mental disorder to make their own decisions". It is for all whose disabilities render it appropriate for them to receive support for the exercise of legal capacity. A key element in support can be a decision when still capable to put in place the appointment of an attorney, with appropriate instructions to the attorney in the power of attorney document, to take effect (or in the case of financial matters to continue in effect) in the event of incapacity.

59. The focus on developing "principles of support" from the viewpoint of developing a National Care Service is dangerously flawed, supplanting private law principles focused on the rights of the individual with the public law approach of the provider of a national service, for whom the individual is the recipient of services provided by a paternalistic regime, rather than a citizen with full rights – the antithesis of the approach. It might be helpful to replace "supported decision-making" with a term such as "capacity support".

Chapter 4

61. Account should be taken of cultural elements, the experience of societies with a longer history of more considerable cultural diversity than ours, and also societal changes, where other societies that have experienced greater change can teach us lessons. Examples include the research outcomes in the former Central Asian Republics of the Soviet Union on the very different balance of outcomes as between Muslim and culturally Russian parts of populations; and more recently the profound impact upon the culture of family support in East Asia resulting from smaller families spreading out further geographically and thus causing a major reduction in the proportion of three-generation households.

    At the foot of page 61, it seems inappropriate in the context of consideration of the role and rights of carers to limit matters to "experiences of mental health law". Carers will not necessarily be aware of the extent to which any relevant laws are a factor in their experiences, far less one particular set of relevant laws only.

62. The reference to mental health practitioners is strangely inadequate in relation to the life experiences of many unpaid carers, who may be more concerned with other areas of life, other issues, and among service providers those providing quite different services.

64. Again, the limitation in the second bullet-point of carer awareness training to mental health staff only is inappropriately narrow.

Chapter 5

66. The opening line refers to mental health law, contradicted by the last line on this page referring to all three. In fact, however, this chapter appears to address human rights within the narrow sector of provision of mental health services, and to do so from the viewpoint of principles applicable in public law to those making decisions about the provision or at least offering of services, as opposed to the necessary private law focus also on the rights of individuals. Thus there is no review or consideration of existing principles under the three Acts, nor of the recommendations of the Three Jurisdictions Report.

67. The Review is a review of law. There is certainly room for driving cultural change, as there is for better practice to ensure proper compliance even with existing law, and they are most certainly "part of the picture", but they must be centred upon an assessment of what the law should be, the extent to which existing law properly operated achieves that, and the extent to which reforms of law – which should be specified – are necessary. The whole flavour of this chapter seems to equate respect for, and non-violation of, human rights with processes of paternalistic provision of services. Provision of services is only part of the picture, and the paternalistic approach here seems to be contrary to a human rights-based approach.

    It is disappointing that the third paragraph suggests that the purpose is to ensure the human rights only of people with mental disorder. That inappropriately omits everyone else within the scope of the Review. The provisions at the foot of this page need to better distinguish between enabling a competent and well-informed decision by the person, and what flows from that, on the one hand, from other situations, and in the case of competent decisions fully respecting those which might be unusual. There are many examples in practice of where an unusual or unexpected assertion or decision by the person is treated

as evidence of incapacity, even to the extent of disbelieving factual assertions. As regards the first paragraph under “Enabling human rights in practice”, which public body should have what responsibility in which situations? This must be absolutely clear in order to meet the requirement for attributable duties.

Regarding the penultimate paragraph, one of the challenges is to note and react to changes in circumstances necessitating changes in assessment. Existing practices and procedures are too inflexible in that respect. The penultimate paragraph excludes bodies which may be best placed for some purposes, an example being OPG supervision of financial guardians. Other issues may depend upon where the person is residing.

Regarding the last point, human rights should not be “important” for courts and tribunals: they should be the starting-point for any involvement, they should be central to all processes, and they should underpin all interventions.

69. The brief reference to “will and preferences” is too simplistic. There needs to be clear explanation and understanding of how the terms are used, how elements are reconciled when they are in conflict with each other, and of how (for example) will is definitive and derived from preferences, but may vary over time when the facts have not changed, or in relation to changes in experience or circumstances.

    Account also needs to be taken of the difficulty which anyone can experience in expressing what they want and mean accurately, in situations of stress, or in situations to some degree disorientating.

    The reference in the last paragraph to a “co-production between the person and the practitioner” needs clarification. What practitioner, how is a suitable practitioner to be identified and made available? Will anyone have a duty to ensure that that happens, and that the “match” is appropriate?

70. “The decisions to be taken – by whom, in whose interests?”: Third paragraph is good so far as it goes, but who has the responsibility in all other circumstances?

    Fourth paragraph: This is good, but the HRE must be a “living document”, adapted to changes.

    Sixth paragraph: Yes – there should be an identified professional, in all circumstances. It is almost impossible to specify who this might be in all relevant circumstances. There should be a coordinator responsible for identifying the appropriate “lead person” in each case. Consideration should be given to the possibility of this being the same person as the “enveloper” suggested in our response to Chapter 4, above.

    To what extent does this describe doing what should be done already, but doing it better? It would certainly be more efficient in the long run for this to be done right across the board. There would need to be remedies to rectify incorrect or out-of-date content.

71. Middle paragraph: The problem frequently is that the stated issues are not the real issues.

Penultimate paragraph: "professional judgement": which profession? Should top of the list not be a request by the person, or conduct amounting to asserting the need for an assessment?

Last paragraph: Surely there should be a right to request one as well as a right to refuse? There is a general risk of the person being too passive in relation to such requirements – the person needing it most being least assertive about seeking it.

72. Crisis intervention: Account should be taken of the role of advance planning, including advance choice documents.

    It is necessary to be careful to avoid becoming too fixated on finding reasons why it can't be done, or why it can't at least be partially done, to be completed later.

73. The limitations to "treatment" on this page are too limiting. On triggers, these should include any situation where a past assessment for any purpose is to be reviewed, or is identified as being inappropriate/out of date.

74. First paragraph: The route should include disagreement with the assessment, and a desire to remove alleged errors or misconceptions which have occurred in the past and have developed "a life of their own" – a common situation in practice.

    On the second paragraph, there should always be independent support and representation of the person.

    On the fourth paragraph, the list should not be closed. Any group that takes action which *prima facie* is appropriate should be able to do so if no other group is doing that.

75. Control of access to material would probably require to be subject to disclosure only to persons subject to some form of professional discipline, though see our comments on sharing of information in our general comments on Chapter 4.

76. Generally, there would obviously be a need for a full implementation strategy, overseen by an Implementation Group (similar to that which coordinated and oversaw implementation of the 2000 Act).

Chapter 6

78. The criticisms on page 78 are not criticisms of current tests, or of applying them. They are criticisms of doing it badly, there being inadequate safeguards against that. The same will happen under any replacement system if there are inadequate safeguards.

80. First paragraph: This is too black-and-white. It is necessary to encompass all degrees of capability and all variations of situations where the person can act competently in relation to some but not all elements of a particular matter.

On the fourth paragraph, these “factors” are among the broad scope of “preferences” from which a person’s will in a particular matter is formed. It is difficult to be completely free from controlling influences, and probably better to recognise that the degree of influence of each needs to be evaluated. Also, many long-lasting influences become part of the person’s personality.

As regards barriers, references to “illness or condition” are too narrow. Many aspects of circumstances can have this effect, including stress generally.

81. On the first paragraph, it is necessary to take into account the extent of unlawful detention during the pandemic, against the background that UK Government was not one of those that derogated from Article 5 ECHR as a result of the pandemic.

    On numbered items:

    1 The supportive and enabling frameworks may also be significant limitations on autonomy, for example where the views of one or more persons are dominant, or family or other conflicts are played out in the context of the process.

    2 Surely “may be unable” should be the criterion: “is unable” risks prejudging the outcome.

    3 How autonomous does the person need to be? What is “autonomous” amidst all the factors that shape even undoubtedly competent decision-making? Is the decision autonomous because it does reflect dominant and significant factors in the person’s life or experiences, or because it is not fundamentally influenced by them?

82. On item 10, the reference to “will and preferences” is too glibly simplistic when there are often conflicts and variations over time among these elements and “will” being a significantly different concept from “preferences”. Generally, it is unclear how these principles balance questions of how to conduct public law duties, with principles regarding process and when interventions are permissible in private law.

83. The role of all aspects of advance planning should be taken into account in this section.

84. On item 4, it is necessary to consider advance instructions as well as advance wishes (see Recommendation (2009)11). On “authentic will”, has any research been carried out on the distinction between authentic and not authentic, and how it can be ascertained?

    On item 5, are “wishes” to be equated to “preferences”, and if so, how are conflicts among them to be resolved? Whenever a decision is not completely straightforward, it is likely to involve balancing conflicting preferences.

    Even in urgent situations, a cooperative, constructing decisions approach should be preferred. Persuasion by a trusted person may be a more significant intervention, for good or bad, than proceeding contrary to the person’s will and preferences. However, proceeding contrary to will and preferences may create enduring fractures of trust and relationships.

85. Conflict between present and past expressed will and preferences is only one part of the story. Changes between past and present will should normally be respected, whereas conflicts between past and present

Law Society of Scotland

preferences require a different approach. See article "Respecting 'will': Viscount Stair and online shopping" (Adrian D Ward and Dr Polona Curk), 2018 SLT (News) 123.

86. The best resolution of a conflict is not always the appropriate resolution. A classic example is the "gift" test: someone with a role has made gifts to some but not all members of the family, and the conflict about this might be resolved by making equivalent gifts to others, but that might well violate relevant principles in relation to the adult whose funds are being given.

    There must be a record and it must be kept up to date; and it must be available to check the up-to-date position.

87. The limitation to "non-consensual treatment" is inappropriate. This should apply to any non-consensual intervention of any kind.

    There should certainly always be an ultimate right of access to an independent judicial or quasi-judicial process. The main perceived barriers to that are experiences of failure by judges or others to impose appropriate tight timeframes and to case-manage appropriately.

88. See also the comments and questions above on pages 79 and 87.

Chapter 7

90. The opening statement is plainly wrong. The requirements of CRPD apply to people with disabilities, for reasons not limited to mental disorders; and people with mental disorders may not necessarily be disabled in consequence.

91. Lacking here seems to be an assessment of the extent to which existing law meets the described requirements; and the extent to which existing law meets those requirements but practice does not.

    Second paragraph: The second paragraph seems unduly to medicalise situations of impairments of capabilities: such medicalisation being regressive by several decades.

    Third paragraph: This is extremely important and needs to be emphasised.

    Regarding the last paragraph, physical environment can have a significant impact: people often behave in ways in which the physical environment in which they are placed suggest that they are expected to behave (personal experience is of people with severe challenging behaviour being accommodated in placements with furniture bolted to the floor, yet not causing undue issues when moved to a "normal" home setting with normal furniture, ornaments on shelves, and so forth.

92. References on this page such as to "mental health and social care services", effects "not unique to psychiatry", voluntary and involuntary patients, and relationships between people and professionals are

all inappropriately limiting in relation to the topic – across all relevant areas of law within the Review's remit – of non-voluntary intervention.

93. Third paragraph: Informed consent can include situations where people are compliant with and even conceal undue influence, sometimes only discernible when they simultaneously comply with two contradictory sources of influence. Also, while there may for many years be no conflict where a person with significant disabilities lives at home with parents, with course of time and with the parents ageing, conflicts of interest (even though not to be identified from expressed disagreement between individuals) that may well arise, taking various forms, such as an adult being progressively infantalised, being denied the normal opportunity to move towards greater independence, or being at risk of excessive disruption and trauma when parents eventually themselves become significantly disabled, or die.

    The last sentence of the third paragraph is good, and important.

    Regarding the last paragraph on this page, the medication example is rather narrow, and other common examples include actual or implied threats of withdrawal of "friendship", or of fracturing of relationships.

94. First paragraph: The reference to administration of medication is rather odd: the same can apply to inappropriate exercise of any of the powers held under AWI provisions.
    The fourth paragraph appears to fail to recognise that any non-voluntary intervention is a quite fundamental decision about a person's rights which must be made in a manner compliant with Article 6 of ECHR.

95. There appears, yet again, to be an inappropriate limitation to medical practices, when what requires to be addressed is the topic of non-voluntary intervention across the board.

96. Monitoring and scrutiny must include recognition, and identification in particular cases, of covert factors, including unintended ones. On the penultimate paragraph, there must be recognition of the varying roles of families in different societies.

97. The limitation to the mental health system seems particularly inappropriate.

99. Strangely, the three areas of legislation are referred to at the end of the penultimate paragraph, whereas the whole of the rest of this chapter seems limited to mental healthcare matters.

100. This section, too, could usefully take account of broader issues arising from Article 5 of ECHR.

102. A particular issue here is the tendency to continue powers under AWI orders even where there is no evidence that it has ever been necessary to exercise them, or at least to do so since the last renewal.

Chapter 8

106. The issue about people knowing what their rights are is major. Answers given when people, particularly those in an institutionalised setting, are asked what are their rights, they tend to state these as the things that are permitted to them or provided to them under the rules of their current placement.

Thus, a patient in a psychiatric institution in a Republic of the former Soviet Union, asked if he knew what his rights were, answered only that he had the right to be fed. It appeared that prior to admission he had a history of destitution and going hungry. Likewise, asking what people know about what to do and where to go can produce interesting results: when introduction of an advocacy service for residents at the Royal Scottish National Hospital in Larbert was considered, residents were asked what they could do or who they could go to with problems amounting to infringement of rights. By far the most popular route was to speak to the maintenance man, because he went everywhere, spoke to everyone, was approachable, and generally passed on what he had heard to the appropriate person in management.

107. Appropriate record-keeping, particularly in relation to any non-consensual interventions, or exercise of non-consensual powers, is vital.

108. It is odd that the preceding page refers to mental health and capacity law, and the second paragraph on this page again refers to all disabled people, but there are also limitations to mental health law. The third paragraph refers in the same paragraph to the Mental Health Act and then to mental health and incapacity laws.

110. On remedies and access to justice, key is the need for attributable and readily ascertainable duties as the counterpart of all rights.

111. First paragraph: Much improved, and probably compulsory, education of solicitors is necessary. An example is the man who happened to be an in-patient in a mental hospital for whom five solicitors ceased acting because they "could not get sensible instructions". They all started with his diagnosis and assumed that the rather improbable story that he had to tell was a consequence of delusions, when the sixth solicitor explained that the solicitor's view of the truth was irrelevant, that what mattered was whether there was evidence to persuade a court on balance to accept the person's story, and upon asking for possible sources of evidence established that the story, though initially presented as improbable, clearly seemed to be true, and was accepted as such by the Court of Session.

112. Last paragraph: Should these requirements not apply to death in any situation of deprivation of liberty in terms of Article 5, including in a family setting? As publicised cases demonstrate, occasionally such enquiry would be fully justified.

113. An equivalent of the "recorded matters" requirement is essential under AWI procedure. At present, the best that the court can do upon identifying a failure in provision is to grant an order for a short period and stipulate that if renewal is sought, it will require to be demonstrated that the deficit has been made good but that powers are still required: this was one of the principal issues in the *Borders Council v AB* case.

Last paragraph: Any delay in discharge from hospital of a person who does not capably consent to remaining there is a deprivation of liberty under Article 5. This links to comments on deprivation of liberty later.

114. Comments on excessive security appeals are equally relevant to excessive powers under AWI, and the right at the foot of the page should apply to all situations of non-voluntary intervention.

115. On complaints, it must be carefully made clear that these are procedures in addition to effective remedies for breach of rights: both may proceed in parallel.

The point in the last paragraph on this page is particularly important.

117. Second paragraph: See general comments on this chapter. The broad statement in the second paragraph seems immediately to be compromised by the limitation to "care and treatment" in the third.

118. Last bullet-point: The awareness needs to be about all potential support needs, not limited to communication needs.

119. Top of page: There is a new concept here of "with sufficient interest". How is this intended to correlate with the two AWI categories of claiming and interest and having an interest?

120. The AWI role of independent advocacy is not sufficiently explained.

121. Advocacy groups often arise not so much from shared experiences as shared wishes which are unfulfilled.

Fourth paragraph: Looking across individual issues for more general themes is often achieved by alert legal practitioners, recognising common experiences from individual cases. This has often been the driver for improvement, with the solicitors in effect prompting the formation of collective advocacy (an example would be the speech therapy issue, resulting ultimately in the responsible government minister committing funds to solve an issue brought to light by coordinated campaigning generally by parents of affected sons and daughters).

123. The narrowing, yet again, to mental health services is inappropriate.

125. Second paragraph: There needs to be an attributable duty to provide "signposting" guidance.

128. At the bullet-point, the reference to "mental health services" appears yet again to be too limited and seems incompatible with the references on page 130 to "mental health and incapacity law" and then to "incapacity and adult support and protection legislation". Are these thrown into this chapter as an afterthought to suggest that they have not entirely been forgotten about?

Chapter 9

133. The limitation to mental health law is, yet again, inappropriate, and particularly so in relation to children and young persons, who individually frequently face confusing engagement with a range of services including, in the case of young people, gaps or overlaps between child and adult services, as well as lack of coordination among different services. For example, it is quite possible for the same young person to be subject, or potentially subject, to the children's hearing regime (which can extend to age 18), provisions derived both from educational additional support needs regimes and family law regimes, and mental health provisions, as well as guardianship or other adult incapacity provisions of the 2000 Act, under which adulthood commences at age 16. The three bullet-points apply equally to adults.

134. It should perhaps be acknowledged that many schools in effect promulgate UN CRC by signage in the schools, etc., and it would probably be useful to bring schools into relevant discussions so that practice at the level of children themselves aligns with policies.

Last paragraph: "provide … obligations" reads strangely. Should this not be characterised as "implement … obligations"?

137. Top of page: These points apply also to adults.

138. "not sufficiently mature" is a dubious term. What does it mean? How is such "maturity" objectively assessed? Is this not in reality an excuse for not listening to children whom someone does not want to listen to?

139. Again, at the bottom of the page these points would appear to be equally applicable in principle to adults, if not in detail. Here and elsewhere, a more holistic and inclusive approach might be to stress throughout that everything applies to everyone except where disapplication or particular provisions are needed for specified groups, aiming for maximum inclusivity and minimum need for potentially discriminatory special provision.

148. For young people (16 – 18), and in particular even people over 18, recent case law on the inter-relationship of guardianship and continued application of child law provisions should be considered and should be explicitly applied/disapplied in the Review's recommendations.

Chapter 10

Guardianship

151. Regarding "position statement" at the foot of this page, it is important that a distinction be drawn between matters of law (the Review being a review of law) and shortcomings resulting from failures of government or authorities to discharge their obligations, or lack of provision for other reasons. In the first category, probably the main cause of delay is failure by local authorities to perform existing statutory obligations to ensure that mental health officer reports are prepared within 21 days of intimation. That in turn is attributable to lack of provision (as we have already emphasised, workload for MHOs more than doubled over a period in which the number of MHOs actively in post reduced), and presumably behind that inadequate funding. A difficulty over provision is where difficulties are experienced in obtaining necessary medical reports: an issue which the Law Society has attempted to address, but requires central action. None of this points to any deficiencies in relevant law.

152. What is the objective reason for proposing a change in terminology, and what is the assessment of the balance of advantages and disadvantages in doing so? There would appear to be substantial disadvantages. The public would require to be educated to understand any new terminology: by and large there is at least some understanding of "guardianship", albeit understanding of the difference between guardianship and powers of attorney is not always understood. That point, more than 20 years after introduction of relevant legislation, points to the difficulty of "embedding" any new terminology.

Law Society of Scotland

The term "decision-making framework" is inappropriate. Firstly, it regressively omits the concept of acting. More importantly, it is unspecific as to who makes decisions for or about whom, whereas "my guardian" is someone quite clearly with the distinct role and responsibility of looking after me and asserting, exercising and protecting my rights where I cannot do so in a way that others will recognise as legally effective.

There may well be need for "an emergency application". This need should be analysed by reference to the best that can be done under existing law, in particular, the emphasis should be upon retaining but accelerating the operation of necessary safeguards, and not on compromising on necessary safeguards.

153. It would be wise to expand "welfare decisions" to cover "health and welfare decisions" or "health and/or welfare decisions", countering misunderstandings (and at times misinformation) that fail to make it clear that where someone has been appointed with powers to consent in the healthcare field, that is the normal source of authority in situations where section 47 otherwise applies, subject to necessary provisions in emergency situations and for dispute resolution.

The most important requirement for a "registered supporter" or otherwise duly authorised supporter (as noted above, our preferred term being "capacity supporter") is to have access to information, including personal data. Existing informal support arrangements most often fail because of difficulties in obtaining information, and anxieties on the part of those holding that information as to whether they can properly divulge it.

155. The comments about co-decision-making are simply wrong. Such arrangements are normally put in place in a power of attorney document, to allow flexibility for the nominated attorney to act simply as supporter, and then as co-decision-maker, before going into full mode of acting solely for the adult. That is far better than a situation of acting fully or not at all. What research has been carried out into operation of such arrangements in practice? What is the evidence for "these views" and for whom was it obtained? On "judicial oversight", except for appointment by the adult, done competently with all Article 12.4 CRPD safeguards in place, any such process must comply with Article 6 ECHR.

On the role of the "decision-making representative" to take decisions, are the recommendations of the Three Jurisdictions Report on provisions required as to how this should be done accepted or rejected?

156. Added to the bullet-points should be where an attorney or other representative is acting in any way inappropriately.

157. Regarding more active involvement of MWC, or some other independent body, this is most required where the appointee has a conflict of interest because of involvement as a provider of services or performer of statutory obligations (notably in the case of local authority chief social work officers).

Application process: From whom was the criticism received, and was it related to the nature of the procedures or deficiencies in the way that they are at present operated?

Does that reference mean that it will be taken into account only in relation to the application process?

158. At the end: The important potential of advance directives, and of the work of the Law Society in that regard, should be taken into account once it is available.

159. It is essential that account be taken of recent and current issues emerging, particularly in recent and current litigation. A current example is a guardian seeking to override the adult's competent decision, and whether the adult's competent decision can ever be overridden by anyone in personal welfare matters. Also, whether relevant AWI principles are there to ensure certainty, rather than empower guardians to override the adult. Another matter to be addressed is the innovative judicial suggestion that a concept of "any person claiming an interest" should be replaced with "any person claiming sufficient interest". That suggestion is in our view clearly contrary to the terms, intention and purpose of the 2000 Act. The Act carefully uses, and differentiates between, "persons claiming an interest" and "persons having an interest", the latter having prior to passing of the Act been adequately defined judicially, and that definition not having been modified since the Act was passed. If the legislature had intended to create a third category of "person claiming a sufficient interest", it would have done so, and would have required to differentiate it from the other two categories, particularly as to the difference between "having an interest" and "claiming a sufficient interest". There have been other recent case law developments that should be addressed in the Final Report.

Power of Attorney

161. The question is not whether responsibilities are divided, but whether that structure works or doesn't. What evidence of the satisfactoriness or otherwise of the system has been obtained from OPG and local authorities? Do the existing provisions and practices for coordination and cooperation work, or do they not? If they don't, what would remedy that?

162. Neither a welfare attorney, nor for that matter a guardian, should ever have power "to deprive a person of their liberty". They might be empowered to authorise such a deprivation, but that should merely trigger appropriate deprivation of liberty safeguards. The glaring gap in Scottish provision in that regard is the lack of DOL safeguards and procedures.

Medical Treatment and Research

164. The reference to "clinicians and GPs who are not specialists in mental health" is odd. The expertise that is required is in assessment of capacity, and techniques to support the exercise of legal capacity. That is a distinct skill from knowledge of the procedures proposed to be authorised by section 47. Both are required, whether provided by the same practitioner or different practitioners.

Further down: The need to maximise autonomy of the adult and to respect will and preferences (subject to previous comments that "will and preferences" are often in conflict, "will" being more significant than "preferences") is important and needs to be emphasised.

165. Top paragraph: The principle of necessity should only be competent in circumstances where it is not possible for valid consent to be given by some other procedure. That distinction underlay the fundamentally different approaches of Scots law (when tutor-dative procedure had been revived) and

Law Society of Scotland

English law (when it had no available procedure). On medical decision-making in emergency situations, see our paper on that topic (and on advance directives) referenced above.

By one means or another, there must be safeguards against mass and automatic issue of section 47 certificates, for example all residents in a care home having identical section 47 certificates referring to dementia, even those – such as stroke victims – for whom there was no reason for such a diagnosis.

166. On "access to justice", what were the results of the Review's assessment of cases where section 50 and section 52 procedures have actually been accessed? When last checked on our behalf, despite all the thought and care that went into the section 50 procedure, there had been very few cases where it had been triggered and none where it had been carried through to an outcome. Has the Review concluded that this is a problem of accessibility, or of communication, or simply that the availability of the procedure (and everyone knows what will happen if need be) has of itself been an effective incentive for voluntary dispute resolution?

167. On section 50, a mis-statement of the law seems to be implied. In a section 50 situation, the authority to treat comes from the appointee holding relevant powers, through exercise of those powers. If the clinician could have sought such authority but didn't, and nevertheless proceeds, that is treatment without lawful authority. If the clinician disagrees with the decision of the appointee, that is where the dispute resolution procedure is necessary in order for the treatment that is subject to the dispute to be lawfully given.

168. Why is it impractical to require the MWC to maintain a list? In the very few cases where this procedure has been triggered, has there in practice been any difficulty in finding someone for the further opinion role? Also, given the very few cases of using the procedure, on what basis has the Review concluded that it "works reasonably"?

Chapter 11

172. Last paragraph: The assertion about "everything seems well" surely contradicts fundamental law as established by the European Court on Human Rights, and the UK Supreme Court, on whether there is or is not a deprivation of liberty in terms of Article 5? If there is, there must be procedure to authorise it. That need not in apparently straightforward cases be a judicial procedure, but there must be a procedure that meets necessary requirements, and that begins with recognising that there is a deprivation of liberty, whether or not it appears to be entirely benign.

173. Second paragraph: The tests for whether there is a deprivation of liberty apply regardless of the location in which the adult is placed.

Third paragraph: The basic point is that, on the one hand, as explained in the in Annex A, due regard should be paid to the principle of assent, but the assent still needs to be competent assent, whether as a result of support for exercise of legal capacity or not, and mere compliance or acquiescence is not of itself evidence of competent consent in relation to applicable law.

Penultimate paragraph: There often will be no need for judicial oversight, yet a need for appropriate non-judicial authorisation procedure which recognises and establishes that there is in law a deprivation of liberty, in which case there must be accessible remedies, including if necessary accessible judicial remedies which are effective.

Last paragraph: Challenge of an apparently unlawful deprivation of liberty, or other grounds for challenge on behalf of a person unable to act for themselves, should continue to be available to anyone claiming an interest, because if the circle of potential applicants is circumscribed the most significant breaches of rights may involve, actively or passively, everyone within that circle.

174. Again, there does need to be a simple non-judicial procedure to recognise and record any situation where there is in fact an Article 5 deprivation of liberty.

Item 1 seems to equate “restriction” to “deprivation”. Either these are treated as separate concepts, or they are not. As noted, the authority in a power of attorney document should be to authorise a restriction or deprivation of liberty, provided that the fact that this is occurring is recognised and recorded in a way that it might be subject to supervision. Under current best practice, powers under which an attorney may authorise a deprivation of liberty are drafted to include a requirement that the attorney notifies the local authority in the event that this is done. Does the Review Team have views about that requirement?

175. Power to authorise a future deprivation of liberty must be valid. At present, powers of attorney that do so often record the specific wish of the granter that if ever it becomes necessary for a DOL to be authorised, they wish that to be done by the person of their choice, the nominated attorney, rather than by a court or anyone else. This does however still require to be subject to appropriate safeguards at time of actual exercise. The provisions of the Law Society Report on Advance Directives regarding the ”delayed action” nature of such an exercise of will in an advance directive apply fully to such an authorisation.

On the fourth paragraph on that page, there should be both non-judicial and judicial processes, with identification of when the judicial process should be followed.

Chapter 12

178. First paragraph: It is inappropriate that the role of “mental disorder” in AWI legislation is excluded.

On the second paragraph, the limitation to “psychiatric detention” is inappropriate. It is an erroneous account of the requirement of Article 5, which relates to any deprivation of liberty.

Regarding the last bullet-point on this page, not only should autism and learning disability be singled out for exclusion, but appropriate provisions should be available for anyone with relevant needs who does not have a mental disability.

179. Certainly in AWI legislation, “mental disorder” by itself is not a criterion for intervention. The same could also be said to apply, at least to some extent, under mental health legislation. Generally, it may

be a gateway or prerequisite, but the actual intervention will be predicated on a further definitive test (in AWI, the impairment of relevant capacity).

On the first paragraph in italics, this does not appear sufficiently to address separately the medically diagnosed cause of relevant disability, the actual relevant disability, the consequences of it for capacity, and the correlation between those consequences and needs in the individual case.

181. First paragraph: The inappropriateness of including learning disability as a “mental disorder”, and to that extent subject to mental health legislation, was identified much longer ago than is implied here. See for example my “Scots Law and the Mentally Handicapped”, published in 1984.[28]

On the fourth paragraph, the emphasis here should be upon a shift away from diagnostic “labels” towards a focus on needs, including needs for fulfilment of the whole range of the individual’s human rights.

The last paragraph on this page is important and should be emphasised.

Chapter 13

Our only particular comment on the text is to point out with reference to the paragraph ending at the top of page 187 that it should also be acknowledged that the same individual from ages 16 to 18, and sometimes higher, could be subject to children’s hearings, and perhaps also the Additional Support Needs Tribunal.

[28] By Adrian D Ward, published by Scottish Society for the Mentally Handicapped (now Enable).

Law Society of Scotland

Annex C

Deprivation of liberty: requirements and issues

The *Bournewood* case (*H.L. v U.K.* (2004) 40 EHRR 761) exposed the UK's failure to provide appropriate provision for authorisation and regulation, in a human rights compatible way, of deprivations of liberty affecting people unable to give valid informed consent. Whether they object or not is irrelevant. Without lawful authorisation, such deprivations of liberty violate Article 5. They are also wrongful civilly, and potentially criminally. They are in essence no different to the abduction and imprisonment, without lawful authority, of anyone who is capable of consenting to what is happening to them but refuses that consent.

England & Wales responded to *Bournewood* with its deprivation of liberty safeguards, which came into force on 1st April 2009, with an updated regime to be introduced this year. That regime has many advantages (we can supply a suggested list of them, if desired). None of those advantages are available in Scotland. We still await provision of a suitable regime. Unlawful deprivations of liberty, and failure even to recognise them, are rife. Failure by Scottish Government to provide for them itself may represent a continuing breach of Article 5 of ECHR.

The following is a quick skim through the criteria for demonstrating a deprivation of liberty to which Article 5 applies:

An Article 5 deprivation of liberty requires an objective element, a subjective element, and imputability to the state.

As to the objective element, the key formulation was provided by Lady Hale in the *Cheshire West* case as the "acid test" of a person being confined in any setting where they are under continuous (or complete) supervision and control, and not free to leave. The confinement must be for a non-negligible period of time.

The subjective element is best described negatively by saying that an objective deprivation of liberty does not violate Article 5 if the person has validly consented. Compliance or lack of objection is irrelevant, as are the relative normality of the placement, the reason or purpose behind it, and whether it is in fact the best arrangement that can be made for the person: in Lady Hale's famous words "a gilded cage is still a cage".

To violate Article 5, a deprivation of liberty must also be imputable to the state. That qualification does not apply to questions of potential abduction or unlawful imprisonment in civil or criminal law. It does include situations, such as ours, where the state has failed to perform its positive obligation under Article 5(1) to protect individuals against deprivation of their liberty carried out by private persons. To comply with Article 5, the basic elements of Article 5.1(e), and Articles 5.4 and 5.5, must be available and complied with. In any decision by anyone to authorise an intervention that could amount to a deprivation of liberty, the evidence before the decision-maker must in terms of Article 5.1(e) demonstrate that the adult is "of unsound mind", in addition to the requirement under the 2000 Act to demonstrate incapacity resulting from a mental disorder.

Law Society of Scotland

As regards what has been happening and is happening in Scotland, the Mental Welfare Commission has been proactive

The pandemic has had a major impact. It has revealed deficiencies, rather than creating them. It has also resulted in grave malpractice. However, before and during the pandemic many of the violations have resulted from elderly and disabled patients being treated as blockages in hospital beds, subject only to targets for reductions in delayed discharges, rather than as human beings with universally recognised human rights, and entitled to the protection of the rule of law.

Prior to the pandemic, it emerged that NHS Greater Glasgow and Clyde had a policy of moving patients from hospital into various care homes without obtaining either valid consent of the patient or, where they were unable to give that, relevant legal authority. The patients were detained in the care homes and were prevented from leaving. These were clear violations of Article 5. This was first identified by Mental Welfare Commission for Scotland in December 2018. Then a lady held against her will for over a year applied to a Mental Health Tribunal for her release. The units weren't hospitals, therefore the Tribunal did not have jurisdiction, but expressed concern. Equality and Human Rights Commission commenced proceedings, initially defended. Then on 20th November 2020 that Commission issued a statement "Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by NHS Great Glasgow and Clyde". NHS Greater Glasgow and Clyde, and the owners of a chain of care homes, acknowledged that their practice was without legal authority and was unlawful.

On 28th October 2020, however, Public Health Scotland published its report "Discharges from NHS Scotland hospitals to care homes". These were 5,204 pandemic-related discharges from 1st March to 31st May 2020.

Many must have lacked relevant capacity to consent to the transfer. 112 lacked sufficient capacity to consent to Covid testing. The primary diagnosis of 272 of them was dementia, and for a further 145 it was delirium. Nothing is said about the legal basis on which any of them were transferred, nor is there any acknowledgement of the necessity for a legal basis, or to record what that was.

According to the Report, the ability of patients to consent to testing was assessed, but not their ability to consent to their proposed placement, nor did the Report acknowledge the need for legality, nor did its recommendations suggest that in future that should be addressed.

The latest twist is that such patients are being shunted into beds elsewhere in the same hospital. However, case authority in England & Wales, which would appear to be equally applicable here, is clear that Article 5 is violated if such patients are held in hospital beyond the point when they do not need to be there for life-saving treatment and are medically fit for discharge. Right now there are patients held in that situation. Reported to us are at least two instances where a patient has left, and has been forcibly brought back. That appears to amount to abduction and wrongful imprisonment, as well as to violation of Article 5.

Some states notified Council of Europe of derogation from Article 5 in consequence of the pandemic. The United Kingdom did not.

Law Society of Scotland

So far as we are aware, we have yet to see cases seeking compensation under Article 5(5). Many such cases could be on their way.

Note the decision of the Sheriff Appeal Court on 13th May 2021 in *JK (Appellant) re Application by Argyll and Bute Council* (in which leave to appeal to the Court of Session has recently been refused). Whether a deprivation of liberty could ever be authorised by a guardianship order was challenged. The relationship between section 64 of the 2000 Act, setting out the categories of powers that might be granted, and section 70, dealing with enforcement of a guardian's powers, was clarified.

One of the consequences of the absence of deprivation of liberty provisions in Scots law is that many – even some mental health officers – seem to be blind to proposed or actual situations of deprivation of liberty even when they are obvious. See for example the case of *Borders Council v AB* (in which a mental health officer maintained that a situation of very obvious deprivation of liberty was not that, and had to be put right by the sheriff).

Law Society of Scotland

For further information, please contact:
Jennifer Paton
Policy Team
Law Society of Scotland
DD: 0131 476 8136
JenniferPaton@lawscot.org.uk