

International Journal of Mental Health and Capacity Law

Articles and Comment

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No longer ‘anomalous, confusing and unjust’: the Mental Capacity Act (Northern Ireland) 2016



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The International Journal of Mental Health and Capacity Law is a peer reviewed open access journal devoted to the intersection between law, mental health and mental capacity. It builds on the well-reputed Journal of Mental Health Law, with a revised name to reflect its wider focus. It also follows the desire of its predecessor to combine academic articles and commentary with material that is designed to be used by practitioners – lawyers, and medical or social work professionals – in these nuanced areas.

The Editors are keen to receive academic articles, both shorter ones of around 5000 words and longer ones of up to 12,000 words; and practice points, case notes and reports of research of around 5000 words. Submissions should be made via the Journal's website - <http://journals.northumbria.ac.uk/index.php/IJMHMCL/index> - and comply with the directions given there as to process. Manuscripts should comply either with the Oxford University Standard for Citation of Legal Authorities (<http://www.law.ox.ac.uk/publications/oscola.php>) or the APA Referencing Style Guide. If you use footnotes, we encourage short footnotes.

Submissions must be original, properly reference any third party material and comply with any copyright limitations. Any possible conflicts of interest must be identified. If an article reflects original research involving human participants, a statement is required that relevant ethical requirements have been met, including an indication as to which body gave ethical approval for the research and the relevant reference number.

All submissions will be peer-reviewed by a double blind peer review process before being accepted for publication; naturally, there will be a process whereby an article may be accepted subject to minor or more major amendments being made. We will endeavour to provide feedback as to why any rejected submission has been rejected.

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INTRODUCTION: FROM THE JOURNAL OF MENTAL HEALTH LAW TO THE INTERNATIONAL JOURNAL OF MENTAL HEALTH AND CAPACITY LAW

Few areas of law and policy are as vibrant as that which surrounds the empowering and disempowering of those who are diagnosed as having some form of mental disorder or as having a compromised capacity to make choices that would otherwise be respected. This vibrancy is almost certainly due to the fact that the normative framework of human rights standards has emerged as a transnational constitutional backdrop for how societies deal with vulnerable people, and also – and probably more importantly – the development of understanding what this human rights framework entails. As a result, changes in mental health law and policy have been a significant feature of recent decades. There has been a steady stream of judgments from courts, including from international courts such as the European Court of Human Rights, as to what a rights framework requires. This developing jurisprudence has played a role in the regularly changing legislation in most common law jurisdictions. Statutes governing matters of mental health law have been updated, and statutes regulating mental capacity issues have been introduced to replace common law approaches. Calls that were made for statutes that combine mental health and mental capacity principles are now becoming more prominent.

These developments are the positive side of an unhappy story. The needs of people affected by such legislation – both to exercise their freedoms on an equal basis and for support – have been breached. The need for and regular success of litigation reflects a failure by the other branches of the state to secure the relevant rights without court intervention. The systemic nature of this problem is reflected in the need for the Convention on the Rights of Persons with Disabilities 2006 (CRPD) and its indication as to what the rights framework requires in the context of those who are viewed as having disabilities, including on the grounds of mental health considerations. Unfortunately, there seems to be no shortage of ongoing concerns that require intervention.

The prevalence of the interface between law and mental health has been reflected by numerous texts dedicated to the area, rather than it being merely a sub-part of broader medico-legal texts, and by the introduction of dedicated academic programmes. The introduction of one such programme at the University of Northumbria was particularly important for a number of reasons, one of which was that the presence of legal academics who were committed to teaching and research in mental health law provided the critical mass that allowed the production of the Journal of Mental Health Law (JMHL).

Writing the foreword to the first edition, published in February 1999 by the University of Northumbria Press, Charlotte Emmett noted her hope as editor that the JMHL would be “readable and relevant”.¹ Relevance was assured from the outset; the first substantive article being a review of judicial review decisions in England and Wales written jointly by a legal academic and a sociology academic. They concluded that social protection was invariably favoured over patient autonomy but added that the

¹ Emmett, C, Foreword, (1999) 1 JMHL 2.

incorporation of human rights standards from the introduction of the Human Rights Act 1998 (UK) might provide a spur towards a different approach.²

The wide range of issues dealt with in the first edition included commentary about the domestic proceedings in the case that gave rise to what was known as the “Bournewood Gap”,³ which in turn led to the European Court of Human Rights determining in 2004, in *HL v UK*,⁴ that it was important for protection against the risk of arbitrary detention that there be better safeguards for people with restricted capacity. This case led to legislative change in England and formed the bedrock of a series of cases in the European Court of Human Rights that provided a basis for the better protection in various jurisdictions of people whose mental capacity was compromised but whose capacity to have rights was undiminished, as is made clear by Article 12 of the CRPD.

Charlotte Emmett passed on the editorship of the JMHL to John Horne, also then an academic member of staff at the University of Northumbria. Now retired, he provided the following reflections to me on hearing confirmation that the JMHL was to become the International Journal of Mental Health and Capacity Law (IJMHCL):

There were twenty-one issues of the JMHL in its life of twelve years. It was my former colleague, Charlotte Emmett, who had the vision, commitment and enthusiasm to launch the journal. She acted as a highly skilful and efficient editor for the first eleven issues, and a huge debt of gratitude is owed to her for establishing the JMHL firstly as a greatly respected platform for consideration and debate about a very wide range of topics, and secondly a source of rich material for citing in various forums by practising lawyers, judges, mental health professionals, academics and students. Both Charlotte and I received considerable support from the Editorial Board (many of the ‘great and the good’ of the mental health law world). Not only did they encourage and advise but also they acted as conscientious referees of submissions we received for consideration for publication. Latterly Dr David Hewitt (Visiting Fellow at Northumbria University) and Mat Kinton (Care Quality Commission) generously fulfilled the invaluable role of Assistant Editors.

When I embarked on this letter, I had an aim, in addition to that of wishing the new journal well, of highlighting some of the articles, shorter ‘comments’, case reviews and book reviews which were published in the JMHL over the years. However on going through past issues, I have found the task of selecting a few to be completely impossible, and have concluded that it would also be somewhat invidious to single out some personal ‘favourites’. I have been reminded of the consistently high quality of the material we published. Each issue was very ‘full’ and ‘a good read’, with the range of subjects covered such as to ensure that each subscriber would have found something of interest and importance to them. Naturally some of the JMHL contents will

² Richardson, G, and Machin, D ‘A Clash of Values? Mental Health Review Tribunals and Judicial Review’ (1999) 1 JMHL 3.

³ *R v Bournewood Community and Mental Health NHS Trust ex p L* [1999] 1 AC 458: the House of Lords determined that an adult man without the capacity to decide where to live and who was compliant with the desire of his psychiatrist that he remain in hospital in his best interests was not detained; but that if he was detained, the common law doctrine allowing what would otherwise be a false imprisonment to be defended on the basis of necessity so long as the situation involved action taken in the best interests of a person without capacity. The House overturned the decision of the Court of Appeal, which had been that detention on the basis of concern about mental health had to be pursuant to the Mental Health Act 1983. Lord Steyn, whose view was that there was detention but that it was protected by the doctrine of necessity, expressed his concern that this conclusion left a gap in the protection of a vulnerable group in society: hence the Bournewood gap in protection.

⁴ (2005) 40 EHRR 32, [2004] MHLR 236.

now be not much more than of historic interest, but so much will still be of relevance to debates and discussion being held now, and no doubt in the future, within many jurisdictions.

Having admitted defeat in attempting to highlight particular articles etc, I do think one particular past issue of the JMHL needs to be expressly referred to. It was the JMHL's penultimate issue (no. 20), published in 2010. I shared responsibility for the editing of this 'Special Issue' with Professor Genevra Richardson (King's College, London), who had chaired the Expert Committee established in 1998 by the then UK Government to advise on reform of mental health law. A different structure to that we usually employed was devised to accommodate the task we set ourselves. That task was to consider (what we called) '*The Proposal*', namely '*A model law fusing incapacity and mental health legislation*', which was put forward by Professor George Szmukler (Institute of Psychiatry, King's College, London), Dr Rowena Daw (Royal College of Psychiatrists, London) and Professor John Dawson (University of Otago, Dunedin, New Zealand). We published in an Appendix their '*Outline of the Model Law*' (in effect a draft statute), but began the issue with a detailed article by them explaining the fusion idea. The next section contained thoughtful and critical '*Commentaries*' by a number of experts (from America, England, Scotland, Northern Ireland, and New Zealand) on specific aspects of the proposal. We then gave the proposers an opportunity to respond, and in so doing not only did they address matters raised by the commentators but also they submitted an addendum to their draft statute. The issue concluded with an overview of the law reform debate to date. A great deal of effort by many people was put into this JMHL special issue. I do commend its contents to your readers and subscribers. The subject-matter deserves ongoing respect, debate and consideration.

This brief outline of the JMHL reveals the pedigree to which the IJMHL will aspire. As is made clear in this letter, a focus on English mental health law was supported by regular coverage of the law relating to capacity and the law of other jurisdictions. The new name reflects an express desire to make that wider coverage clear, particularly as it is informed by the backdrop of transnational human rights standards, and to ensure that there is a proper focus on the growing importance of the law in providing protection for people whose mental capacity is compromised. This leads me to the one point of difference I have with John Horne. The JMHL did not come to an end with its 21st issue: rather, it entered a period of hiatus, from which it has now emerged! The IJMHL is not a new journal, it is a successor journal. For that reason, our archive includes past editions of the JMHL.

Significantly, during this period of hiatus, the University of Northumbria has decided to put into practice a policy of making sure that research is promulgated by making the IJMHL an open access journal rather than one for which a subscription is required. This change has also happened in relation to other journals associated with the Law School there.

Aside from this change in access to the Journal and the express recognition of its wider scope, other matters will follow very much the same formula as marked the value of the JMHL. The editorial board will operate a double blind peer review process to ensure quality; we encourage academic articles from a wide variety of perspectives - legal, medical, social work and service user perspectives, and from cross-disciplinary teams of authors; and we also encourage the submission of case notes and practical writings that inform good practice in this important area of law. Our aim remains the same as that set out by Charlotte Emmett in 1999: a journal that is "readable and relevant".

Kris Gledhill
AUT Law School, Auckland, New Zealand

EDITORIAL

We are delighted to present the first issue of the International Journal of Mental Health and Capacity Law. As indicated by our Editor-in-Chief, Kris Gledhill, this re-invigorated journal continues the tradition of the well-respected Journal of Mental Health Law. Indeed, the articles in this issue emphasise the impact of mental health and mental capacity law, policy and related rights on individuals with mental disorder and the implications for practitioners as well as presenting some comparative jurisdictional approaches to the various issues.

In the intervening years since the last edition of the Journal of Mental Health Law, European Convention on Human Rights (ECHR) law has continued to be developed by the European Court of Human Rights and many states have ratified the UN Convention on the Rights of Persons with Disabilities (CRPD). The effect of this is being felt in several jurisdictions in terms of law, policy and practice, as well as in ongoing national and international debate.

Reinforcing the truly international focus of the journal going forward, we are very fortunate to be able to commence this issue with an article by Professor Rosalind Croucher AM, President of the Australian Law Reform Commission and Adjunct Professor at Macquarie University, Sydney, Australia. Her article, entitled “Seismic shifts — reconfiguring ‘capacity’ in law and the challenges of Article 12 of the United Nations Convention on the Rights of Persons with Disabilities”, considers the very real potential for the right to equal recognition before the law, identified in Article 12 CRPD and radically interpreted by the UN Committee on the Rights of Persons with Disabilities in its General Comment No 1 (2014)¹, to revolutionise how the right to exercise legal capacity is interpreted and given effect in all jurisdictions by challenging existing perceptions of how legal capacity is interpreted to ensure that all persons have a genuinely equal right to make decisions that affect their lives.

Amongst other things, the aforementioned UN Committee on the Rights of Persons with Disabilities General Comment rejects ‘best interests’ assessments in the context of the exercise of legal capacity. The second article, “With and without ‘best interests’: the Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000 and constructing decisions” is therefore very pertinent to this. In this article, Alex Ruck Keene and Adrian Ward provide a practitioners’ view of whether the use of the term ‘best interests’ in the Mental Capacity Act 2005 in England and Wales, and its absence from the Adults with Incapacity (Scotland) Act 2000, actually makes a material difference to how actions are taken, or decisions are made, in relation to individuals deemed to lack capacity.

The following two articles focus on the rights of psychiatric patients. In “When is a voluntary patient not a voluntary patient?”, Hope Davidson argues that when it comes to the treatment and detention of voluntary psychiatric patients the Irish courts are out of step with the jurisprudence of the European Court of Human Rights. She also considers the recommendations of the Expert Group on the Irish Review of

¹UN Committee on the Rights of Persons with Disabilities, General Comment No 1 (2014) *Article 12: Equal Recognition before the Law*, CRPD/C/GC/1, adopted 11 April 2014.

the Mental Health Act 2001 in this respect. In “Can use of the Mental Health Act be the ‘Least Restrictive Option’ for Psychiatric In-patients?”, Beth Ranjit then considers whether, in England and Wales, the Mental Capacity Act 2005, as is often thought, actually offers a less restrictive option to the Mental Health Act 1983, particularly insofar as cooperative patients without capacity or reluctant patients with capacity are concerned.

A 2010 special issue of the Journal of Mental Health Law explored the viability of fused capacity and mental health legislation and this has now become a reality in Northern Ireland. It therefore seems appropriate to complete this issue with Colin Harper, Gavin Davidson and Roy McClelland’s article “No longer ‘anomalous, confusing and unjust’: the Mental Capacity Act (Northern Ireland) 2016”, in which the authors discuss the development and content of this innovative piece of legislation, the origins of which can be found in the 2002 Bamford Review. It is also interesting to note the extent to which the legislation has been informed by Article 12 UNCRPD, but also the potential tensions that exist between the requirements of this treaty and those of the ECHR given that Northern Ireland, like other jurisdictions within the UK, must comply with both.

Finally, I would like to thank and acknowledge the considerable support and input provided by the rest of our international and multi-disciplinary editorial team for this first issue - Simon Burrows, Dr Piers Gooding and Dr Giles Newton Howes - as well as the overall guidance provided by Kris Gledhill as Editor-in-Chief.

Professor Jill Stavert
Edinburgh Napier University
Lead Editor

SEISMIC SHIFTS – RECONFIGURING ‘CAPACITY’ IN LAW AND THE CHALLENGES OF ARTICLE 12 OF THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

ROSALIND F CROUCHER AM*

Internationally, the idea of ‘capacity’ has been shaken up and tossed around, and it is a process that is continuing. Medical and legal ideas have been unpicked and interrogated through the lens of human rights. The Hippocratic oath and law’s pragmatic transactional focus have locked horns in an intellectual battle in which the prize is a model of dignity and equality for those whose ability to make decisions is questioned.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) of 2007 signalled a turning a point in terms of international commitment markers.¹ Its definition of disability was a wide one, including ‘those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.’ It reflects a social approach to disability, requiring a policy focus on the person and their ability, with the support they require to interact with society and their environment; placing the policy emphasis not on ‘impairment’ but on ‘support’. Article 12, ‘Equal recognition before the law’, represents the pole star in this area for legal policy makers and those engaged in intellectual discourse around the concepts of agency and capacity. Article 12, moreover, underpins the ability of persons with disability to achieve many of the other rights in the Convention. In countries with an ageing population like Australia and the United Kingdom,² and the increase in the presentation of cognitive impairment and other disabilities that may accompany it,³ Article 12 will be of increasing significance in the fields of elder law and policy.

By ratifying the CRPD, state signatories accepted the obligations to recognise that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life, and to take appropriate measures to provide persons with disability access to the support they may require in exercising their legal capacity. While implementation is clearly a multifaceted challenge, particularly in countries where a federal system splits responsibilities between the federal government and the governments of its states or provinces, a document like the CRPD both reflects and propels shifts in thinking.

* President, Australian Law Reform Commission. Adjunct Professor, Macquarie University. In this article I draw upon the ALRC report, *Equality, Capacity and Disability in Commonwealth Laws*, ALRC Report 124 (2014), of which I was the Commissioner in charge, and particularly chapter 2 of the report, which I wrote.

¹ *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

² Australia: see, eg, Australian Bureau of Statistics, *Reflecting a Nation: Stories from the 2011 Census, 2012–2013: Who are Australia’s Older People?* Cat No 2071.0 (2012). UK: see, eg, <https://21stcenturychallenges.org/britains-greying-population/>. Global data: World Economic Forum, *Global Agenda Council on Ageing Society, Global Population Ageing: Peril or Promise?* (2011), 5.

³ The number of older persons with disability as a proportion of the total number of persons with disability is likely to increase with population ageing: see, eg, in relation to Australia, Australian Institute of Health and Welfare, *Australia’s Welfare 2011* (2011), 11.

And the CRPD did reflect shifts in thinking; a paradigm shift from a model that was expressed in terms of 'best interests' to one that seeks to give expression to the 'will and preferences' of a person and which moves from an approach of substituted decision-making to supported decision-making. This model finds its practical voice in contexts such as 'deputyship' or 'guardianship', as it was historically known, and other situations involving assistance in or the making of decisions for others.

In July 2013, the Australian Law Reform Commission (ALRC) was given Terms of Reference to consider the recognition of people with disability before the law and their exercise of legal capacity on an equal basis. It resulted in the report, *Equality, Capacity and Disability in Commonwealth Laws*, ALRC Report 124 (2014). In leading this important inquiry I came to it as an academic lawyer and as a legal historian.⁴

My background was in succession and property law and I was very familiar with law's approach to capacity questions; ones that arise usually in retrospect when a transaction – such as a contract or a will – is challenged or sought to be undone on the basis of a lack of legal capacity. Law manages such matters in a functional way. Capacity is considered as fluctuating and calibrated to the transaction in hand. This is certainly how testamentary capacity is tested, in which the leading case involved someone who had been committed to a 'lunatic asylum'.⁵ The decision about his capacity to make a will was a legal one, not a medical one.⁶ Mr Banks was institutionalised because of his mental health issues. He was diagnosed as having paranoid schizophrenia because of delusions, believing that devils or evil spirits were chasing him and that Featherstone Alexander was pursuing him, notwithstanding that he was dead. Banks was considered to be 'insane'. However, he managed his financial affairs, his testamentary plans were sensible ones, and his delusions were considered irrelevant to his scheme of testamentary disposition. His 'mental disease' was not considered as affecting his testamentary capacity. His will stood.

Legal capacity sets the threshold for individuals to take certain actions that have legal consequences. For example, a range of transactions may involve an age threshold as a benchmark of when a person is regarded as being able to act independently and with binding effect – to have legal *agency* to make 'legally effective choices'.⁷ Legal capacity goes to the validity – in law – of choices and being

⁴ I was assisted wonderfully by Graeme Innes, then Disability Discrimination Commissioner, who was given an additional 'hat' as a part time Commissioner of the ALRC.

⁵ *Banks v Goodfellow* (1870) LR 5 QB 549.

⁶ The presumption of capacity arises if the will is rational on its face and is duly executed. See, eg, Gino Dal Pont and Ken Mackie, *Law of Succession* (LexisNexis Butterworths, 2013) ch 2. This was expressed in the legal maxim '*omnia praesumuntur rite et somemniter esse acta*': all acts are presumed to have been done rightly and regularly.

⁷ Terry Carney and David Tait, *The Adult Guardianship Experiment—Tribunals and Popular Justice* (Federation Press, 1997) 3. With respect to the idea of legal agency, see: Mary Donnelly, *Healthcare Decision-Making and the Law—Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) 24; Bernadette McSherry, 'Legal Capacity Under the Convention on the Rights of Persons with Disabilities' (2012) 22 *Legal Issues* 23 and (2012) 20 *Journal of Legal Medicine* 22. The right to recognition as a legal agent is also reflected in art 12(5) CRPD, which outlines the duty of States Parties to 'take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit and shall ensure that

accountable for the choices made. ‘Those who make the choice’, Emeritus Professor Carney states, ‘should be able to provide valid consent, and make decisions for which they can be held accountable. They should, in short, be legally competent.’⁸

As the law generally approaches these questions retrospectively, it starts with a *presumption* of capacity; a challenge on the basis of a lack of capacity (in the sense of agency) is brought to rebut the presumption of legal capacity, as in the example of John Banks’ will. The common law – including doctrines of equity – also includes protective doctrines for vulnerable people, such as the doctrines concerning undue influence and unconscionable transactions.⁹ Where a lack of the required level of understanding is proved in the particular circumstances, the transaction may be set aside. Such doctrines focus on a transaction and the circumstances surrounding it. They are decision-specific and involve assessments of understanding relevant to the transaction being challenged – a functional approach. As a lawyer, this appeared respectful and based on the premise of autonomy. The common law presumption of capacity has, after all, been described as ‘the law’s endorsement of autonomy’.¹⁰

But in leading the ALRC inquiry on capacity, my eyes were opened. We had to *start* somewhere else.¹¹ If you start from a presumption, you separate people; between those *with* capacity and those *without*. For in every presumption lies the possibility of rebuttal. It is a binary model, and for those with lived experience of disability it is deeply troubling. What the idea of equality means to people with disability is *not* a definition of capacity based on a presumption. The United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) emphasised that the idea of equality reflected in Article 12 is essentially about the exercise of human rights: ‘[e]quality before the law is a basic and general principle of human rights protection and is indispensable for the exercise of other human rights’.¹²

Legal capacity is clearly a different concept from ‘mental capacity’ and should not be confused with it.¹³ The UNCRPD commented that the Convention ‘does not permit perceived or actual deficits in mental capacity to be used as justification for denying legal capacity’.¹⁴ This reflects two concerns: first, that legal capacity should not simply be *equated* with mental capacity; secondly, that people with cognitive

persons with disabilities are not arbitrarily deprived of their property’: United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1 on Article 12 of the Convention—Equal Recognition before the Law*, 2014 [11].

⁸ Ibid.

⁹ See, eg, Dyson Heydon and Mark Leeming, *Cases and Materials on Equity and Trusts* (LexisNexis Butterworths, 8th ed, 2011) ch 14.

¹⁰ Mary Donnelly, *Healthcare Decision-Making and the Law—Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) 93.

¹¹ The starting point we concluded upon was expressed as the first of the ‘National Decision-Making Principles’: ‘All Adults have an equal right to make decisions that affect their lives and to have those decisions respected’. That is, we started with the *right*, not the rebuttable presumption.

¹² United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1 on Article 12 of the Convention—Equal Recognition before the Law*, 2014 [1].

¹³ See, eg, the distinction between medical and legal perspectives in Terry Carney, ‘Guardianship, “Social” Citizenship and Theorising Substitute Decision-Making Law’ in Israel Doron and Ann M Soden (eds), *Beyond Elder Law* (Springer, 2012) 1.

¹⁴ United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1 on Article 12 of the Convention—Equal Recognition before the Law*, 2014 [12].

impairment should not be assumed to have limited legal capacity, in the sense of being able to exercise legal agency. What is clearly not appropriate in the context of the CRPD is a disqualification or limitation on the exercise of legal capacity *because of* a particular status, such as disability, or, like John Banks, because of a particular mental health condition. The approach should therefore be on the support needed to exercise legal agency, rather than an assumption or conclusion that legal agency is lacking because of an impairment of some kind, whether physical or mental.

In adopting an approach that shifted away from 'substitute decision-making' to 'supported decision-making', the ALRC report embraced the paradigm shift embodied in the CRPD. There is an important distinction between them but it is also the point about which most confusion has arisen. There is an evident tension in the way that the labels of 'supported decision-making' and 'substitute decision-making' are used; the discourse around Article 12, including the submissions made to the UNCRPD in response to its draft General Comment on Article 12 in 2013,¹⁵ has exacerbated this tension.¹⁶

Any discussion about substitute decision-making needs to distinguish two separate issues: the first is the *appointment* of a person to act on behalf of another and the scope of the person's powers; the second is the *standard* by which that appointee is to act. They are entirely separate points but are often confused. The appointee may be chosen by the person themselves, for example through instruments such as enduring powers of attorney, or by a court or tribunal, in the appointment of a guardian, deputy or financial administrator. The standard is the test by which any decision-making by the appointee is to occur. The danger in analytical terms is to condemn the appointment of a person to act on behalf of another simply by virtue of the appointment, presupposing that the appointee will not act in a way that places the individual at the centre of the decision-making process.

Decision-making support has a long history, conventionally summarised in the evolution and development of guardianship regimes.¹⁷ Traditional guardianship laws have been described as exceedingly paternalistic,¹⁸ protecting the estate of the person under protection, and not promoting their autonomy, especially where plenary forms were used involving a complete vesting of authority in another person. The

¹⁵ United Nations Committee on the Rights of Persons with Disabilities, *Draft General Comment on Article 12 of the Convention—Equal Recognition before the Law*, 2013. The submissions in response are at <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>. The final General Comments No 1 and No 2 were adopted by the UNCRPD on 11 April 2014.

¹⁶ General Comments are provided by way of guidance and are different from legally binding obligations as reflected in the CRPD itself. The Rules of Procedure of the UNCRPD provide that it may prepare General Comments 'with a view to promoting its further implementation and assisting States Parties in fulfilling their reporting obligations': UNCRPD, *Rules of Procedure* (5 June 2014) r 47.

¹⁷ For the history of guardianship, see, eg: William Blackstone, *Commentaries on the Laws of England* (1765) vol 1, 292–294; Terry Carney, 'Civil and Social Guardianship for Intellectually Handicapped People' (1981) 8 *Monash UL Rev.* 199; John Seymour, 'Parens Patriae and Wardship Powers: Their Nature and Origins' [1994] *Oxford Journal of Legal Studies* 159; Sarah Burningham, 'Developments in Canadian Adult Guardianship and Co-Decision-Making Law' (2009) 18 *Dalhousie J. Legal Stud.* 119; Shih-Ning Then, 'Evolution and Innovation in Guardianship Laws: Assisted Decision-Making' (2013) 35 *Sydney Law Review* 133.

¹⁸ Eg, Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) [6.95]–[6.96].

disability rights movement of the 1960s led to increasing pressure to move away from such models, championing a social rather than a medical model of disability.¹⁹

Such efforts sought to limit the *scope* of appointment of substitute decision-makers, such as guardians, to achieve the ‘least restrictive option’. But they also focused on the standard by which the appointee was to act: ‘best interests’ standards were ones that preceded, and were to be contrasted with a ‘substituted judgment’ approach. The ‘best interests’ principle was seen to reflect the idea of ‘beneficence’; a dominant theme in medical ethics in which the ‘primary imperatives were for doing good for the patient, the avoidance of harm and the protection of life’.²⁰ A ‘best interests’ standard ‘requires a determination to be made by applying an objective test as to what would be in the person’s best interests’. A ‘substituted judgment’ standard, in contrast, is ‘what the person would have wanted’,²¹ based, for example, on past preferences. Substitute decision-making can therefore apply in two broadly different ways: one involves an objective ‘best interests’ standard and the other involves a focus on what the person wants or would have wanted (‘substituted judgment’).²²

Even in a reformed context of being committed to advancing individuals’ rights, however, ‘best interests’ standards were still retained in language and in form. ‘Best interests’ and the person’s wishes are both used – a combination of subjective and objective.

For example, the Mental Capacity Act 2005 (UK) s 4(6) requires a person making a determination of ‘best interests’ to consider, ‘so far as is reasonably ascertainable’:

- (a) the person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- (c) the other factors that he would be likely to consider if he were able to do so.²³

In addition, s 4(7) requires the decision-maker to take into account, ‘if it is practicable and appropriate to consult them’, the views of:

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- (b) anyone engaged in caring for the person or interested in his welfare,
- (c) any donee of a lasting power of attorney granted by the person, and
- (d) any deputy appointed for the person by the court,
- (e) as to what would be in the person’s best interests and, in particular as to the matters mentioned in subsection (6).

¹⁹ *Ibid* [2.8]

²⁰ Mary Donnelly, *Healthcare Decision-Making and the Law—Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) 11. Donnelly refers to the Hippocratic Oath.

²¹ Explanatory Notes, *Mental Capacity Act 2005* (UK) [28].

²² The latter approach was the one advocated by the ALRC. The ‘best interests’ approach was also rejected by the Scottish Law Commission in its Report 151, *Incapable Adults*, 1995 [2.50]. See Adrian D Ward in ‘Abolition of Guardianship? “Best interests” versus “best interpretation”’ (2015) *Scots Law Times*.

²³ A similar model is included, for example, in the Mental Health Act 2014 (WA), pt 2 div 3, ‘Best interests of a person’.

Of such a hybrid standard, Dr Mary Donnelly writes that it ‘attempts to mitigate the consequences of a loss of capacity while staying within a best interests framework’.²⁴ The overall question is an objective one, but it is informed by past and present wishes and the opinion of others as to what would be in the person’s best interests. In its application it appears that the UK section is being applied more towards the subjective than the objective, using the decision in *Aintree University Hospital NHS Foundation Trust v James* as the illustration and the comments of Lady Hale that the purpose of the best interests test in the 2005 Act is ‘to consider matters from the patient’s point of view’.²⁵

By the second decade of the 21st century, the approach being advocated was described as ‘supported decision-making’, placing the person who is being supported at the front of the decision-making process. The decision is *theirs*. Supported decision-making emphasises the ability of a person to make decisions, provided they are supported to the extent necessary to make and communicate their decisions. It focuses on what the person *wants*.

As our exploration of the literature revealed, however, in the context of developing – and championing – ‘supported decision-making’, ‘substitute’ has often been equated with ‘guardianship’, and both are assumed to represent a standard that is not consistent with the rights of persons with disability. The fact that someone is appointed as a substitute becomes problematic of itself, rather than focusing upon *how* the substitute is to act. Interwoven in the discussion about ‘substitute’ and ‘supported’ decision-making is therefore a lack of conceptual clarity about the role that a person’s wishes and preferences play when another acts for them as a ‘substitute’ decision-maker; and the role that a ‘supporter’ plays in assisting a person to make decisions.

Conceptual confusion is also exacerbated when models use ‘best interests’ language, but are expressed in terms of giving priority to the person’s wishes and preferences, such as in the Mental Capacity Act 2005 (UK). Given the tensions around the usage and understanding about ‘substitute’ decision-making – and the blurring between ‘substituted judgment’ and ‘substitute decision-making’ – we concluded that it was preferable to move away from this language altogether. The terms we recommended were ‘supporter’ and ‘representative’ and they were articulated in a model focused on Commonwealth decision-making. Indeed, given how loaded and conflicted the language and discourse is in some respects, we advocated what I described as a ‘new lexicon’.²⁶

The next challenge for signatories to the CRPD is to translate the UNCRPD’s conclusions in relation to Article 12 into their review of their guardianship and

²⁴ Mary Donnelly, *Healthcare Decision-Making and the Law—Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010) 203. This approach, she writes, is ‘not without difficulties’.

²⁵ [2013] UKSC 67. A more recent legislative example is the *Assisted Decision-Making (Capacity) Act 2015* (Ireland), which does not use ‘best interests’ language at all.

²⁶ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, ALRC Report 124 (2014) [1.8]. It is interesting to note that the language of ‘decision-making representatives’ has been adopted in the *Assisted Decision-Making (Capacity) Act 2015* (Ireland).

deputyship laws. While the General Comment about Article 12 was prompted by what the UNCRPD described as ‘a general misunderstanding of the exact scope of the obligations of States Parties under Article 12’,²⁷ the hardening of the position between the draft and final versions of the General Comment is quite confronting.²⁸ The UNCRPD suggested that substitute decision-making regimes should be abolished and replaced by supported decision-making regimes and the development of supported decision-making alternatives. Most importantly, the Committee commented that ‘[t]he development of supported decision-making systems in parallel with the retention of substitute decision-making regimes *is not sufficient to comply with Article 12*’.²⁹ What is required is ‘*both* the abolition of substitute decision-making regimes and the development of supported decision-making alternatives’.³⁰ This may not sit entirely comfortably where States Parties are committed to reforming their guardianship laws towards supported decision-making models, but still see the need for the appointment of a substitute decision-maker in certain cases as a matter of last resort.

And how is Article 12(4) to be reconciled with this approach? It provides that:

States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.

The requirements of safeguards that ‘respect the rights, will and preferences’ of the person, and that they be ‘proportional’, ‘tailored to the person’s circumstances’, ‘apply for the shortest time possible’ and are subject to ‘regular review’ seem implicitly to acknowledge measures that may be regarded as ‘substitute’ models. We concluded that, while substitute decision-making models that reflect the constraints identified in Article 12(4) may technically *not* be contrary to the CRPD, ‘[t]here is still considerable debate over the significance of the [CRPD] for guardianship’.³¹ The burning question is whether ‘guardianship’/‘deputyship’ is compatible with the CRPD? Or is it rather a question of *what kind of* guardianship (or whatever other label is used) is incompatible with it? Namely, is it only guardianship where decisions are made without reference to the wishes and preferences of the person under protection?

²⁷ United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1 on Article 12 of the Convention—Equal Recognition before the Law*, 2014 [3].

²⁸ This was also pointed out by Adrian D Ward ‘Abolition of Guardianship? “Best interests” versus “best interpretation”’ (2015) *Scots Law Times*

²⁹ *Ibid* [24]. Emphasis added.

³⁰ *Ibid*. Emphasis added.

³¹ John Chesterman ‘The Future of Adult Guardianship in Federal Australia’ (2013) 66 *Australian Social Work* 26, 31. See Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, ALRC Report 124 (2014) [2.8].

Australia expressed concern that the draft General Comment was characterising the entirety of Article 12 ‘in absolute terms’,³² although Article 12 itself is not expressed in this fashion:

Australia considers that while it is important that the legal capacity of persons with disabilities is respected to the fullest extent possible, there are circumstances in which substituted decision-making may be the only available option. Australia considers that guidance from the Committee on the most human rights compatible approach in situations where a person does not have, either temporarily or permanently, the capacity to make or communicate a decision, would be useful to States Parties.³³

Australia argued that, in a number of respects, the draft General Comment sought to extend the scope of Article 12 beyond that of existing expressions of both equality before the law and ‘legal capacity’ in international human rights law. It stated that the most significant example of this is ‘the characterisation of Article 12 as requiring supported decision-making and not permitting substituted decision-making in any circumstances’:

The statement that there are no circumstances permissible in which a person may be deprived of the right to recognition as a person before the law, or to have this right limited, relates to article 16 of the ICCPR, rather than article 12 of the Convention. The ICCPR provides for this in article 4(2), which states that no derogation from that right is permissible even in times of public emergency. The Convention does not contain a similar provision. However, Australia accepts that this is applicable in relation to article 12(1).³⁴

Australia reiterated that it did not consider Article 12 required the abolition of all substitute decision-making regimes and mechanisms.³⁵ Other States Parties expressed similar concerns with the language of the draft General Comment.³⁶ A joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission observed, for example:

This absolutist approach appears to base the minimum acceptable standard on the maximum desired conduct, rather than taking a more pragmatic approach which reflects the state of *opinio juris*, the complexity of the issues and the emerging nature of supportive decision making regimes.

The draft does not, for example, appear to give consideration to the changes that have been made in a significant number of countries to develop a human rights-based approach to legal capacity that provide a range of measures, beginning with the presumption of capacity, and are tailored to individual capabilities and needs.

While stating an absolutist position, the draft offers little in terms of guidance as to how it should be observed, including in difficult cases.³⁷

³² Australian Government, Submission to the UN Committee on the Rights of Persons with Disabilities, *Draft General Comment on Article 12 of the Convention—Equal Recognition before the Law*, 2014, [13].

³³ *Ibid* [16].

³⁴ *Ibid* [21].

³⁵ *Ibid* [24].

³⁶ See submissions to the UNCRPD on the draft General Comment from, eg, Denmark, New Zealand and Norway: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>.

³⁷ Joint Submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission, UN Committee on the Rights of Persons with Disabilities, *Draft General Comment on*

There are distinct threads in such submissions. First, that an approach of supporting decision-making is paramount; secondly, that any appointment of a person to act on behalf of another should be limited, a last resort and subject to safeguards compatible with human rights; and thirdly, that the CRPD does not prohibit the appointment of a person to act on behalf of another.

What is *not* clearly disentangled, however, is separating the fact of an appointment in certain circumstances and how the person is to act. Both are subsumed in the argument that, in some limited circumstances, 'substitute decision making' may be appropriate, without closely interrogating what substitute decision-making means. The argument is therefore expressed in terms of 'supported' *versus* 'substitute' decision-making.

The ALRC considers that the focus of analysis needs to be on how support is translated into a principles-based model that may guide law reform. How should support be articulated as the principal idea, consistent with the Convention and the concerns of the UNCRPD? What is the standard by which supporters and anyone appointed to act on behalf of another are to act? What is the standard to apply when the will and preferences of a person are not evident and cannot be determined? What is a human rights compatible approach?

The most difficult policy challenges concern those who require the most support. Where a person's will and preferences are difficult, or impossible to determine, they may need someone else to make decisions on their behalf. These hard cases should not, however, be treated as a barrier to building law and legal frameworks that move towards supported decision-making in practice, as well as in form.

For the ALRC, the inquiry was a deeply reflective and respectful process and we embraced the task of proposing a new model in Commonwealth laws as the opportunity to make a singular contribution in this crucial field. We recognised, however, that changes in law, of themselves, do not effect change, but changes in law are important and can play a normative role. As remarked in one important joint submission:

Changing laws and implementing new policies regarding legal capacity is only the first step in realising the right to equal recognition before the law for people with disability.³⁸

An important first step, indeed. And while supported decision-making is, after all, much more than just about law,³⁹ the intellectual engagement around Article 12

Article 12, 28 February 2014:
<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx>, 4.

³⁸ People with Disability Australia, Australian Centre for Disability Law, Australian Human Rights Centre, *Submission 136*. Others who supported this approach included: ACT Disability, Aged and Carer Advocacy Service, *Submission 108*. The submissions are published at <http://www.alrc.gov.au/inquiries/disability/submissions>.

³⁹ Bernadette McSherry 'Support for the Exercise of Legal Capacity: The Role of the Law' (2015) 22 *Journal of Legal Medicine* 739; Terry Carney, 'Participation and Service Access Rights for People with Cognitive Impairments: An Australian Perspective' (2015) 4 *Laws* 37; Piers Gooding, 'Supported Decision-Making: A Rights-Based Disability Concept and its Implications for Mental Health Law' (2013) 20 *Psychiatry, Psychology and Law* 431.

helps propel thinking and practice and the commitment nationally and internationally towards the equal right of all adults to make decisions that affect their lives and to have those decisions respected.⁴⁰

⁴⁰ The first of the National Decision-Making Principles in Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, ALRC Report 124 (2014).

WITH AND WITHOUT 'BEST INTERESTS': THE MENTAL CAPACITY ACT 2005, THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000 AND CONSTRUCTING DECISIONS

ALEX RUCK KEENE and ADRIAN D WARD*

I. INTRODUCTION

This article compares the bases upon which actions are taken or decisions are made in relation to those considered to lack the material capacity in the Mental Capacity Act 2005 ('MCA') and the Adults with Incapacity (Scotland) Act 2000 ('AWI'). Through a study of (1) the statutory provisions; and (2) the case-law decided under the two statutes, it addresses the question of whether the use of the term 'best interests' in the MCA and its – deliberate – absence from the AWI makes a material difference when comparing the two Acts. This question is of considerable importance when examining the compatibility of these legislative regimes in the United Kingdom with the Convention on the Rights of Persons with Disabilities ('CRPD').

The article is written by two practising lawyers, one a Scottish solicitor, and one an English barrister. Each has sought to cast a critical eye over the legislative framework on the other side of the border between their two jurisdictions as well as over the framework (and jurisprudence) in their own jurisdiction. Its comparative analysis is not one that has previously been attempted; it shows that both jurisdictions are on their own journeys, although not ones with quite the direction that might be anticipated from a plain reading of the respective statutes.

The article is divided as follows:

Part 1 considers the meaning and significance of 'best interests' in the General Comment No 1 (2014) issued by the Committee on the Rights of Persons with Disabilities ('the Committee') entitled 'Article 12: Equal Recognition before the Law' ('the General Comment');¹

Part 2 compares the statutory provisions;

Part 3 examines the MCA in more detail, and the cases decided thereunder;
Part 4 examines the AWI in more detail, and the cases decided thereunder;

Part 5 offers some observations upon the results of the analysis in Parts 1-4.

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¹ Available online at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en

II. PART 1: THE MEANING AND SIGNIFICANCE OF 'BEST INTERESTS'

By ratifying CRPD and its Optional Protocol, the UK committed itself to be bound by CRPD. 'Best interests' does not appear in CRPD, nor do two terms relevant to the discussion in this paper, namely 'substitute decision-making' and 'supported decision-making.' However, the terms appear in the General Comment, an interpretation of Article 12 of CRPD offered by the UN Committee. The interpretation of CRPD by the UN Committee is not binding on the UK. That interpretation should nevertheless receive careful consideration in assessing compliance of the UK jurisdictions with CRPD.

Article 12 reaffirms that persons with disabilities have the right to recognition everywhere as persons before the law (Article 12.1). It requires States Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life (Article 12.2); to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity (Article 12.3); and to ensure that 'all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law' (Article 12.4, which proceeds to specify safeguards, including that such measures 'respect the rights, will and preferences of the person'). Article 12.5 requires States Parties to take all appropriate and effective measures to ensure the equal right of persons with disabilities in specified property and financial matters.

Article 12 uses 'capacity' in the broadest sense, to encompass all aspects of legal status and legal personality of an adult. 'Capacity' in MCA and 'incapacity' in AWI are used with the different meaning of factual capability. In AWI, 'incapacity' is explicitly derived from the definition of 'incapable'.

Paragraph 7 of the General Comment urges that 'substitute decision-making regimes' be abolished. According to paragraph 26, such regimes should be replaced with 'supported decision-making, which respects the person's autonomy, will and preferences'. At first sight, it would appear that this could only be applicable to people factually capable of making valid decisions, if – when such be needed – they are provided with sufficient support. That the contrast between substitute decision-making and supported decision-making is not so limited is clear from paragraph 21 of the General Comment, which reads:

Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the 'best interpretation of will and preferences' must replace the 'best interests' determinations. This respects the rights, will and preferences of the individual, in accordance with article 12, paragraph 4. The 'best interests' principle is not a safeguard which complies with article 12 in relation to adults. The 'will and preferences' paradigm must replace the 'best interests' paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others.

A 'best interpretation' approach is thus contrasted with a 'best interests' approach. Where an individual is factually incapable of validly acting or deciding, the core issue in relation to CRPD as interpreted in the General Comment is not that someone other than the individual will be required to consider the basis upon which to take an action or make a decision. The issue is whether the basis is a 'best interpretation'

approach within a ‘supported decision-making’ regime, or a ‘best interests’ approach in a ‘substitute decision-making’ regime.

The General Comment describes characteristics of supported decision-making regimes at length, particularly in paragraph 29, but does not provide clear guidance in situations of factual incapability to act or decide in the matter in question beyond that given in paragraph 21 (quoted above). A definition of substitute decision-making regimes is however offered in paragraph 27, as follows:

27. Substitute decision-making regimes can take many different forms, including plenary guardianship, judicial interdiction and partial guardianship. However, these regimes have certain common characteristics: they can be defined as systems where (i) legal capacity is removed from a person, even if this is in respect of a single decision; (ii) a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; [and/or]² (iii) any decision made by a substitute decision-maker is based on what is believed to be in the objective ‘best interests’ of the person concerned, as opposed to being based on the person’s own will and preferences.

If the conjunctive version of the definition is adopted then if, in terms of element (iii), the basis of deciding in situations of factual incapability is the ‘best interpretation’ approach rather than the ‘best interests’ approach, the regime is not a substitute decision-making regime.

If the partially disjunctive definition is adopted, then if the basis of decision-making is ‘best interests’, the regime is a substitute decision-making regime; if not, the characterisation of the regime as substitute or supported decision-making depends upon whether the other elements apply.

For purposes of this article, we proceed therefore on the basis that the true test for compatibility is not whether a decision-maker is appointed, but whether the appointed decision-maker takes their decisions on a ‘best interests’ rather than a ‘best interpretation’ basis (as these terms are used in the General Comment).

III. PART 2: THE STATUTORY PROVISIONS COMPARED

In this section, we compare and where relevant contrast the key features of the MCA and the AWI simply by reference to the statutory provisions, rather than delving into (1) *why* each regime looks the way it does (beyond a brief introductory comparison); or (2) *how the courts* have been applying the regimes in practice; or (3) *how others*

² The English-language version of the General Comment dated 19th May 2014 and issued following the 11th session of the UN Committee 31st March – 11th April 2014, and the official versions in other languages, all appear to have ‘and’ or its equivalents, so that the three elements of the definition are conjunctive. However, in at least one subsequent English-language iteration, ‘and’ has been altered to ‘or’, so that the elements are disjunctive.² More recently, it has been suggested informally to the authors that the intention of the UN Committee is that element (i) should be followed by ‘and’ and that elements (ii) and (iii) should be alternatives, with ‘or’ between them. If the intention is that all three elements are to be taken separately, then the authors’ view is that the English regime would fail, but there may be more arguments to be had as to the Scottish regime. They are not addressed in this paper.

with significant roles have been applying the regimes in practice. We do not assume any necessary familiarity with the relevant regimes.³

Both Acts are predicated upon principles, but even at this stage the drafting differences between them are substantial. They require to be understood, from each side of the geographical border between the two jurisdictions, in order to address the comparisons which form the objective of this article.

The differences in structure and content are significant from the outset, upon comparison of s 1 ('the principles') of the MCA and s 1 ('general principles and fundamental definitions') of the AWI, notwithstanding the similarities in titles. We return in Part 5 to individual observations as to whether, especially as applied in practice, the differences between the two statutes are as great as (or greater than) they are painted in this Part. They are not the result of any deliberate differentiation. We state the MCA position first, in part because it contains the phrase 'best interests' that is such a lightning rod in the context of the CRPD. We could equally have begun with AWI: indeed, AWI as enacted had already reached substantially its final form in 1995,⁴ whereas the MCA was introduced into the Westminster Parliament in 2003). The two Acts evolved from broadly parallel law reform processes, conducted with awareness of each other but not unduly influenced by the other, rendering the question 'why are they different?' irrelevant for the purposes of this paper, and probably more a matter for sociological, rather than legal or political, analysis.

A. The Structures of the Acts

The MCA is predicated upon acts being done or decisions being made on behalf of an individual⁵ lacking capacity in relation to a matter (see MCA s 1(5), s 4 and s 5). The AWI, by contrast, is predicated upon interventions in the affairs of adults (see AWI s 1), and includes provision for measures applicable in circumstances where such adults are incapable of taking an action or in relation to a material decision (see e.g. AWI s 53(1) in relation to intervention orders and AWI s 58(1)(a) in relation to guardianship orders).

In both instances, subject only to an exception in relation to the AWI discussed below, the individual in question will be factually incapable of validly acting or deciding in the relevant matter, and a person or persons other than that individual will be required to consider the basis upon which to take an action or make a decision. Both statutes therefore set down how such actions or decisions are to be taken (including, in both cases, not doing something for or on behalf of the individual).

³ A useful introduction focused primarily upon England and Wales, but also including an overview of the position in Scotland can be found in Gordon Ashton (ed), *Mental Capacity Law and Practice* (3rd edition, Jordans 2015).

⁴ See the draft Bill appended to the 1995 SLC Report referred to in Part 4 below.

⁵ The MCA applies to those aged 16 and above (with certain limited exceptions and certain limited provisions of application to those below the age of 16). The same also applies to the AWI.

B. The Principles and their Accompanying Definitions

MCA s 1 commences with three ‘screening’ principles, containing a presumption of capacity (MCA, s 1(2)), a requirement to provide all practicable assistance before a person is treated as incapable (MCA s 1(3)), and a declaration that a person must not be treated as incapable ‘merely because he makes an unwise decision’ (MCA s 1(4)).

C. AWI Contains No Equivalent ‘Screening’ Principles

MCA s 2 defines when ‘a person lacks capacity in relation to a matter’. As noted below, that definition is carried back to MCA s 1(5) (which provides the basis for determining what decisions or actions can be taken on behalf of the individual lacking capacity).

The equivalent definition in the AWI is the definition of ‘incapable’ in AWI s 1(6), which, in contrast to the MCA, is not carried back to the principles in AWI s 1(1) – (5), discussed below. The AWI principles simply apply to ‘an adult’. They can thus apply to an adult whose relevant capacity is not impaired, if something done under or in pursuance of AWI results in an intervention in the affairs of that adult. Ward developed this point further in his article ‘Two ‘adults’ in one incapacity case? – thoughts for Scotland from an English deprivation of liberty decision’,⁶ when he hypothesised what might have been the treatment under the AWI if the facts addressed in *A Local Authority v WMA and MA*⁷ had arisen before a Scottish court.

As regards the basis for acting or deciding on behalf of a person lacking the material decision-making capacity, the MCA then states, and in this regard is predicated upon, two overarching principles:

- a. An action done or a decision made under the act for or on behalf of a person who lacks capacity must be done, or made, in his best interests (MCA s 1(5));
- b. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action (MCA s 1(6)). It should perhaps be noted that that requires consideration of whether there is a need for any action or decision at all.

Two characteristics of the above are notable. Firstly, the two principles quoted immediately above apply only to ‘a person who lacks capacity’. Secondly, MCA s 1(5) places major focus upon the concept of ‘best interests’. MCA s 1(5) is fleshed out by MCA s 4, which identifies the steps to be taken in determining what is in the best interests of the person. The extent to which there is a hierarchy in MCA s 4 as regards these steps is discussed in some detail in Part 3.

The Scottish principles, which stand in place of MCA s 1(5), as fleshed out by MCA s 4, and MCA s 1(6), are as follows:

⁶ [2013] SLT (News) 239-242

⁷ [2013] EWHC 2580 (COP)

1. –

- (1) The principles set out in subs (2) and (4) shall be given effect to in relation to any intervention in the affairs of an adult under or in pursuance of this Act, including any order made in or for the purpose of any proceedings under this Act for or in connection with an adult.
- (2) There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.
- (3) Where it is determined that an intervention as mentioned in subs (1) is to be made, such intervention shall be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention.
- (4) In determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of –
 - (a) the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult;
 - (b) the views of the nearest relative, named person and the primary carer of the adult, in so far as it is reasonable and practicable to do so;
 - (c) the views of –
 - (i) any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention; and
 - (ii) any person whom the sheriff has directed to be consulted, in so far as it is reasonable and practicable to do so; and
 - (d) the views of any other person appearing to the person responsible for authorising or effecting the intervention to have an interest in the welfare of the adult or in the proposed intervention, where these views have been made known to the person responsible, in so far as it is reasonable and practicable to do so.
- (5) Any guardian, continuing attorney, welfare attorney or manager of an establishment exercising functions under this Act or under any order of the sheriff in relation to an adult shall, in so far as it is reasonable and practicable to do so, encourage the adult to exercise whatever skills he has concerning his property, financial affairs or personal welfare, as the case may be, and to develop new such skills.

AWI s 1(3) is broadly equivalent to MCA s 1(6). There are echoes of some of the other AWI principles in the supplementary provisions of MCA s 4. However, a ‘best interests’ test was explicitly rejected for the purposes of the AWI. Instead of focusing the basis for acting and deciding on behalf of a person/adult upon the single concept of ‘best interests’, the AWI provides a set of general principles none of which is stated to take precedence or priority over any other: see the relevant passage from Scottish Law Commission Report No 151 on *Incapable Adults* quoted below. Thus, where the MCA has MCA s 1(5) – the ‘best interests’ test – and subsidiary principles in MCA s 4 relevant to determining what is in a person’s best interests, the AWI has AWI s 1(1), (2), (4) and (5), none of them occupying a dominant position (except as noted below), with AWI s 1(3) ranking equally with them. The AWI accordingly has no principles serving the subsidiary purpose of guiding how to determine the application of any one dominant principle, except to the limited extent noted in the next paragraph.

AWI s 3(5A) was added to the AWI by the Adult Support and Protection (Scotland) Act 2007 (ASP). It provides a principle which is subsidiary to AWI s 1(4)(a), for the purpose of assisting the ascertainment of the adult’s wishes and feelings for the purpose of sheriff court proceedings, by requiring the sheriff to take account of them as expressed by an independent advocate (as defined).

There is an inequality among the various principles in AWI s 1(4) to the extent that the obligation to take account of the adult's wishes and feelings, if ascertainable, is absolute. That is emphasised by the inclusion of 'by any means of communication' and by the exclusion of the qualification, which appears in the other paragraphs of AWI s 1(4): 'insofar as it is reasonable and practicable to do so'.

It should be reiterated that the principles set out in AWI s 1(1) – (5) can, in principle, apply equally to an adult whose relevant capacity is not impaired, if something done under or in pursuance of the AWI results in an intervention in the affairs of that adult. To that extent they could be said to be non-discriminatory on grounds of disability.

D. The Judiciaries

It is relevant to the following discussion that since the inception of the MCA England & Wales have had the advantage of a specialist court, the Court of Protection, exercising jurisdiction under the MCA. In Scotland, the 1995 SLC Report on *Incapable Adults* No 151 recommended that jurisdiction under what became the AWI be entrusted to specialist sheriffs, and provisions to that effect were included in the draft Bill annexed to the Report, but that recommendation was not implemented, and still has not yet been implemented.⁸

E. Vulnerable Adults

We note in passing that another significant difference between England & Wales, and Scotland, is that in England & Wales any necessary protection of adults who are vulnerable⁹ and at risk, but not necessarily incapable, is dealt with by the High Court under the inherent jurisdiction; whereas in Scotland such situations are addressed under the statutory provisions of the ASP. The remedies available under the ASP are prescribed in that Act, and appear to be more restricted than those under the inherent jurisdiction.

IV. THE MCA¹⁰

A. Background

The MCA was the result of many years of dedicated reform effort, commencing with a Law Commission Consultation Paper in 1991. While the need to have a

⁸ Under the provisions of the Courts Reform (Scotland) Act 2014 the Lord President (the head of the judiciary in Scotland) may designate specialist categories of sheriff to whom sheriffs principal would allocate specific sheriffs; and procedure to create all-Scotland specialisms to which all-Scotland sheriffs would be appointed. At time of writing any decision to implement these provisions in relation to the AWI jurisdiction awaits appointment of a new Lord President, following the retirement of Lord Gill (the principal architect of these and other reforms).

⁹ This term is not now used in relation to safeguarding in England following the passage of the Care Act 2014, but retains meaning, not least in relation to the exercise by the High Court of its inherent jurisdiction: see *L (Vulnerable Adults with Capacity: Court's Jurisdiction), In re (No 2)* [2012] EWCA Civ 253; [2013] Fam 1.

¹⁰ This section draws (with permission) upon an article written by Ruck Keene and Cressida Auckland entitled 'More presumptions please: wishes, feelings and best interests decision-making' [2015] *Elder Law Journal* 231.

mechanism in place to make decisions on behalf of those lacking the cognitive capabilities to do so was not seriously under debate, the basis on which such decisions were to be made was less clear. Drawing on the frameworks in place in other jurisdictions and under the pre-existing common law, two alternative mechanisms were suggested to facilitate the making of these decisions. Substituted judgment, which attempted to reach the decision which the person would themselves have made if they had capacity, was contrasted with an approach predicated upon an objective assessment of what was in the person's 'best interests'. While the 'best interests' assessment had dominated healthcare decisions since the decision of *Re F (An Adult: Sterilisation)*,¹¹ it may be noted that in at least one domain – statutory wills – the status quo prior to the MCA was one of substituted judgment, whereby the judge was required to consider the 'antipathies' and 'affections' of the particular person concerned.¹²

After much consultation, it was the objective mechanism that found favour with the Law Commission, who highlighted the difficulties posed by substituted judgment when making decisions for those who have never had capacity,¹³ as well as the effect it had of giving a lower priority to the person's present emotions than those anticipated in the person had they had unimpaired capacities.¹⁴ The Law Commission did, however, consider that 'the two tests need not be mutually exclusive', instead pushing for a compromise 'whereby a best interests test is modified by a requirement that the substitute decision-maker first goes through an exercise in substituted judgment'.¹⁵

The result of this long drafting process was (for these purposes) ss 1(5) and 4 MCA 2005 which provide – in combination – the requirement that decisions should be made in the person's 'best interests', taking into account a number of relevant factors. Crucially, under s 4(6), the decision-maker must, 'so far as is reasonably ascertainable', consider:

- (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by her when she had capacity),
- (b) the beliefs and values that would be likely to influence her decision if she had capacity, and
- (c) the other factors that she would be likely to consider if she were able to do so.

However, s 4(6) is only one of the list of factors in the 'checklist'. In addition, the decision cannot be made merely on the basis of the age or appearance of the person lacking capacity;¹⁶ the likelihood of the person regaining capacity must be considered;¹⁷ and the individual must, as far as is reasonably practicable, be permitted and encouraged to participate in the decision.¹⁸ The decision-maker must never be motivated by a desire to bring about death,¹⁹ and must take account 'if it is

¹¹ [1990] 2 AC 1

¹² *Re D(J)* [1982] Ch 237

¹³ Law Commission, *Mental Incapacity* (Law Com No 231,1995) para 3. 25

¹⁴ *Ibid.*, 3.29

¹⁵ Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* (Law Com No 128,1993) para 2.4

¹⁶ Mental Capacity Act 2005, s 4(2)

¹⁷ *Ibid* s 4(3)

¹⁸ *Ibid* s 4(4)

¹⁹ *Ibid* s 4(5)

practicable and appropriate to consult them', of the views of others engaged in the care of the person, or interested in their welfare.²⁰

On the face of the statute, no one of these factors is to take priority. Indeed, the Report of the Joint Committee on the *Draft Mental Incapacity Bill*²¹ was clear that this was deliberate: determining the best interests of the individual 'required flexibility' and was said to be best achieved by 'enabling the decision-maker to take account of a variety of circumstances, views and attitudes which may have a bearing on the decision in question.' It was for this reason that they did not recommend any weighting or giving priority to the factors involved in determining best interests. In a similar vein, as the Government identified, there was a deliberate policy decision that 'a prioritisation of the factors would unnecessarily fetter their operation in the many and varied circumstances in which they might fall to be applied'.²²

This approach was carried through into the Code of Practice accompanying the MCA. While the individual's wishes and feelings, beliefs and values 'should be taken fully into account', they will 'not necessarily be the deciding factor'.²³

B. The MCA in Practice

Given the decision not to prioritise any of the factors in s 4, it is of little surprise that the case law on the relative weight that should be ascribed to a person's wishes and feelings superficially lacks coherence.

It is possible to suggest, however, that a dialogue can be seen emerging in the case-law between two lines of thought: on the one hand that a rebuttable presumption exists in favour of giving effect to a person's wishes and feelings; and on the other that the individual's wishes and feelings represent just one factor in the balance sheet which should not receive special consideration.

This dialogue found its roots in *Re S and S (Protected Persons)*²⁴ where talk of 'presumptions' first emerged. HHJ Marshall QC forcefully remarked:

... where P can and does express a wish or view which is not irrational (in the sense of being a wish which a person with full capacity might reasonably have), is not impracticable as far as its physical implementation is concerned, and is not irresponsible having regard to the extent of P's resources (ie whether a responsible person of full capacity who had such resources might reasonably consider it worth using the necessary resources to implement his wish) then that situation carries great weight, and effectively gives rise to a presumption in favour of implementing those wishes, unless there is some potential sufficiently detrimental effect for P of doing so which outweighs this.²⁵

It would, in HHJ Marshall's view, take significant detriment to P to be sufficient to outweigh the 'sense of impotence' and 'frustration' of having one's wishes

²⁰ Ibid s 4(7)

²¹ (HL 2002-03, 189-I, HC 1083-I)

²² *Government Response to the Scrutiny Committee's Report on the Draft Mental Incapacity Bill* (CMD 6121, February 2004)

²³ Para 5.38

²⁴ *C v V* [2009] WTLR 315, [2008] COPLR Con Vol 1074

²⁵ Ibid [57]

overruled.²⁶

What, after all, is the point of taking great trouble to ascertain or deduce P's views, and to encourage P to be involved in the decision making process, unless the objective is to try to achieve the outcome which P wants or prefers, even if he does not have the capacity to achieve it for himself?²⁷

The approach espoused by HHJ Marshall was, however, short-lived. No sooner had the judgment been handed down in *Re S and S*, than Lewison J responded in *Re P*²⁸ that HHJ Marshall 'may have slightly overstated the importance to be given to P's wishes'.²⁹ Lewison's approach found favour with Munby J in *Re M*,³⁰ the latter specifically endorsing the 'compelling force' of the judgment. Relying on the drafting of the Act, Munby J was clear that: '[t]he statute lays down no hierarchy as between the various factors which have to be borne in mind',³¹ and while 'P's wishes and feelings will always be a significant factor to which the court must pay close regard', 'the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific'.³² Munby J indicated that the important considerations in determining the weight to be ascribed to the wishes and feelings of the individual were:

- a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings...
- b) the strength and consistency of the views being expressed by P;
- c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to;
- d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and
- e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests.³³

The case-law that follows could largely be characterised as a dialogue between these two competing views,³⁴ but against this backdrop, the MCA first came before the Supreme Court in *Aintree University Hospital NHS Foundation Trust v James*,³⁵ in which Lady Hale emphasised that the purpose of the best interests test was, in the view of Lady Hale, 'to consider matters from the patient's point of view':

Insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.³⁶

In placing the emphasis on the patient's *own* views, and by stressing the importance of considering decisions from the perspective of the individual concerned, the Supreme Court confirmed the place of the individual at the centre of the assessment,

²⁶ Ibid [58]

²⁷ Ibid [55]

²⁸ [2009] EWHC 163 (Ch), [2009] COPLR Con Vol 906

²⁹ Ibid [41]

³⁰ *Re M (Statutory Will)* [2011] 1 WLR 344; *ITW v Z and others* [2009] EWHC 2525 (Fam)

³¹ Ibid [32]

³² Ibid

³³ Ibid [35]

³⁴ Discussed at greater length in the article cited above n 7.

³⁵ [2013] 3 WLR 1299, [2013] COPLR 492

³⁶ Ibid [45]

recognising the subjectivity that any assessment of an individual's best interests must inevitably entail. It is perhaps not entirely surprising that the sole judgment was given by Lady Hale, who (in a previous existence as Brenda Hoggett) had played a key role in the Law Commission's work identified above, in which a compromise had been attempted between substituted judgment and objective best interests assessment.

Case law decided subsequent to the decision in *Aintree* has (with some exceptions³⁷) increasingly followed a model of placing greater emphasis upon identifying the wishes and feelings of the individuals concerned (in particular those wishes identified prior to the loss of capacity). Further, these wishes are taking on a much higher priority in the assessment of 'best interests'; and clear and convincing justification is required before they are departed from.

Nowhere is this perhaps more evident than the decision of Peter Jackson J in *Wye Valley NHS Trust v B*,³⁸ concerned with medical treatment urgently required to save the life of an elderly man with long-standing mental health difficulties who was said not to have the capacity to consent to or refuse the treatment but was profoundly opposed to the proposed procedure. The treating Trust submitted that the views expressed by a person lacking capacity were in principle entitled to less weight than those of a person with capacity. Peter Jackson J accepted that this was true 'only to the limited extent that the views of a capacitous person are by definition decisive in relation to any treatment that is being offered to him so that the question of best interests does not arise.'³⁹

Importantly, however, he went on:

once incapacity is established so that a best interests decision must be made, there is no theoretical limit to the weight or lack of weight that should be given to the person's wishes and feelings, beliefs and values. In some cases, the conclusion will be that little weight or no weight can be given; in others, very significant weight will be due.⁴⁰

Rightly, Peter Jackson J emphasised:

...[t]his is not an academic issue, but a necessary protection for the rights of people with disabilities. As the [MCA] and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an 'off-switch' for his rights and freedoms. To state the obvious, the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important. It would therefore be wrong in principle to apply any automatic discount to their point of view.⁴¹

Not least because he made a determined effort to understand Mr B's perspective – including by spending time with him at his hospital bed-side – Peter Jackson J found himself able to hold that he was quite sure that it was not in Mr B's best interests to

³⁷ The most glaring being that of the Court of Appeal in *RB v Brighton and Hove City Council* [2014] EWCA Civ 561, [2014] COPLR 629, a decision under appeal to the European Court of Human Rights at the time of writing.

³⁸ [2015] EWCOP 60, [2015] COPLR 843

³⁹ *Ibid* [10]

⁴⁰ *Ibid* [10]

⁴¹ *Ibid* [11]

...take away his little remaining independence and dignity in order to replace it with a future for which he understandably has no appetite and which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure. There is a difference between fighting on someone's behalf and just fighting them. Enforcing treatment in this case would surely be the latter.⁴²

V. THE AWI

A. Background

The direction of development of Scots law over the two decades preceding enactment of AWI was significantly towards what in the language of the General Comment would be characterised as a regime of best interpretation of will and preferences, rejecting a best interests approach. Disappointingly, since then that trend has halted, and to an extent has been reversed.

In personal welfare matters Scotland had, from 1913 to 1984, enshrined in statute precisely the form of guardianship which is described in paragraph 27 of the General Comment as a 'substitute decision-making regime', and which – according to paragraph 7 of the General Comment - should be abolished. That form of guardianship was introduced by the Mental Deficiency and Lunacy (Scotland) Act 1913 and continued in subsequent legislation. Guardians had the same powers as parents of a young child, regardless of the actual capabilities of each adult to whom such guardians were appointed. The route towards the AWI could be seen as starting with the progressive realisation of the inappropriateness of subjecting adults to such guardianship, so that the numbers in such guardianship dwindled from 2,440 in 1960 to around 300 by 1982, the year in which the Scottish Home and Health Department and the Scottish Education Department, Social Work Services Group, issued its *Review of the Mental Health (Scotland) Act 1960*, proposing radical reform. Three decades before the General Comment, Scotland implemented that key recommendation by abolishing such guardianship.⁴³ Abolition inevitably created a vacuum in safeguarding and promoting the rights of persons/adults. That vacuum was filled principally by re-introduction, in modernised form, by courts operating in the civil law tradition, of the former Roman law concept of appointment of tutors-dative to adults, the first such case being *Morris, Petitioner*,⁴⁴ which Ward described in *Revival of Tutors-Dative*.⁴⁵ Modernisation from and including *Morris* took the form of limited powers tailored to need, an emphasis upon provision of support, and time-limiting to ensure review. Subsequent developments included, in appropriate cases, provisions anticipatory of what is now termed supported decision-making such as cases where, in particular matters, tutors were authorised to identify and present viable alternatives from which the adult could make a choice.

If the views of the UN Committee are applied retrospectively to the revival and development of tutors-dative in Scots law over the period from *Morris* in 1986 to Part 6 of AWI coming into force in 2002, it is reasonable to characterise the tutory regime

⁴² Ibid [45]

⁴³ In terms of the Mental Health (Scotland) (Amendment) Act 1983 as consolidated into the Mental Health (Scotland) Act 1984.

⁴⁴ Unreported, 1986

⁴⁵ [1987] SLT (News) 69

as being at least well on the road towards a supported decision-making regime based on best interpretation. This is rather than a substitute decision-making regime based on best interests. It also demonstrates a trend towards the former in contrast to the trend towards the latter in decisions under AWI as identified below.

In the area of property and affairs, however, Scots law remained substantially unreformed. The standard technique for managing the property and affairs of adults deemed to be incapable was appointment of curators bonis: a regime which, until it was abolished with effect from 1st April 2002 by implementation of relevant provisions of the AWI, graphically demonstrated the injustices resulting from the lack of safeguards such as those required under Article 12.4 of CRPD. This was a regime undoubtedly within the definition of unacceptable substitute decision-making as described in the General Comment, already perceived as ripe for abolition long before CRPD. Unacceptable aspects of that regime, and their consequences, were described at some length in *The Power to Act* (SSMH).⁴⁶ Some inroads were made by the reintroduction of the former Roman law tutor-at-law, the first such case being *Britton v Britton's Curator Bonis*.⁴⁷ As operated in practice, these appointments addressed the lack of respect for the will and preference of persons/adults in the otherwise unreformed area of property and financial decision-making.

In parallel with the Roman law-based developments described above, the Scottish Law Commission commenced the work leading ultimately to the AWI. In September 1991 the Commission produced Discussion Paper No 94 *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* ('the SLC Discussion Paper'). Following wide-ranging consultation and discussion, in September 1995 the Commission published its *Report on Incapable Adults* (Report No 151 – 'the SLC Report'). Government published its own Consultation Paper *Managing the Finances and Welfare of Incapable Adults* in February 1997. There was however increasing anxiety that the pace of deliberation did not match the urgency of the need for law reform. Following sustained campaigning, and steps towards devolution, the Scottish Executive published its proposals in *Making the Right Moves: Rights and Protection for Adults with Incapacity* (August 1999). The AWI followed as 'the first large Bill on a major policy area to be passed by the Scottish Parliament'.⁴⁸

B. The SLC Discussion Paper (1991)

From the outset of the reform process, the purposes of any intervention were made clear. As paragraph 1.7 of the Discussion Paper made clear:

There is also a greater awareness of the rights of the mentally disabled. The philosophy that lies behind the new approach is one of minimum intervention in the lives of the mentally disabled consistent with providing proper care and protection and maximum help to enable individuals to realise their full potential and make the best use of the abilities they have.

The inherent tensions between autonomy and protection, again, were clearly understood from the outset and described in paragraph 1.8.

⁴⁶ Ward, *The Power to Act* (SSMH, 1990)

⁴⁷ 1992 SCLR 947

⁴⁸ Mr Iain Gray, Deputy Minister for Community Care, speaking in the Scottish Parliament on 29th March 2000

There is an inherent conflict or tension between the principles of maximum freedom for mentally disabled people and their protection. Giving mentally disabled people exactly the same rights as mentally normal people would often result in the disabled harming themselves and others and becoming victims of exploitation and abuse. Protection from these consequences necessarily involves some curtailment of the rights that normal people enjoy. Indeed a certain level of protection may enhance the ability of the mentally disabled to enjoy their other rights to a greater extent.

By contrast, as to the core question addressed in this paper, the process of consultation and consideration produced a significant shift. Paragraphs 2.86 and 4.75 of the Discussion Paper, dealing respectively with personal welfare and financial matters, both included the following (close in its intention to the MCA position described in paragraph above):

We tend to favour continuation of the 'best interests' rule coupled with requiring the guardian to consult with and have regard to the wishes of the mentally disabled person, family and carers. The previously expressed views of the disabled person could and should be taken into account but should not override the judgment of the guardian as to the current best interests of the incapacitated person.

C. Evolution of Principles and Terminology, Rejection of 'Best Interests'

Prior to instructing the first draft Bill, the SLC team had however already decided to recommend rejection of the 'best interests' test. That rejection was subsequently expressed in the SLC Report as follows:

Our general principles do not rely on the concept of best interests of the incapable adult. ... We consider that 'best interests' by itself is too vague and would require to be supplemented by further factors which have to be taken into account. We also consider that 'best interests' does not give due weight to the views of the adult, particularly to wishes and feelings which he or she had expressed while capable of doing so. The concept of best interests was developed in the context of child law where a child's level of understanding may not be high and will usually have been lower in the past. Incapable adults such as those who are mentally ill, head injured or suffering from dementia at the time when a decision has to be made in connection with them, will have possessed full mental powers before their present incapacity. We think it is wrong to equate such adults with children and for that reason would avoid extending child law concepts to them. Accordingly, the general principles we set out below are framed without express reference to best interests.⁴⁹

In the passage from the SLC Discussion Paper quoted above, the reference to 'best interests' was coupled with references to the wishes of the adult and others, including previously expressed views of the adult. It is accordingly relevant to balance the ensuing rejection of a 'best interests' criterion with the development of the status accorded to the views and wishes of the adult. In the first draft Bill instructed by SLC, reference to the wishes and feelings of the adult was subsidiary to the principles of minimum necessary intervention and the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention, which was set out in s 1(3). Section 1(4) required that in determining what intervention satisfied the requirements of s 1(3), account should be taken, so far as was reasonably practicable, of 'the wishes and feelings of the mentally disordered adult, in particular any written directions given by him while he was mentally

⁴⁹ Scottish Law Commission, *Report on Incapable Adults*, (Scot Law Com No 151, 1995) para 2.50

capable'. In the draft Bill annexed to the SLC Report, the principles were stated as in the AWI, as quoted in paragraph 24 above. Section 1(4)(a) is not subsidiary to any other principle. It directs that account shall be taken of the present and past wishes and feelings of the adult, if ascertainable by any means.

The term 'paradigm shift' was not used in relation to either the eventual proposals in the SLC Report or the AWI itself. The concept of a shift from 'old law' to 'new law'⁵⁰ was however well understood. Further, following passage of the AWI Ward suggested the term 'constructing decisions' for the processes of decision-making required by the AWI. This is a process requiring respect for the competent decisions of every adult, regardless of disability, and a process of what the General Comment terms 'best interpretation' to the extent that the adult is unable to make, or to communicate with any amount of assistance, competent decisions. Ward described the resulting processes fully in Chapter 15.⁵¹

While that could be claimed to be a description of a 'supported decision-making regime', incorporating – in relation to factual incapacity – a 'best interpretation' approach rather than a 'best interests' approach, questions remain as to whether the AWI is sufficiently robust in *requiring* such an approach and in excluding what may amount in fact (and regardless of terminology) to a paternalistic 'best interests' approach; and whether that outcome is consistently achieved in practice. Those questions lead us to the next section of this Part 4.

D. The AWI: Case Law Evolution

Perhaps due to the lack of a specialised judiciary, coupled with the smaller volume of cases generated by a smaller population, it is not possible to identify from a review of Scottish case law such differing lines of thought as were identified in Part 3. There have been significant lines of development, through several individual cases, in matters such as use of the AWI to authorise Will-making and similar (in the absence of any 'statutory Will' provisions in Scots law), but there have been no equivalent progressive and differing lines of development in relation to whether (for example) the benefit principle equates to a best interests test, or the relative weight to be given to the benefit principle when balanced against the others, particularly the past and present wishes and feelings of the adult. That is not to say, however, that there have not been significant decisions in these matters. However, it is surprisingly rare for decisions under the AWI to refer to many (or indeed any) precedents under the AWI regime. Where short lines of authority have been developed, contradictory views tend to be formed extraneously – in one case, in the pronouncements of Scottish Government, and in relation to another, a clear but uncited decision of the Supreme Court in an English case.

For the above reasons, the structure of this Scottish section differs from the equivalent section for England & Wales above. All relevant available decisions under AWI are listed in the Appendix to this paper, and are referred to – where not more

⁵⁰ Described by Ward in *Adults with Incapacity Legislation* (W Green 2008) 3

⁵¹ 'Constructing Decisions' in *Adult Incapacity* (W Green 2003)

fully – simply by the numbering in the Appendix.⁵² A further feature has shaped this section. Because Scottish guardianship law evolved from the re-introduction and development of tutory described above, some of the experience under that regime remains relevant.

One startling result of analysis of the cases in the Appendix is that, despite the explicit rejection of a best interests test for the purposes of the AWI as narrated above, the frequency with which sheriffs have at least in part chosen to base their decisions on what they considered to be in the relevant adult's best interests. This occurred in cases 10, 13, 21, 22 and 25, that is to say 5 or 18.5% of the cases in the Appendix. It is necessary, however, to look more closely at this finding.

Until his retirement in early 2015, Sheriff John Baird was for all practical purposes a specialist sheriff, being lead sheriff for AWI cases in Glasgow Sheriff Court. In the course of his career he dealt with well over 3,000 AWI cases. Twelve (44%) of the decisions in the Appendix are his, being cases 3, 4, 5, 7, 8, 9, 11, 17, 19, 20, 23 and 24. In all of these he referred to the benefit principle. None of his decisions is based on any 'best interests' concept. Indeed, in case 24⁵³ he considered a Minute lodged by a consultant geriatrician in charge of a long stay patient in an acute NHS hospital, seeking directions to be given to the appointed guardian. The adult's daughter was her guardian and had for some time refused to exercise her powers enabling her to make arrangements for the adult's long term care, despite being advised that the adult could not return home. The applicant considered that the adult required continuing medical care which could be provided most suitably in a facility such as a care home and asked the court whether in order to secure the adult's welfare and best interests it was necessary for her to reside in a facility providing NHS continuing care, and if so, that the court make an order directing the guardian to consent to the adult residing at the care home and to direct her to convey or make arrangements for the adult's conveyance thereto. The specific question before the court was: 'In order to secure the Adult's welfare and best interests is it necessary for her to reside in a facility which provides NHS continuing care?' Sheriff Baird pointed out that 'benefit', not 'best interests', was the relevant test, but use of the latter term points to a disappointing level of knowledge of the AWI principles even among professionals likely to be much engaged with aspects of the AWI regime. Sheriff Baird in fact referred to 'benefit' rather than 'best interests' in all of the decisions listed.

If Sheriff Baird's decisions are set aside, and also setting aside case 1 in view of the careful and limited use of 'best interests' by Sheriff Ireland in that case (see below), the remaining decisions are those of a total of ten different sheriffs (or sheriffs principal), of whom five – or one half – have founded upon 'best interests' in at least one of their decisions.

We are left with the difficulty of what the sheriffs who have used the term 'best

⁵² Ward thanks his colleague on the core research group of the Three Jurisdictions Project, Rebecca McGregor, for compiling this list and highlighting relevant key features in each case. Rebecca is a research assistant in the Centre for Mental Health and Incapacity Law, Rights and Policy at Edinburgh Napier University.

⁵³ *B, Minuter* 2014 SLT (Sh Ct) 5

interests' in their decisions actually meant by it. Case 3⁵⁴ and case 10⁵⁵ both address the question of whether a guardianship order was appropriate in relation to decisions to change the place of residence of an adult who (in each case) was compliant but had been assessed as not capable of making a valid decision in the matter. Sheriff McDonald at Kilmarnock in case 10 stated that she was following the views of Sheriff Baird at Glasgow in case 3. Both referred to the full range of relevant principles, Sheriff Baird without mention of 'best interests', but Sheriff McDonald's judgment included:

This relates to the question as to whether or not intervention is in the best interests of the adult.

It is my view that the best interests of the adult would be served by allowing her sons to take decisions for her. Section 1(4)(a) of the Adults with Incapacity (Scotland) Act 2000 indicates that the present and past wishes and feelings of the adult, so far as they can be ascertained, must be taken into account. I heard evidence from the adult's two sons that it was their mother's wishes that they should deal with all of her affairs. This was not disputed by the respondent. Further, in terms of s 1(4)(b), the views of the nearest relative must also be taken account of and, again, the adult's two sons indicated that they wished to be appointed welfare guardians. These sections are not mutually exclusive, but should be read in conjunction with each other.

The decisions in cases 3 and 10 produced disagreement not by other judges, but Scottish Government in *Guidance for Local Authorities (March 2007) Provision of Community Care Services to Adults with Incapacity*, referring to *Muldoon*, stated that: 'The Scottish Executive does not agree with this interpretation of the ECtHR cases'. This however was not a matter of the relative weight to be attributed to different principles. In general terms, the frequent use of the words 'best interests' above appears to point to the thinking of a generalist judiciary, well-schooled in child law, where the best interests of the child are a paramount consideration, and still guided by that thinking – as well as that language – in the very different situation of adults for whom the best interests text was rejected for purposes of the AWI jurisdiction.

In the context of any attempt to ensure compliance with CRPD, case 3 (*Muldoon*) bears further consideration. Sheriff Baird held that in every case where a court is dealing with the question of determining the residence of an adult who is incapable but compliant, 'the least restrictive option will be the granting of a guardianship order under the Act (assuming of course that all the other statutory requirements are satisfied), for that way only will the necessary safeguards and statutory and regulatory framework to protect the adult (and the guardian), come into play.' Sheriff Baird's conclusion that imposing a decision as to place of residence upon a compliant but incapable adult was a breach of Article 5 of ECHR resonates to an extent with the subsequent decision of the Supreme Court in *P v Cheshire West*.⁵⁶ But if a 'constructing decisions' (or best interpretation) approach had been applied to the facts, that might perhaps have warranted the very different conclusion that the adult's contentment with her placement was sufficient to authorise it, and that her desire not to have a guardian should be respected, as there was no contravention of her rights sufficient to overrule in that regard her identified will and preferences.

⁵⁴ *Muldoon, Applicant* 2005 SLT (Sh Ct) 52

⁵⁵ *M, Applicant* 2009 SLT (Sh Ct) 185

⁵⁶ [2014] UKSC 19

As to the contrast between a supported decision-making approach based on best interpretation, or a substitute decision-making approach based on best interests, among the cases listed in the Appendix, this is most clearly found upon consideration of the first and last, being case 1⁵⁷ and case 27.⁵⁸ While the decision of Sheriff Seith Ireland in case 1 (*JM*) uses the term 'best interests', he does so only to the extent of equating 'benefit' with 'best interests', then in effect (in that case) giving priority to 'the views of the adult'. Sheriff Principal Stephen in case 27 (*G*) does not use the words 'best interests', but more significantly she appears to equate the benefit test with a best interests approach and – significantly – to treat it as overriding other considerations. Both cases were contests between a relative of the adult and the local authority chief social work officer for appointment as guardian.

In case 1 (*JM*) the 'constructing decisions' methodology proposed in Chapter 15 of *Adult Incapacity* was adopted in the successful arguments for the respondent, Mrs M. Her husband Mr M had been seriously injured in an accident in 1987. After 15 years in hospital, authorities decided that it was appropriate to discharge him on the basis that he no longer needed full-time medical or nursing care. He and Mrs M were happily married. They shared the same outlook and values. Mrs M was initially resistant to discharge because she feared that Mr M would not receive the care which his difficult needs required. However, a placement which appeared to be suitable had been identified, the drawback being that it offered short-term rather than long-term care, so that further decisions about suitable placement were likely to be required within two years. The central question was whether the court should simply make its own objective decision as to what seemed to be in Mr M's best interests, or whether – having found that either contender would be suitable for appointment – the sheriff should arrive at a decision taking into account Mr M's known views which he had been able to express before his accident, the marriage which he and his wife had entered and sustained, and the values which they shared. Sheriff Ireland's judgment included the following passage:

However, coming to a concluding answer to that question has been neither straightforward nor easy for the court. This has required anxious consideration of the general principles set out in section 1 of the Act and the duties placed on the court in appointing a guardian in terms of section 59 of the Act.

...the legislative purpose of the Adults with Incapacity Act goes beyond, in my view, the test of what is in the best interest of the adult. That may be a necessary starting-point - and the test the court has to make of welfare guardian in terms of section 59 has, by implication, the requirements of a 'best interests' approach. However, most importantly, section 59 has to be read against section 1(2) of the Act. In summary, this provides that there should be no intervention in the affairs of an adult unless the person responsible for authorising the intervention (in this case the court), is satisfied that the intervention will benefit the adult. This, in my view, means the court which authorises the intervention, in this case the appointment of a welfare guardian, has to have the best interests of the adult in mind, equiperating 'benefits' with 'best interests' which I hold as a reasonable construction.

Yet the legislative intention of the Scottish Parliament can be found to have gone beyond 'best interests' by an examination of section 1(4), especially paragraphs (a), (b) and (d) which I have quoted above.

⁵⁷ *North Ayrshire Council v JM* 2004 SCLR 956

⁵⁸ *G v West Lothian Council* 2014 WL 6862565

I construe these provisions as requiring the court to have regard to the views of the adult (JM) as expressed prior to his incapacity, and as far as is ascertainable, at present, as may be evidenced by the views of the nearest relative (PM) and his daughter (FM).

This can clearly be categorised as a decision based upon a supported decision-making approach, applying a best interpretation of Mr M's will and preferences.

By contrast, in deciding case 27 (G), which was an appeal from the decision of Sheriff Susan A Craig in case 25, Sheriff Principal Mhairi Stephen said:

This is indeed the core principle namely that it is the welfare of the adult and the benefit to the adult which is the overarching principle. The court then has to consider the least restrictive option and take into account the present and past wishes and feelings of the adult and the views of the nearest relative and the primary carer of the adult in so far as it is reasonable and practicable to do so. The sheriff also requires to take into account the views of any other person who appears to the sheriff to have an interest in the welfare of the adult.

It must be a cause for concern that the journey in time from the first case considered (case 1, reported in 2004) to the last (case 27, decided a decade later) has been a journey away from a 'constructing decisions' approach, giving primacy to the 'will and preferences' of the adult or their best interpretation, towards a 'best interests' approach in the sense used, and criticised, by the UN Committee.

VI. OBSERVATIONS

If the MCA and the AWI as enacted are considered and compared in the retrospective light of CRPD and the views of the UN Committee, they might be seen simplistically as representing the two contrasting models of substitute decision-making based on best interests (the MCA) and supported decision-making based on best interpretation (the AWI). In the case of the AWI, the contrast might seem to be emphasised by consideration of the development of re-introduced tutors to adults in the period 1986 – 1992, and how that experience was carried forward into the AWI, and into early anticipations as to how the AWI should be operated.

Looked at more carefully, however, both Acts ultimately require a structured consideration of a series of questions and analysis of a set of factors relating to the individual in question, against an overarching set of principles. Further, and by reference to the requirement in Article 12(4) CRPD for 'measures relating to the exercise of legal capacity [to] respect the rights, will and preferences of the person,' we would suggest that neither can – at present – properly be said to do so, because on their face neither Act:

1. Expressly places an obligation upon anyone to take steps to identify the wishes and feelings (to the extent that this can be said to be synonymous with the will and preferences) of the individual;
2. Expressly provides that (or how) the wishes and feelings have priority. The 'constructed decision-making' hierarchy identified above in relation to Scotland is not expressly provided for in s.1(4) AWI: for instance by the use of 'particular regard' or some equivalent term in relation to s.1(4)(a)). The MCA provides that consideration must be given to the person's past and present wishes and feelings 'and in particular' any relevant written statement made by him when he had capacity but that could narrowly be read solely as requiring particular regard in the context of consideration of wishes and feelings, as opposed to

requiring particular regard to be given to such written statements in the overall consideration of best interests;

3. Expressly provides how 'respect' for ascertainable wishes and feelings is to be secured, for instance by requiring reasons to be given for departure from them.

It is further important to understand how both Acts have been applied in practice. We have sought to identify above how (on the one hand) the evolution of the case-law in England & Wales could be seen as exemplifying a trend towards paying greater heed to the individual's wishes and feelings (and, perhaps, suggesting what 'respect' might look like in practice), while (on the other) judicial decisions in Scotland have disappointingly trended, particularly in the last decade, towards what seems in practice to bring a more paternalistic 'best interests' approach – even using that rejected terminology – and away from greater respect for the individual's will and preferences, and past and present wishes and feelings.

For these reasons, both stemming from the language of the Acts and from the way that language has been interpreted in practice, we conclude that compliance with CRPD would undoubtedly require amendment of both Acts. In particular, and as a minimum, s 4 of MCA and s 1 of AWI would require to be re-cast.

VII. APPENDIX

Scottish Cases

In the foregoing paper, these cases are in places referred to only by the numbers allocated below. Note that case 25 was appealed, and case 27 is the appeal decision.

1. *North Ayrshire Council v JM* – 2004 SCLR 956
2. *Frank Stork and Others Pursuers* – 2004 SCLR 513
3. *Muldoon, Applicant* – 2005 SLT (Sh Ct) 52
4. *B, Applicant* – 2005 SLT (Sh Ct) 95
5. *Re T (application for intervention order)* – 2005 Scot (D) 10/7
6. *Fife Council Pursuer against X Defender* – 22 December 2005 (Scottish Court Opinions)
7. *B's Guardian, Applicant* – 2006 SLT (Sh Ct) 23
8. *M, Applicant* – 2007 SLT (Sh Ct) 24
9. *A's Guardian, Applicant* – 2007 SLT (Sh Ct) 69
10. *M, Applicant* – 2009 SLT (Sh Ct) 185
11. *G v Applicant* – 2009 SLT (Sh Ct) 122
12. *Cooper, Appellant* – 2009 SLT (Sh Ct) 101
13. *JM v JM Senior v LM* – 2009 WL 1657166
14. *H's Curator Bonis, Applicant* – 2010 SLT (Sh Ct) 230
15. *W v Office of the Public Guardian* – 2010 WL 2976720
16. *City of Edinburgh Council v D* – 2011 SLT (Sh Ct) 15
17. *Application in respect of M* – 2012 SLT (Sh Ct) 25
18. *H's Guardian v H* – 2013 SLT (Sh Ct) 31
19. *In the Case of Applications by the Guardian of P* – 2012 WL 5894489
20. *JM v Mrs JM* – 2013 WL 425718
21. *A and B, Solicitors as Continuing Attorneys, Solicitors, Aberdeen, C, as Welfare Attorney, Aberdeen v D, Aberdeen* – 2013 WL 617382
22. *CJR v JMR* – 2013 WL 1563208

23. *Application on behalf of MH* – 2013 WL 617656
24. *B, Minuter* – 2014 SLT (Sh Ct) 5
25. *G v West Lothian Council* – 2014 WL 6862565
26. *A.D. v J.G.* – 2015 WL 1786073
27. *West Lothian Council v For appointment of Guardian to JG* – 2015 WL 1786069

**WHEN IS A VOLUNTARY PATIENT NOT A VOLUNTARY PATIENT?
AN EXAMINATION OF THE DEGREE TO WHICH THE IRISH COURTS HAVE
SOUGHT TO ENGAGE WITH THE JURISPRUDENCE OF THE EUROPEAN
COURT OF HUMAN RIGHTS, IN RELATION TO THE TREATMENT AND
DETENTION OF VOLUNTARY OR 'INFORMAL' PATIENTS¹**

HOPE DAVIDSON*

I. INTRODUCTION

Faced with the difficulty of reconciling the tensions between the need for treatment, and respecting patients' rights, case law suggests that the courts in Ireland have tended to maintain a deferential approach to the medical profession and not to give voice to the significant rights protections set out in the jurisprudence of the European Court of Human Rights ('ECtHR') and instead view the legislation in this area, the *Mental Health Act 2001* through a paternalistic prism.² This has given rise to what seems at first glance to be the extraordinary logic in what is now the leading, and only, Irish Supreme Court case in the area, *E.H. v Clinical Director St Vincent's Hospital*.³ This case states that a voluntary patient is not a voluntary patient in so far as one ordinarily understands the word. In the Supreme Court, Kearns J, said:

'The terminology adopted in s.2 of the Act ascribes a very particular meaning to the term 'voluntary patient'. It does not describe such a person as one who freely and voluntarily gives consent to an admission order.'⁴

This suggests an interpretation of the 2001 Act which is not immediately reconcilable with the considerable body of jurisprudence of the European Court of Human Rights.

II. THE EUROPEAN CONVENTION AND WINTERWERP⁵

Mindful of illegal incarcerations that took place in the Second World War, the European Convention on Human Rights 1950 ('ECHR') states, and echoes the Irish Constitution in this regard, that no one shall be deprived of their liberty save in accordance with law,⁶ and that anybody so deprived has the right to have that detention reviewed.⁷ Article 5(4) of the Convention states that: 'Everyone who is

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¹ The term 'voluntary' is used in the Irish Mental Health Act 2001 whilst the term 'informal' is used in the Mental Health Act 1983 in England and Wales. As Eldergill observes, the wording in s2 and s 29 of the Mental Health Act 2001 suggests that what is meant by voluntary admission in an Irish context is in fact informal admission as there is no requirement under the Irish legislation to have capacity to 'volunteer' for admission, as would be the case in most jurisdictions. A. Eldergill, 'The Best is the Enemy of The Good: The Mental Health Act 2001' (2008) *J. Mental Health L.* 21, p26.

² The Department of Health Expert Group reports growing concern at the 'paternalistic approach that has been adopted by the judiciary in the interpretation of the Act'. Department of Health *Report of the Expert Group on the Review of the Mental Health Act 2001*, (2015), p12.

³ [2009] ILRM 149

⁴ *EH v Clinical Director St Vincent's Hospital* [2009] 2 ILRM 149, at 161

⁵ *Winterwerp v The Netherlands* (1979) 2 EHRR 387

⁶ ECHR 1950, Art 5 (1) and Article 40.4 1 *Bunreacht na hEireann* 1937

⁷ Article 5(4) ECHR. However, as Richardson observes, 'Certain groups of unsightly people can simply be detained'. G. Richardson, 'The European Convention and Mental Health Law in England

deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful'.⁸

The seminal case of *Winterwerp v The Netherlands*⁹ in 1979 sets out how these provisions are to be applied *viz-à-viz* the detention of mental health patients, namely: (1) the person must be shown to be of unsound mind;¹⁰ (2) the mental disorder must be of a degree or kind warranting involuntary confinement; and (3) the detention remains compatible with Article 5 only so long as the disorder persists.¹¹ How the review of detention procedures were to be interpreted was not, however, set out in the case.

III. CROKE V SMITH (NO 2)¹²

In the Irish case of *Croke v Smith (No 2)*,¹³ a challenge was brought to the provisions of the *Mental Treatment Act 1945*, the precursor to the *Mental Health Act 2001*, which allowed for indefinite and unchecked detention. While Budd J in the High Court¹⁴ acknowledged the ECHR's 'persuasive influence',¹⁵ he found that a chargeable patient reception order 'which allows for detention until removal or discharge by proper authority or death, without any automatic independent review, falls below the norms required by the constitutional guarantee of personal liberty'.¹⁶ The Supreme Court subsequently¹⁷ failed to acknowledge the ECHR or the principles set out in *Winterwerp*.¹⁸ It was satisfied that an ordinary review during the course of medical care would constitute a sufficient guarantee of personal liberty.

and Wales: Moving Beyond Process?' (2005) 28 *International Journal of Law and Psychiatry*, 127, 130.

⁸ In *X v United Kingdom* (1981), (*Application no. 7215/75*) at para 33, the ECtHR found 'that Article 5 par. 4 (art. 5-4) had been violated, since X had not been entitled to take proceedings by which the lawfulness of his detention consequent upon his recall to hospital could be decided speedily by a court.'

⁹ *Winterwerp v The Netherlands* (1979) 2 EHRR 387

¹⁰ 'The Convention does not state what is to be understood by the words "persons of unsound mind". This term is not one that can be given definitive interpretation..., it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes....' *Ibid.*, para 37.

¹¹ *Winterwerp v The Netherlands* (1979) 2 EHRR 387, para 402

¹² Budd J. July 27 and 31, 1995; Supreme Court, July 31, 1996: [1998] 1 IR 101

¹³ Budd J. July 27 and 31, 1995; Supreme Court, July 31, 1996: [1998] 1 IR 101

¹⁴ *Croke v Smith (No 2)* [1995] IEHC 6 (31st July 1995)

¹⁵ *Ibid.* While we remain an ultra-dualist State constitutionally, the challenges of giving further effect to international human rights law in domestic courts are significant' D. O'Connell, 'Time to start taking European Convention on Human Rights more seriously' <http://www.irishtimes.com/news> 2nd September 2013 (date accessed 12th of September 2016)

¹⁶ *Croke v Smith (No 2)* [1995] IEHC 6 (31st July 1995) See also Costello P in *R.T. v. The Director of the Central Mental Hospital* [1995] 2 IR 65, at 79 'So, it seems to me that the constitutional imperative to which I have referred requires the Oireachtas to be particularly astute when depriving persons suffering from mental disorder of their liberty and that it should ensure that such legislation should contain adequate safeguards against abuse and error in the interests of those whose welfare the legislation is designed to support. And in considering such safeguards regard should be had to the standards set by the Recommendations and Conventions of International Organisations of which this country is a member.'

¹⁷ *Croke v Smith (No 2)* [1998] 1 IR 101

¹⁸ *Winterwerp v Netherlands* (1979) 2 EHRR 387

Mr Croke took his case to the European Court of Human Rights and while the Irish government then sought to rely on the remedy of *habeas corpus*¹⁹ to satisfy the 'detention shall be decided speedily by a court' requirement, as set out in Article 5(4),²⁰ a 'friendly settlement' was ultimately agreed between the parties. The ensuing legislation, the *Mental Health Act*, was enacted in 2001. The key features of it were that it enabled independent review tribunals²¹ for those *formally detained* and second-opinion safeguards for certain treatments in the absence of consent.²²

IV. DE FACTO DETENTION

A. *H.L. v U.K.*²³

The problem persisted, however, for those psychiatric patients who were *not formally detained*, classed as 'informal' in England and 'voluntary' in Ireland.²⁴ These patients appeared to be going under the radar, and in the case of *H.L. v United Kingdom* in 2005 the ECHR found:

'striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons²⁵ is conducted. The contrast between this dearth of regulation and extensive network of safeguards applicable to psychiatric committals covered by the [Mental Health Act] 1983 is, in the Court's view, significant.'²⁶

Further, it found that the absence of any procedural safeguards failed to protect against arbitrary deprivations of liberty and therefore violated Article 5(1) of the ECHR.²⁷ This has led to the Deprivation of Liberty Safeguards²⁸ in England and Wales which extend the provisions of the Mental Capacity Act 2005 to cover the deprivation of liberty of, amongst others, (compliant) incapacitated mental health patients. In Ireland, the Assisted Decision-Making (Capacity) Act 2015 has recently been enacted, although is not yet operative, and safeguards in relation to deprivation of liberty are to be dealt with in the Disability Equality (Miscellaneous Provisions) Bill which is currently being drafted.

¹⁹ Article 40.4.2 *Bunreacht na hEireann 1937*. Roundly criticised by commentators as an ineffective remedy, see M.Keys 'Challenging the lawfulness of psychiatric detention under habeas corpus in Ireland' (2002) 24 *D.U.L.J.* 26 and C.Murray, 'Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland' (2007) 1 *Dublin University Law Journal* 279 and ruled on by the ECHR in *X v United Kingdom* (7215/750) [1981] ECHR 6

²⁰ Article 5(4) ECHR

²¹ s 17 *Mental Health Act 2001*

²² s 60 *Mental Health Act 2001*

²³ *H.L. v United Kingdom* (2005) 40 EHRR 32

²⁴ See n1 above.

²⁵ Though whether HL was compliant is questionable. As Lady Hale has observed, 'L would clearly have objected to his admission to hospital had he not been sedated in order to get him there' B. Hale 'Taking Stock', (2009) *J Mental Health L.* 111, p113.

²⁶ *H.L. v United Kingdom* (2005) 40 EHRR 32, para 120

²⁷ *Ibid.*, para 124

²⁸ Introduced into Mental Capacity Act 2005 via s 50 of the Mental Health Act 2007. It must be noted that these safeguards are not without their critics. See P. Fennell, 'The Deprivation of Liberty Safeguards in England: The Case for Abolition' (2012), *Centre for Disability Law and Policy, NUIG*; L. Series, 'Case Study: the Limits of the Functional Approach in the English Mental Capacity Act 2005', (2013), *Centre for Disability Law and Policy, NUIG*; and *House of Lords, Select Committee on the Mental Capacity Act 2005*, 'Mental Capacity Act 2005: post-legislative scrutiny', March 2014.

On the facts of the case in *H.L. v United Kingdom*, *H.L.* did not attempt to leave the institution in which he was detained, but in *Storck v Germany*²⁹ the Court found that a person who attempts to leave an institution and is prevented from doing so cannot be regarded as someone who validly consents to admission, irrespective of status or capacity³⁰. What is interesting about the ruling in *Storck*, is that it 'provides the basis for an approach to decision-making that looks beyond questions of capacity and incapacity and addresses issues of willingness, restraint and force.'³¹ In the 2008 case of *Shtukurov v. Russia*³² the ECtHR found, effectively reinforcing *Storck*:

that while the applicant lacked de jure legal capacity to decide for himself' that this did not 'necessarily mean that the applicant was de facto unable to understand his situation.'³³

This is very pertinent to the Irish case which is next discussed.

B. *E.H. v Clinical Director of St Vincent's Hospital*³⁴

In *E.H. v Clinical Director of St Vincent's Hospital* the applicant sought a declaration that the definition of a voluntary patient under the 2001 Act was incompatible with Article 5 of the ECHR. This was on the basis that it was recorded on the applicant's form that she did not have the capacity to consent to admission on a voluntary basis (upon revocation of her involuntary detention order) and yet she was admitted as a voluntary patient notwithstanding. This has led to the by now well-known dictum in Ireland:

'The terminology adopted in s.2 of the Act ascribes a very particular meaning to the term 'voluntary patient'. It does not describe such a person as one who freely and voluntarily gives consent to an admission order.'³⁵ Instead the express statutory language defines a "voluntary patient" as a person receiving care and treatment in an approved centre who is not the subject of

²⁹ *Storck v Germany* (61603/00) [2005] ECHR 406

³⁰ '... assuming that the applicant was no longer capable of consenting following her treatment with strong medication, she cannot in any event be considered to have validly agreed', *ibid.*, para 76.

³¹ M. Donnelly *Healthcare Decision Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge University Press, 2010), p220.

³² *Shtukurov v. Russia* (44009/05) [2008] ECHR 223

³³ *Ibid.*, para 108. 'Capacity and incapacity are not concepts with clear a priori boundaries. They appear on a continuum....There are, therefore, degrees of capacity'. M. Gunn, 'The Meaning of Incapacity' (1994) 2 *Medical Law Review* 8, at p9, as quoted in J. Herring, "Losing it, Losing What? The Law on Dementia" (2009) 21 *Child and Family Law Quarterly* 3, p 4.

³⁴ *E.H. v Clinical Director of St Vincent's Hospital* [2009] I.E.H.C.69, *E.H. v Clinical Director of St Vincent's Hospital* [2009] IESC 46

³⁵ It is worth recalling at this point the words of Denham J in *In Re a Ward of Court* [1996] 2 IR 79, at 156, in relation to consent: 'If medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights' or indeed as Patricia Rickard-Clarke, of the Law Reform Commission, observes, voluntary 'has to mean consent to something, it can't mean anything else', 'Mental Capacity in the context of the Mental Health Act 2001', (2010) *Mental Health Law Conference, Faculty of Law, U.C.C.* 'It had been submitted by the applicant's legal team in the High Court and in the Supreme Court that the word "voluntary" must be given its ordinary meaning, "a meaning which respects the provisions of the Constitution and a meaning which, having regard to the State's obligations pursuant to s. 2(1) of the Human Rights Act 2003, respects the necessity for a freely given consent to detention by a person who has capacity to give it.' A. Hynes, 'The Mental Health Act 2001 in Practice' (Mental Health Law Conference, U.C.C., 2010).

an admission order or a renewal order. This definition cannot be given an interpretation which is *contra legem*.³⁶

But probably more worrying is when Kearns J goes on to say: 'Any interpretation of the term in the Act must be informed by the overall scheme and paternalistic intent of the legislation as exemplified by the provisions of sections 4 and 29 of the Act.'³⁷ In so doing he fails to recognise that the 2001 Act was not intended to be a reiteration of the 1945 Act³⁸ and that the 'best interests'³⁹ standard as set out in s4 is not merely medical best interests but that the need to respect 'the right of the person to dignity, bodily integrity, privacy and autonomy' is clearly stated.⁴⁰ Indeed, as the Irish Human Rights Commission went on to observe, in its submission as *amicus curiae*⁴¹, in the later case of *P.L. v Clinical Director of St Patrick's University Hospital (No 2)*⁴² 'paternalism cannot be given such a broad application as to defeat the significant recognition given to the patient's human rights, accorded by the *Mental Health Act, 2001*'.⁴³ If the friendly settlement agreed in *Croke*⁴⁴ was the impetus behind the new legislation then surely it follows that the legislation was to bring Ireland in to line with the ECHR and the *Winterwerp* principles?⁴⁵ Kearns J was clearly satisfied that the fact that the medical professionals were 'poised to reinstate' the involuntary order (and thereby the specific statutory protections) was sufficient to guard against

³⁶ Per Kearns J, *EH v Clinical Director St Vincent's Hospital* [2009]2 I.L.R.M., 149, at 161. Donnelly calls it 'a departure from common sense' (M. Donnelly, ' "Voluntary" psychiatric patients need protection' *Irish Times*, 9th of February 2012)., Additionally, as Craven observes, 'Quite apart from any question of statutory interpretation, if the *lex* referred to includes, as it reasonably might, the general law on consent, the interpretation contended for cannot, as a result be considered to be *contra legem*. Such a restrictive approach might be considered *contra corpus iuris*' (C. Craven, 'Issues of Consent –Detention & Treatment' November 2010, *The Law Society of Ireland* p 11).

³⁷ Per Kearns J, *EH v Clinical Director St Vincent's Hospital* [2009]2 I.L.R.M.,149, at 161.

³⁸ The new Act is different. Eldergill, among others, observes: '[I]t must be emphasised that the main purpose of the 2001 legislation was patently not just to repeat the paternal character of the Act of 1945. Nor was it intended simply to ensure the care and custody of people suffering from mental disorder. The 1945 Act promoted and secured those objectives' (A. Eldergill, 'The Best is the Enemy of The Good: The Mental Health Act 2001' (2008) *J. Mental Health L.* 21, p23).

³⁹ 'The inclusion of best interests in s.4 has provided a justification for the continuing reliance on paternalism as the guiding principle in Irish mental health law' cautions Murray. C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform' (2013) 1 *The Irish Jurist* 161, p175).

⁴⁰ S 4 (3) *Mental Health Act 2001*

⁴¹ *P.L. v Clinical Director of St Patrick's University Hospital, Outline Submissions of the Human Rights Commission*, (19th June, 2012).

⁴² [2012] IEHC 547

⁴³ *P.L. v Clinical Director of St Patrick's University Hospital, Outline Submissions of the Human Rights Commission*, 19th June, 2012, p20. 'The MHA 2001 does contain a number of important safeguards and rights which had not previously existed in Ireland, such as automatic periodic review of detention by tribunals and second-opinion safeguards for certain invasive medical treatments'. C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform', (2013) 1 *The Irish Jurist* 161, p166.

⁴⁴ *Croke v Ireland* (33267/96) [2000] ECHR 680

⁴⁵ 'It is noted however, that in *Croke v Smith (No 2)* [1998] 1 IR 101 the Supreme Court held that, on the facts of that particular case, the Constitution did not require automatic review by an independent tribunal of the patient's detention. However, it is submitted that the Oireachtas has now expressed a clear intention, that this would not be the case by enacting the Mental Health Act 2001.' *P.L. v Clinical Director of St Patrick's University Hospital, Outline Submissions of the Human Rights Commission*, 19th June, 2012, para 50, p24.

arbitrary detention.⁴⁶ This sounds like a reasoning similarly deferential to the medical profession to that given by the Supreme Court in *Croke*⁴⁷ on the 1945 Act. It also 'glosses over the fact that from December 10 to 22, the protections were not available'⁴⁸ and this is not as Craven observes 'apparently reconcilable with the due process requirements of the Convention'.⁴⁹

In many ways *E.H.* was not an ideal test case to advance the rights of the voluntary patient. In *E.H.* it is fair to say that on the facts the patient may not have been 'arbitrarily' deprived of her liberty, and since the purpose of the safeguards as set out in *Winterwerp* was to guard against 'arbitrary' detention there may have been less sympathy for the situation the applicant found herself in. Kearns J had a difficulty with her having capacity to instruct counsel and yet not to consent to admission. In addition, by the time the *habeas corpus* application came around the fact that the applicant was lawfully detained on an involuntary order 'led the court to question whether the arguments before it were moot'.⁵⁰ However since the applicant in *E.H.* was in a very similar position to *H.L.*, being an informal patient without capacity, it seems odd not to consider *H.L.* as of precedential value.⁵¹ A fundamental difficulty in the *E.H.* case, in common with the case we now move on to consider, *P.L.*,⁵² is that in neither case was there a suggestion that the applicant was well enough to be discharged and for that reason the Court may have been looking in a paternalistic way to find that the detention was lawful so that treatment might be continued.⁵³

C. *P.L. v Clinical Director of St Patrick's University Hospital*.⁵⁴

In *P.L.* the applicant sought declarations that 'the respondents were not entitled to prevent him from leaving the hospital without involuntarily admitting him in accordance with the MHA 2001'.⁵⁵

⁴⁶ Any deprivation of liberty should be consistent with the purpose of Article 5, namely to protect individuals from arbitrariness. See *Herczegfalvy v Austria* (1992) 15 EHRR.

⁴⁷ When it extinguished the trail blazed by Budd J in the High Court. D. Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Round Hall 2009), p7.

⁴⁸ 'This reasoning glosses over the fact that from 10 to 22 December, protections against arbitrary deprivations of liberty were not available' D. Whelan, 'Can the Right to Personal Liberty be Interpreted in a Paternalistic Manner?: Cases on the Mental Health Act 2001', forthcoming, (2012-2013) *Irish Human Rights Law Review*, p17 of 20.

⁴⁹ C. Craven, 'Issues of Consent –Detention & Treatment' November 2010, *The Law Society of Ireland*, p 13 of 31.

⁵⁰ C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform' (2013) 1 *The Irish Jurist* 161, p 173

⁵¹ D. Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Round Hall 2009) p167, M. Donnelly, Falling between the gaps: Formulating reform in a dual-model system. 23 June 2012, *Mental Health Law Reform: New Perspectives and Challenges* (Amnesty International Ireland and the Centre for Disability Law and Policy, NUIG, and C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform' (2013) 1 *The Irish Jurist* 161, p 171.

⁵² *P.L. v Clinical Director of St Patrick's University Hospital* [2012] IEHC 15

⁵³ As Murray observes: 'The practical effectiveness of the rights protections contained in the MHA 2001 depends to a significant extent on the judicial approach taken to their implementation.' C Murray 'Reinforcing Paternalism within Irish Mental Health Law - Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*' (2010) 17 *Dublin University Law Journal* 273, p273.

⁵⁴ [2012] IEHC 15

The case is as complete an illustration of the myriad difficulties encountered in attempting to treat a voluntary patient while staying on the right side of the legal regime as we are likely to get:

'Mr McDonagh for the applicant does not dispute that the applicant is suffering from a mental illness for which he needs care and treatment. At issue, rather, is whether there is any lawful basis for the applicant's de facto detention in the hospital, in circumstances where on the 12th October 2011 the Renewal Order was revoked and the applicant was "discharged" though not permitted to leave, where he initially thereafter agreed to remain and be treated as a voluntary patient, but has on several occasions thereafter expressed a wish, and has in fact attempted, to leave the hospital, has verbally indicated a withdrawal of his consent to remain as a voluntary patient, has been physically restrained from attempting to leave and forcibly sedated, but has not been detained pursuant to the provisions of Sections 23 and 24 of the Act because he was not considered by Dr. Power to be a person who fulfilled the criteria for admission under those sections.'⁵⁶

Proceeding to analyse that argument piece by piece we might comment as follows: If the applicant needs treatment then that is arguably in his 'best interests' pursuant to s4 of the Act and so he could have been formally detained under the legislation. He expressed a wish to stay on without formal detention, which was acceded to and this acknowledges his 'will and preference'.⁵⁷ He then expressed a wish to leave. This wish is inconsistent with his earlier wish⁵⁸ and could call in to question his capacity⁵⁹, though no finding of incapacity could or would be made under the Act, such as would have had any impact on his status as a voluntary patient. He was forcibly restrained⁶⁰ and sedated, which the Committee on the Prevention on Torture (CPT) have previously commented on,⁶¹ and ultimately the second opinion doctor

⁵⁵ C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform', (2013) 1 *The Irish Jurist* 161, p173. The recent case of *Atudorei v. Romania* suggests 'that the failure of the authorities to initiate the involuntary procedure for hospitalisation in the applicant's case underlines the uncertainty and ambiguity of the applicant's deprivation of liberty' and as being capable of engaging Article 5(1) of the ECHR. *Atudorei v. Romania* (50131/08) (2014) ECHR 947, para 147.

⁵⁶ *P.L. v Clinical Director of St Patrick's University Hospital* [2012] IEHC 15, at 30.

⁵⁷ This is the language of Article 12 UN Convention on the Rights of Persons with Disabilities (Equal recognition before the law).

⁵⁸ 'Psychotic patients may often have no unitary "will" as the law conceives it, but rather fluctuate back and forth between mutually exclusive desires, unable to resolve conflicting wishes'. P.Appelbaum and G.Gutheil "Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients. *Bulletin of the AAPL* Vol. VII, No.3, p313.

⁵⁹ As Dworkin argues '[I]f [a person's] choices and demands, no matter how firmly expressed, systematically or randomly contradict one another, reflecting no coherent sense of self and no discernible even short-term aims, then he has presumably lost that capacity that is the point of autonomy to protect.' R.Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Alfred A. Knopf, 1993) p 224

⁶⁰ Although this is expressly permitted for voluntary patients under s 69 (4)(b) of the 2001 Act provided that the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (The Mental Health Commission, October 2009) have been complied with.

⁶¹ The administration of medication 'for behaviour control rather than for decreasing symptoms of their disease' has been criticised by the CPT: 'At present, such use of "chemical restraint" does not qualify as a means of restraint under Irish law and is therefore not subjected to oversight. The CPT recommends that use of "chemical restraint" be governed by clear rules and subjected to the same oversight as regards other means of restraint.' *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*(CPT) from 25 January to 5 February 2010, Strasbourg, 10 February 2011, para 132, p65.

disagreed with his treating psychiatrist as to the necessity of formal detention. Arguably therefore he had an 'independent review' of his detention. It appears as Murray has noted 'that the reason the renewal order was revoked was that the treating consultant psychiatrist was of the opinion that the applicant was improving'⁶² and this is part of what moving from involuntary to voluntary status is about.

Peart J, in *P.L.*, highlights, while ultimately determining that the applicant's detention was lawful in the particular case, that the danger is that:

'[F]or all practical purposes the applicant in the present case is in precisely the same locked ward and under precisely the same care and treatment plan'⁶³ which he was under while the subject of the Renewal Order prior to its revocation. He is not permitted to leave the hospital when he expresses a wish to do so, yet he has none of the protections and safeguards of an involuntary patient. His status as a voluntary patient appears to disadvantage him in this way and arguably gives rise to the mischief that he could remain indefinitely in this locked ward as a "voluntary patient" with no recourse to review or even access to a legal representative to assist him...'⁶⁴

Peart J effectively acknowledges the rights issues but finds, indeed as he did in *M.McN. v HSE*⁶⁵ that he cannot bring himself to have a vulnerable person potentially released unprotected,⁶⁶ finding instead that:

'a wide margin of appreciation'⁶⁷ ought to be allowed to clinicians when faced with a patient who expresses a wish to leave, to not immediately permit him to do so, in order to provide an opportunity to discuss matters with him with a view to persuading him to once again co-operate as a voluntary patient in his own best interests, rather than simply accepting the expressed wish at face value immediately, and discharging him there and then.'⁶⁸

However, as the 2008 Annual Report of the Mental Health Commission pointedly identifies:

⁶² C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform', (2013) 1 *The Irish Jurist* 161, p174.

⁶³ 'In reality, the difference between her position and that of a hypothetical detained psychiatric patient...would have been one of form, not substance.' As Lord Dyson JSC observed in *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 at paragraph 34.

⁶⁴ *P.L. v Clinical Director of St Patrick's University Hospital (No.1)* [2012] IEHC 15, at 48 .He does however say that the regulation of treatment for voluntary patients might benefit from being addressed by the Supreme Court. See M. Carolan, 'Voluntary mental patient not being held unlawfully' *Irish Times*, 25th January, 2012.

⁶⁵ *M. McN v Health Service Executive* [2009] IEHC 236, High Court, Peart J, May 15, 2009.

⁶⁶ '[I]t would be grossly negligent for the hospital, following the required revocation of the admission/renewal order, to immediately bring these vulnerable patients to the front door of the hospital, lead them down the steps and to pavement and say to them 'we no longer have any legal basis for keeping you in hospital, so off you go – home or wherever you can'....' *M.McN v Health Service Executive* [2009] IEHC 236, High Court, Peart J, May 15, 2009, p 37. Contrast this however with Clarke J in *JH v Russell* [2007] IEHC 7, at 6.5: 'While I fully understand the pressures which may have led those in charge of Mr H to attempt to devise means of ensuring his continued treatment, (which they clearly considered desirable) notwithstanding the defective legislation within which they were operating, I was nonetheless satisfied that the detention was unlawful'

⁶⁷ The Court recalls that in deciding whether an individual should be detained as a "person of unsound mind", the national authorities are to be recognised as having a *certain* margin of appreciation. *Shtukurov v Russia* (44009/05) ECHR 223, para 67

⁶⁸ *P.L. v Clinical Director of St Patrick's University Hospital* [2012] IEHC 15, at 50.

'It is a fact of life that when individuals, especially vulnerable individuals, are detained, an imbalance of power exists between those detained and those holding the keys. Without rigorous human rights standards and frequent inspections, this is fertile ground for abuse or neglect'.⁶⁹

In *S.M. v the Mental Health Commission and Ors*,⁷⁰ McMahon J while observing that 'such statutory provisions which attempt to detain a person or restrict his or her liberty must be narrowly construed', ordered a stay of four weeks to allow the "relevant authorities" to determine what the appropriate order was in the circumstances.⁷¹ Whelan notes that this appears to be 'an unjustifiably lengthy period of time to postpone the release of a patient in unlawful custody.'⁷² The problem, as Lady Hale, or Hoggett (as she then was), has observed is that you can only secure your release in to the community if appropriate supports are there.⁷³ There has not been the progress in setting up community support that would have been envisaged by, *inter alia*, *A Vision for Change*⁷⁴ with the result that 'patients continue to be readmitted on an inpatient basis when they could be more appropriately treated in the community.'⁷⁵ This may in part be influencing the judiciary's cautious attitude or continuing paternalism in respect of a patient's detention. However, it is hard to disagree with Murray's conclusion in *P.L.*, that it is 'an extraordinary interpretation of the MHA 2001' to find that a 'capable, unwilling "voluntary" patient who was refused permission to leave the hospital, with no possibility of an independent procedure to review the ongoing need for him to remain in the hospital' was 'not unlawfully detained or deprived of his liberty'.⁷⁶

The fact that fewer people are now being treated on an involuntary basis is suggestive of co-operation in treatment⁷⁷ rather than compulsion but if it is unregulated it may be voluntary in name only. One cannot help but feel that voluntary patients now are in an eerily similar position to involuntary patients under the 1945 Act where '[t]here was no mechanism for an automatic review of the decision to admit, for example, and once admitted, a patient's stay could be renewed indefinitely at the discretion of the person in charge of the institution, without the need for any kind of formal review'.⁷⁸

⁶⁹ *Mental Health Commission Annual Report 2008* (Mental Health Commission, 2009) p57.

⁷⁰ *S.M. v The Mental Health Commission, the Mental Health Tribunal and the Clinical Director of St. Patrick's Hospital* [2009] 3 IR 188

⁷¹ *Ibid.*, at 203

⁷² D.Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Round Hall 2009), p 40.

⁷³ B.Hoggett, *Mental Health Law* (London 1976).

⁷⁴ Expert Group on Mental Health Policy, *A Vision for Change* (Dublin, 2006).

⁷⁵ Mental Health Research Unit of Health Research Board, *Selected Findings and Policy Implications from 10 Years of HRB Mental Health Research*, 2009, p8.

⁷⁶ C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform', (2013) 1 *The Irish Jurist* 161, p174

⁷⁷ Though it looks like, to borrow an expression from the medical world this might be a false positive.

⁷⁸ P. Casey, P. Brady, C. Craven and A. Dillon, *Psychiatry and the Law*, 2nd ed. (Dublin: Blackhall Publishing, 2010), p437.

V. CASE LAW IN RELATION TO CONSENT TO TREATMENT

There is as yet little Irish case law in relation to consent to treatment.⁷⁹ As Lady Hale, of the UK Supreme Court, observed previously '[t]he Bournemouth amendments⁸⁰ deal only with safeguards against arbitrary deprivation of liberty. They do not introduce safeguards against unjustified medical treatment.'⁸¹ Consent can be complicated in a physical health scenario⁸² but the case of *M v Ukraine*⁸³ suggests that *E.H.* for instance would certainly fall foul of what the ECtHR would expect in terms of a valid consent to treatment for a mental health patient:

'[T]he Court takes the view that a person's consent to admission to a mental health facility for in-patient treatment can be regarded as valid for the purpose of the Convention only where there is sufficient and reliable evidence suggesting that the person's mental ability to consent and comprehend the consequences thereof has been objectively established in the course of a fair and proper procedure and that all the necessary information concerning placement and intended treatment has been adequately provided to him'.⁸⁴

This issue has been addressed by the Expert Group on the Review of the Mental Health Act 2001 in their Report in which they recommend that:

'[a]ll voluntary patients on admission to an approved centre should be fully informed of their rights, including information relating to their proposed treatment as well as their rights regarding consent or refusal of treatment and their right to leave the approved centre at any time.'⁸⁵

It was held in *Storck v Germany*⁸⁶ that 'even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will.'⁸⁷ Indeed as the Committee on the Prevention of Torture observed:

The CPT's mandate relates to persons deprived of their liberty, and not to voluntary patients. However, in the course of the visit, the CPT's delegation observed that many so-called "voluntary" patients were in reality deprived of their liberty; they were accommodated in closed units from which they were not allowed to leave and, in at least certain cases, were returned to the hospital if they left without permission. *Further, if staff considered it necessary, these patients could also be subjected to seclusion and could be administered medication for prolonged periods against their wish.*⁸⁸

⁷⁹ *K.C. v Clinical Director of St Loman's Hospital* [2013] IEHC 310, High Court, Hogan J., July 4, 2013; *Health Service Executive v M.X.* [2011] I.E.H.C. 326, High Court, MacMenamin J., July 29, 2011; *M.X. v Health Service Executive* [2012] I.E.H.C. 491 High Court, MacMenamin J., November 23, 2012 (Source: *Mental Health Commission Case Law Summary October 2013*). It is worth noting that this also a problem for involuntary patients.

⁸⁰ *Deprivation of Liberty Regulations*, Introduced in to Mental Capacity Act 2005 via s 50 of the Mental Health Act 2007

⁸¹ B. Hale, 'The Human Rights Act and Mental Health Law: Has it Helped?' (2007) *J. Mental Health L.* 7, p 11

⁸² See D. Madden, *Medicine Ethics and the Law*, 2nd Ed (Bloomsbury, 2011)

⁸³ *M v. Ukraine*, (2452/04) 19th April, 2012

⁸⁴ *M v. Ukraine* (2452/04) 19th April, 2012, para 77

⁸⁵ Department of Health, *Report of the Steering Group on the Review of the Mental Health Act 2001*, 5th of March 2015, Recommendation 25, p 90.

⁸⁶ *Storck v Germany* (61603/00) [2005] ECHR 406

⁸⁷ *Ibid.*, para 143.

⁸⁸ *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 January to 5 February 2010, Strasbourg, 10 February 2011 para 117, p65.*

A. *MX v HSE*⁸⁹

In the 2012 case of *M.X*, MacMenamin J stated: 'By virtue of ss. 2-5 of the European Convention on Human Rights Act 2003, this court is required to interpret laws of this State in compliance with the State's obligation under the ECHR provisions'.⁹⁰ He had noted that '[t]he incursion into the plaintiff's constitutional rights is very significant. It involves medical treatment against her will.'⁹¹ While he acknowledged that the paternalistic nature of Act had been emphasised in cases such as *E.H*, he considered that this case was different as it was about treatment rather than liberty.⁹² If the reasons for drawing a distinction between liberty and consent to treatment were not entirely clear, the case itself was a welcome acknowledgment of the relevance of international human rights principles. In the Grand Chamber judgment *Stanev v. Bulgaria*⁹³ judgment the ECtHR stated that it felt 'obliged to note the growing importance which international instruments for the protection of people with mental disorders are now attaching to granting them as much legal autonomy as possible.'⁹⁴ MacMenamin J found in *M.X*⁹⁵ that there was no space on the relevant form, Form 17,⁹⁶ to record the patient's view on medication and his ruling in this regard has led to Form 17 being changed. It may seem a small change but it is very important as an example of the recognition of the right of a patient to be heard. As Bartlett asks: '[C]an we afford to have the process independent of the voices of the very people the service affects?'⁹⁷ and, as Murray observes, '[a]t the heart of the CRPD is a commitment to positive rights, and this introduces a new perspective on discussions of rights-based mental health law.'⁹⁸

B. *K.C. v Clinical Director of St Loman's Hospital*⁹⁹

The recent case of *K.C.* continues the paternalistic vein. In that case Hogan J ruled that the provisions of s. 23 (and, by extension, s. 24) which enable a holding power to prevent a voluntary patient from attempting to leave, pending examination by an independent Consultant Psychiatrist, do not 'impliedly prevent the making of an admission order'¹⁰⁰ when they do not attempt to leave.

K.C. is a very important case in terms of treatment as it reveals the practical difficulties when a voluntary patient does not attempt to leave but does not consent

⁸⁹ *M.X. v Health Service Executive* [2012] IEHC 491

⁹⁰ *Ibid.*, para 61

⁹¹ *Ibid.*, para 5

⁹² *Ibid.*, para 59

⁹³ *Stanev v. Bulgaria* (36760/06) [2012] ECHR 46

⁹⁴ *ibid.*, at para 244

⁹⁵ *M.X. v Health Service Executive* [2012] IEHC 491, at para 28

⁹⁶ *Form 17, Mental Health Act 2001 s 60*. Treatment without consent, administration of medicine for more than 3 months, involuntary patient.

⁹⁷ P. Bartlett and R. Sandland, *Mental Health Law: Policy and Practice*, 4th Ed., (Oxford: Oxford University Press, 2014), p 2.

⁹⁸ C. Murray, 'Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform', (2013) 1 *The Irish Jurist* 161, p 161.

⁹⁹ *K.C. v Clinical Director of St Loman's Hospital* [2013] IEHC 310

¹⁰⁰ *Ibid.*, para 21. Anecdotally there was some disquiet among tribunal members as to whether that was the intended interpretation of the section.

to any treatment. This is why the Expert Group on the review of the Mental Health Act believe that consent to admission should include some understanding that you are consenting to being admitted for treatment¹⁰¹ and that if that acceptance were not forthcoming that the admission would not proceed.¹⁰² The Canadian case of *Starson v Swayze*,¹⁰³ although it concerns an involuntary patient is a salutary lesson. In that case, Professor Starson refused medication and his health eventually declined to a point where he lost capacity, was eventually treated and improved, but not before he had spent nine years in hospital.

VI. CONCLUSION

Case law in relation to the voluntary patient is only in its infancy in Ireland. The cases have only begun to come before the courts since about 2008, two years after the operative date of the Mental Health Act 2001. Prior to that, a great deal of the case law in relation to detention came from cases against the Central Mental Hospital ('CMH'), which is the national forensic psychiatric unit.¹⁰⁴ The reason for this was that patients in the CMH would already have had legal representation from their legal cases and there is a well-established 'rights culture' in prison¹⁰⁵ and by extension in the CMH. While the rights protections may be slow in filtering through for the wider community of detained patients it is immensely welcome that an avenue has been presented, via the introduction of automatic legal representation for involuntary patients in the 2001 Act.¹⁰⁶ While the overriding approach of the judiciary is undoubtedly paternalistic it is very welcome that the rights issues are beginning to be aired before the courts and that a greater awareness is being created of the issues involved. With the advocacy brought about by the 2001 Act we have found that very many people were unlawfully detained under the 1945 Act.¹⁰⁷ Unfortunately as legal representation is only available to involuntary patients the cases that come before the courts tend to be people who are essentially very unwell and while judges, such as Peart J and MacMenamin J, recognise the existence of their rights they tend ultimately to fall back on a paternalistic default setting. Perhaps if representation or

¹⁰¹ 'It was submitted that a voluntary patient who might meet the 23 criteria for a mental disorder could withhold consent to treatment and consequently their condition might deteriorate yet their status cannot be changed unless they indicate a wish to leave the approved centre'. Department of Health, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*, 27th of April 2012, p23. In their Final Report, the Expert Group recommend 'that it should no longer be a requirement that a patient must first indicate a wish to leave the approved centre before the involuntary admission process is initiated.' *Report of the Expert Group on the Review of the Mental Health Act 2001*, (2015), p56.

¹⁰² Which is more like the 1945 Act.

¹⁰³ *Starson v Swayze* [2003] SCC 32

¹⁰⁴ *Re Philip Clarke* [1950] IR 235, *R.T. v. The Director of the Central Mental Hospital* [1995] 2 IR 65, *Croke v Smith (No 2)*[1998] 1 IR 101.

¹⁰⁵ Many factors might be at play in the apparent low rate of use of the habeas corpus procedure, including the lack of information about rights, or the lack of a "rights culture" in psychiatric hospitals. Keys, M 'Challenging the lawfulness of psychiatric detention under habeas corpus in Ireland' (2002) 24 *D.U.L.J.* 26.

¹⁰⁶ S 16(2) (b)

¹⁰⁷ A. Hynes, 'The Mental Health Act 2001 in Practice' Mental Health Law Conference February 26 2010. U.C.C.

advocacy were available to voluntary patients¹⁰⁸ it might be easier to establish a more general application of rights protection.¹⁰⁹ This could be singularly useful in relation to consent to treatment which has not as yet been considered by the Irish courts to any substantial degree.

¹⁰⁸ The case law concerning voluntary patients tends - *E.H.* and *P.L.* being examples - to concern patients who had been involuntary and had therefore been assigned a legal representative who continued to act for them notwithstanding that they had become voluntary patients.

¹⁰⁹ 'This can be contrasted with the approach in the context of challenges to detention in excess of time limits contained in criminal justice legislation. In these circumstances the courts are more disposed to find that there has been a breach of the fundamental rights of the party detained.' C. Murray, "Reinforcing Paternalism within Irish Mental Health Law - Contrasting the Decisions in *EH v St. Vincent's Hospital and Others* and *SM v The Mental Health Commission and Others*" (2010) 17 *Dublin University Law Journal* 273, p273.

CAN THE USE OF THE MENTAL HEALTH ACT BE THE 'LEAST RESTRICTIVE' APPROACH FOR PSYCHIATRIC IN-PATIENTS?

BETH RANJIT*

I. INTRODUCTION

In England and Wales, involuntary admissions for assessment or treatment in mental health wards are based on the legal framework of the Mental Health Act 1983 (as amended in 2007) or the Mental Capacity Act 2005, with the Deprivation of Liberty Safeguards introduced in 2007. But what is the “least restrictive” approach and are we truly safeguarding in-patients’ liberty by curbing use of the Mental Health Act in particular groups?

II. WHAT IS LIBERTY IN LAW?

The Human Rights Act 1998 is the source for the legal protection of liberty in English and Welsh law. Article 5 enshrines the right to liberty, stating that no one should be deprived of their liberty unless they meet certain criteria, such as conviction of a crime. Article 5.1(e) includes the following exemption:

‘the lawful detention of...persons of unsound mind, alcoholics or drug addicts...’¹

In 1998, the legal detention of “persons of unsound mind” was solely the province of the Mental Health Act 1983, permitting both detention and treatment without consent of compulsory patients.

However, the 1983 Act did not provide for the treatment of physical health complaints or regulate other life-altering decisions for people unable to give informed consent. From this need and to protect the incapacitated arose the Mental Capacity Act 2005, allowing individuals without capacity to be assessed, treated and accommodated without their agreement – including in mental health units.

It is the Mental Capacity Act that introduced the concept of ‘least restriction’ into the legislation, with its fifth statutory principle:

‘Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.’²

With the substantial amendments to the Mental Health Act in 2007, the concept of ‘minimising restrictions on liberty’³ was added to the guiding principles and the Code of Practice 2008 elaborated further with the Least Restriction Principle:

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¹ Human Rights Act 1998 sch 1 pt 1 Article 5 para 1(e) [<http://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/1/chapter/4>]

² Mental Capacity Act 2005 pt 1 s 1(6) [<http://www.legislation.gov.uk/ukpga/2005/9/section/1>]

³ Mental Health Act 1983 (as amended in 2007) s 118(2B)(c) [<http://www.legislation.gov.uk/ukpga/1983/20/section/118>]

'People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty...'⁴

The Code of Practice was updated in 2015 and the "least restrictive option" was more narrowly defined:

'Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained.'⁵

Due to the use of the word 'lawfully', this tenet implies that any alternative legal framework would be preferable to the Mental Health Act. This reinforces the idea that the Mental Health Act is the most restrictive way a person can be admitted to a mental health unit.

At this time, the Mental Capacity Act was also amended to include the Deprivation of Liberty Safeguards (DoLS). DoLS was designed to plug the so-called 'Bournewood gap'⁶, situations where a person is deprived of their liberty in a hospital or care home but falling outside the scope of the Mental Health Act.

III. DOES ADMISSION TO A MENTAL HEALTH UNIT CONSTITUTE A DEPRIVATION OF LIBERTY?

The Supreme Court judgment on *P v. Cheshire West*⁷ held that there is a deprivation of liberty when the person is under continuous supervision and control and is not free to leave. While the Mental Health Act Code of Practice cautions that blanket or global restrictions on liberty should be avoided, the reality of mental health units is that in-patients are subject to regular checks by staff, their routine is governed by the ward staff, and the door is locked in 58% of cases⁸. The degree or intensity rather than the nature or substance forms the dividing line between a *restriction* on liberty and the more significant *deprivation*, such as under what circumstances a locked door may be opened or the level of observations required.

In *A PCT v. LDV*, the judgement listed three conditions which satisfied a deprivation of liberty:

'(a) an objective element of a person's confinement in a certain limited space for a not negligible time; (b) a subjective element, namely that the person has not validly consented to

⁴ Department of Health. Code of Practice, Mental Health Act 1983. TSO (The Stationery Office), 2008. p. 5

⁵ Department of Health. Code of Practice, Mental Health Act 1983. TSO (The Stationery Office), 2015. p. 22
[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF]

⁶ *HL v. United Kingdom* [2004] ECHR 471 [<http://www.bailii.org/eu/cases/ECHR/2004/471.html>]

⁷ *P v. Cheshire West and Chester Council and P and Q v. Surrey County Council* [2014] UKSC 19 [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/uk/cases/UKSC/2014/19.html>]

⁸ Mental Health Act Commission. *In place of fear? 11th Biennial Report 2003–5*. London: TSO (The Stationery Office), 2005

the confinement in question, and (c) the deprivation of liberty must be one for which the State is responsible.⁹

This means that a capacitous person can accept these restrictions on their liberty via informed consent to an informal admission to a mental health unit. However, a non-capacitous person must be admitted under an appropriate legal framework if the degree or intensity of a restriction of liberty amounted to a deprivation.

IV. CLINICAL CONSEQUENCES: LEGISLATION IN ACTION

What does this mean for clinicians when a person is assessed for admission to a mental health unit? Is informal admission always less restrictive of a person's liberty than detention under the Mental Health Act, as the revised Code of Practice would have us believe?

In 2013, I evaluated use of emergency medical detention – Section 5(2) – on two adult in-patient wards in South West London and St George's Mental Health Trust. Of 527 admissions, 75 patients were detained under Section 5(2). 35 patients were detained within 72 hours of admission. On closer examination, these patients fell into two categories: non-capacitous and non-consenting.

By examining these groups in further detail, we can understand the pitfalls of shunning detention under the Mental Health Act at admission for the capacitous, reluctant patient and the non-capacitous, compliant patient.

V. THE CAPACITOUS, RELUCTANT PATIENT

Outside the legal frameworks of the Mental Health Act and the Mental Capacity Act/Deprivation of Liberty Safeguards, valid informed consent is required for an admission to a mental health unit.

The Deprivation of Liberty Safeguards Code of Practice 2008 identified a non-exhaustive list of factors that point towards a deprivation of liberty. These include that the person is admitted for care and treatment of a mental disorder, they will be subject to supervision and use of medication to control their mental state, that their property may be searched, and that staff must grant permission to use the door.¹⁰ These form a familiar list to the in-patient psychiatrist and, while the judge in *A PCT v. LDV* was careful not to be proscriptive of what was required for informed consent, he pointed to understanding these factors as being integral to the process.

If an assessed person is not keen on admission, she may be persuaded by a loved one or professional. Persuasion is an important tool for a psychiatrist, but only if the person can freely make either an affirmative or negative decision. If the only acceptable outcome is agreement, this steps over the line into coercion. If the person

⁹ *A PCT v. LDV, CC & B Healthcare Group*. [2013] EWHC 272 (Fam) para. 13 [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWHC/Fam/2013/272.html>]

¹⁰ Department of Health. Mental Capacity Act 2005, Deprivation of liberty safeguards, Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. TSO (The Stationery Office), 2008, p. 17

refuses to come in, but agrees when the issue of detention is raised, the Mental Health Act Code of Practice is clear:

'The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)'¹¹.

The reality of a locked door in an inpatient mental health unit is also an important aspect of consent. Admission to an acute mental health unit stems from a risk to self or others. If someone at such risk then asks to leave the unit, they will be subject to assessment by a nurse and then probably a doctor. In the *Bournewood* judgment, Lord Steyn stated:

'if "L" had shown any sign of wanting to leave, he would have been firmly discouraged by staff and, if necessary, physically prevented from doing so. The suggestion that "L" was free to go is a fairy tale.'¹²

For how many informal in-patients is this true? My audit of Section 5(2) use indicates their number may be significant, particularly as it does not account for those successfully persuaded to stay without resorting to legal detention.

In *Storck v. Germany*, the Court ruled there had been a deprivation of liberty where a person had initially consented to admission, agreeing with the Bremen Regional Court's assertion:

'Even assuming the applicant's initial consent, it would have lapsed by the applicant's uncontested attempts to escape.'¹³

Patients who repeatedly ask to leave and are repeatedly persuaded to stay may not be trying to pick the lock, but they are expressing their desire to escape the confines of the unit and they are being denied without a formal right of appeal.

There is also the question of advocacy. Who can give informal in-patients advice on their rights under these circumstances? If the person was detained under the Mental Health Act, she could access an Independent Mental Health Advocate (IMHA) and free legal advice. If she was treated under the Mental Capacity Act, with or without DoLS, she would have an Independent Mental Capacity Advocate (IMCA) to promote her best interests and would also be entitled to free legal advice for appealing. However, non-Tribunal Legal Aid is means-tested in England – though Wales provides an IMHA service to all its in-patients. While wider mental health advocacy technically exists, it is significantly under-resourced. Advocacy is only guaranteed in England with a legal detention.

¹¹ Department of Health. Code of Practice, Mental Health Act 1983. TSO (The Stationery Office), 2015. p. 116
[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF]

¹² L, In re [1998] UKHL 24 [<http://www.bailii.org/uk/cases/UKHL/1998/24.html>]

¹³ *Storck v. Germany* [2005] 43 EHRR 96 [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/eu/cases/ECHR/2005/406.html>]

VI. THE NON-CAPACITOUS, COOPERATIVE PATIENT

In the case of a non-capacitous, cooperative patient, potentially either the Mental Health Act or the Mental Capacity Act could be used. As both have 'least restrictive' clauses, how does the assessing team decide which route to take?

It is extremely unlikely that the Mental Capacity Act can stand alone here. Consider the restrictions on liberty that must be endured by the capacitous in-patient for informal admission. However, with the person under consideration unable to understand these restrictions or evaluate the risks of defying them, the degree and intensity is liable to increase. Will the door be opened and the person allowed to leave unescorted if they cannot comprehend why they are in the unit? In such situations, the Deprivation of Liberty Safeguards must be applied.

In *AM v. SLAM NHS Foundation Trust*, the judgment considered the non-capacitous, compliant patient eligible for admission under either the Mental Health Act or the Mental Capacity Act/DoLS regime. The Mental Health Act's 'necessity test' means that DoLS has 'effective priority' if the assessment and treatment can be carried out under the Mental Capacity Act framework. However, Judge Charles took care to highlight that

'authorisation of a detention under DOLS will not inevitably be less restrictive'¹⁴.

The DoLS process involves the hospital manager granting the unit an urgent authorisation to admit the patient and at the same time applying for a standard authorisation from the supervisory body (the local authority in England). This urgent authorisation requires one person to request it, rather than the recommendations of two Section 12 doctors and the agreement of an Approved Mental Health Practitioner.

The supervisory body then has 21 days to arrange the assessment. Compare that to the 7-day guidance for a Section 2 appeal. If the supervisory body goes on to make the authorisation, it can last up to 12 months, and, in the interim, review is at the discretion of the supervisory body and the hospital. The person subject to the authorisation can ask for a review, and legal challenges can be mounted through the Court of Protection, but these are expensive and long-winded routes.

The idea of introducing a tribunal-like system for DoLS was considered by the House of Lords in their Mental Capacity Act and DoLS review but they decided that an increased number of hearings would require the composition of the tribunals to be modified, risking loss of expertise and greatly increasing costs¹⁵.

Thus, is the Mental Capacity Act/DoLS path less restrictive than the Mental Health Act, with its time-limited detentions, right of appeal and relatively easy access to First

¹⁴ *AM v. (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health* [2013] UKUT 0365 (AAC) para. 68(ii) [<http://www.bailii.org/cgi-bin/markup.cgi?doc=/uk/cases/UKUT/AAC/2013/365.html>]

¹⁵ Select Committee on the Mental Capacity Act 2005. *Mental Capacity Act 2005: post-legislative scrutiny*. (HL 2013-14 139) [<http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm>]

Tier Tribunals and Managers' Hearings? It is far from inevitable that DoLS is less restrictive than the Mental Health Act.

The rapidly deteriorating patient who lacks capacity is also of concern. If he is admitted informally to an acute in-patient ward – as a purported 'least restrictive option' – what happens if he becomes unsafe in the open ward environment? To be transferred to a Psychiatric Intensive Care Unit (PICU), a patient must be detained under the Mental Health Act¹⁶. Waiting for a Mental Health Act Assessment prolongs the time spent by the person in an unsafe environment, with unnecessary danger to himself, other patients and staff. In my service evaluation, I identified 6 patients who proceeded rapidly to PICU from an informal admission, 4 within 24 hours of admission.

VII. CONCLUSIONS

With legislative emphasis on the 'least restrictive option', assessing healthcare teams consider avoiding use of the Mental Health Act is the least restrictive route. However, with the reluctant, capacitous patient or the non-capacitous, compliant patient, this may not be the case in actuality.

For the capacitous patient who wants to leave, the responsible clinician must be confident that consent is truly informed and the right to leave more than a 'fairy tale' for informal admission to avoid an unlawful deprivation of liberty. For the non-capacitous, compliant patient, the Mental Capacity Act and DoLS path can only be considered the least restrictive option once the Mental Capacity Act and DoLS have a robust appeal and review framework and the potential need for PICU has been negated or appropriately addressed. The Law Commission's consultation on DoLS suggest that it is not fit for purpose and are proposing replacing the system with 'Protective Care'¹⁷, which may provide a framework that is less restrictive than the Mental Health Act in actuality rather than in theory.

Assessment under the Mental Health Act in these complex cases may, in fact, be the least restrictive option and in the person's best interests.

¹⁶ Department of Health. *Mental Health Policy Implementation Guide, National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*. TSO (The Stationary Office), 2002. [<http://napicu.org.uk/wp/wp-content/uploads/2013/04/2002-NMS.pdf>]

¹⁷ Law Commission. *Mental Capacity and Deprivation of Liberty, A Consultation*. TSO (The Stationary Office), 2015. [http://www.lawcom.gov.uk/wp-content/uploads/2015/07/cp222_mental_capacity.pdf]

NO LONGER 'ANOMALOUS, CONFUSING AND UNJUST': THE MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016

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I. INTRODUCTION

Northern Ireland is a distinct legal jurisdiction which is one of the four countries of the United Kingdom (Dickson, 2013). It is a small jurisdiction in the north east corner of the island of Ireland. In 2015 its population was estimated to be 1,851,600, which is about 30% of the island's total population and about 3% of the UK's population (Office of National Statistics, 2016). Since 2002 there has been a broad and extensive process to develop new legislation relating to mental health and mental capacity which is of interest as it represents a new departure in terms of such legislation. The Mental Capacity Act (Northern Ireland) 2016¹ legislates a fusion approach to mental capacity/mental health law (Dawson & Szmukler, 2006; McCallion & O'Hare, 2010). The provisions of the Act apply in general to people who are aged 16 and over and it goes beyond a proposed 'model law' of the fusion type in that it incorporates criminal justice provisions (Szmukler, Daw & Dawson, 2010).

This article provides an overview of the process of development of the Mental Capacity Act (Northern Ireland) 2016. The Act has its origins in the Recommendations of the Bamford Review of Mental Health and Learning Disability which are considered first. The publication of these recommendations was followed by an extended policy development process which is discussed next. Following an overview of the contents of the Act, key issues which emerged during the policy development and legislative processes are outlined.

II. THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY

The Bamford Review of Mental Health and Learning Disability was established in 2002 to look at the law, policy and provisions which affect people with mental health needs or a learning disability in Northern Ireland.² The inclusiveness of the Bamford Review has helped ensure that the voices of the most important drivers for reform were given priority—the voices of users of services and their carers. The review completed its task in 2007 with the publication of its report on legislative reform.³ Its call was for 'a holistic person-centred approach, which is respectful of the individual and delivered in a way that avoids stigma; services should be 'Recovery'

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¹ The Act and its Explanatory Memorandum are available at: <http://www.legislation.gov.uk/nia/2016/18/contents/enacted>

² Information about the work of the Bamford Review, who was involved and copies of its Reports are available at: <http://www.dhsspsni.gov.uk/bamford.htm/>

³ Bamford Review of Mental Health and Learning Disability (2007). A Comprehensive Legislative Framework. This is available (along with an Executive Summary and an Easy Read Summary) at: <http://www.dhsspsni.gov.uk/index/bamford/published-reports/cl-framework.htm>

focused...to empower people to achieve their potential and lead a fulfilling life.’ (Bamford Review, 2007: 8).

The proposed ‘Comprehensive legislative framework’ for mental health and learning disability provided a vision for reform of mental health legislation which indicated clear directions such reform should take. In Northern Ireland the current mental health legislation is the Mental Health (Northern Ireland) Order 1986.⁴ The Order is essentially traditional mental health legislation with provisions for detention and compulsory treatment in hospital and for guardianship.⁵ Entry to its powers is through ‘mental disorder’ and risk of harm criteria. ‘Mental disorder’ is defined at Article 3(1) as ‘mental illness, mental handicap and any other disorder or disability of mind’. There are certain exclusions from the definition of ‘mental disorder’ at 3(2): ‘personality, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.’ The ‘mental disorder’ also has to be ‘of a nature or degree which warrants his [sic] detention in a hospital for assessment (or for assessment followed by medical treatment)’ (Article 4(2)(a)). The risk criterion is set out in 4(2)(b) and is that ‘failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons.’ There is a short Code of Practice for the Order.⁶ The Review saw shortcomings in the Mental Health (Northern Ireland) Order 1986 and recommended a new approach (Bamford Review, 2007). Northern Ireland has not had mental capacity legislation in place alongside the Mental Health Order, with capacity law remaining at common law. The Bamford Review saw an opportunity for both service modernisation and law reform in a comprehensive manner and these two reform processes were seen as intrinsically linked (Bamford Review, 2007).

Taking a social model approach to mental disabilities, the Review recognised that people with mental health difficulties or a learning/intellectual disability ‘experience a range of barriers which prevent them from exercising their rights’ (Bamford Review, 2006: 11). One of the barriers identified relates to presumed lack of capacity:

Assumptions are often made by others about the capacity of people with mental health difficulties or a learning disability to participate in or contribute to the life of their community, or to make decisions. These assumptions are often due to ignorance and prejudice, arising from a lack of information and understanding about mental health or learning disability. (Bamford Review, 2006: 1)

Rather than recommending new mental health legislation with separate mental capacity legislation, as was the approach taken in England and Wales⁷ and in Scotland⁸, the Review sought a comprehensive approach which avoided the complexity of multiple legal options in addressing similar situations:

⁴ Mental Health (Northern Ireland) Order 1986. Available at: <http://www.legislation.gov.uk/nisi/1986/595>

⁵ For an overview of the Mental Health (Northern Ireland) Order see White (2004) Chapter 11.

⁶ Code of Practice available at: http://www.gain-ni.org/flowcharts/downloads/mental_health_order_1986_code_of_practice.pdf

⁷ Mental Health Act 1983 (as amended) <http://www.legislation.gov.uk/ukpga/1983/20/contents>; Mental Capacity Act 2005 <http://www.legislation.gov.uk/ukpga/2005/9/contents>

⁸ Mental Health (Care and Treatment) (Scotland) Act 2003 <http://www.legislation.gov.uk/asp/2003/13/contents>; Adults with Incapacity (Scotland) Act 2000 <http://www.legislation.gov.uk/asp/2000/4/contents>

The key proposal for statutory reform is that Government should adopt a coherent and co-ordinated approach to legislative provision. This should be through the introduction of comprehensive provisions for all people who require substitute-decision-making. A single legislative Framework is proposed for interventions in *all* aspects of the needs of people requiring substitute decision-making, including mental health, physical health, welfare or financial needs. (Bamford Review, 2007: 53)

The Bamford Review focused firmly on human rights and equality concerns (Bamford, 2006):

A rights-based approach is proposed as the guiding principle for reform of legislation which should respect the decisions of all who are assumed to have capacity to make their own decisions. Grounds for interfering with a person's autonomy should be based primarily on impaired decision-making capacity. New legislative solutions are, therefore, required for issues posed by the effects of disorder of the brain or mind on an individual's decision-making capacity and which affects his/her own personal health, the need for care and treatment, safety and the welfare or the safety of others. (Bamford Review, 2007: 26)

The Review understood the foundation for such an approach as being well-established principles of human rights and equality which had not previously been fully applied to people with mental disorder or a learning disability. 'Justice', one of the foundational principles articulated in the Review, required non-discrimination:

persons with a mental disorder or a learning disability should retain the same rights and entitlements as other members of society. (Bamford, 2007: 37)

Central to the Bamford proposals for legislative reform is the repeal of separate and discriminating mental health legislation. The Review concluded that 'having one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust' and so '...the Review considers that Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory.' (Bamford, 2007: 36).

The proposals of the Bamford Review were thus for a form of 'fusion' legislation (Dawson & Szmukler, 2006) which combines respect for decision-making capacity where it exists, regardless of whether an individual has a physical or mental health issue. The basic principle of respect for decision-making autonomy should equally apply for decisions relating to mental health care and treatment. This principle of non-discrimination, or of equal respect for the dignity and rights of an individual, should also extend to decisions to deprive someone of their liberty. The Review envisaged legislation which did not create a 'double-standard' for people with mental health issues or a learning disability.

III. THE DEVELOPMENT OF THE MENTAL CAPACITY (NORTHERN IRELAND) ACT 2016

Following the conclusion and recommendations of the Bamford Review, an extensive process of detailed policy formation followed. The Review had recommended that the proposed legislative framework be applicable to all people in society, including those subject to the criminal justice system (Bamford, 2007). The

policy formation process thus involved the Department of Health, Social Services and Public Safety (DHSSPS)⁹ and the Department of Justice (DoJ)¹⁰.

Considerable time was been taken in the development of the new legislative framework. Building on the inclusive approach taken in the Bamford Review, the development of the Act has benefited from extensive engagement with a wide range of civil society actors and this is a key reason for the length of time taken.

The Northern Ireland government generally accepted the recommendations of the Review, but a further period of policy development was necessary before it was generally accepted that the specific legislative proposals delivered on the Bamford vision. The initial response of the Northern Ireland Executive to the recommendations of the Bamford Review was a proposal for two separate pieces of legislation dealing with mental health and mental capacity respectively, along the lines adopted in other UK jurisdictions (DHSSPS, 2008). The proposal was to amend the Mental Health (Northern Ireland) Order 1986 and to introduce new capacity legislation. This 'parallel' approach was that recommended in the DHSSPS public consultation on policy proposals in 2009 (DHSSPS, 2009a). In the light of responses to the consultation, which overwhelmingly supported the Bamford Review's recommendation for a single Bill approach, the Minister for Health, Social Services and Public Safety committed to the development of a single Bill (DHSSPS, 2009b: 27).

Following on from the Good Friday Agreement, the devolution of justice powers from Westminster to Northern Ireland was only carried out in 2010 which meant that work on the criminal justice policy provisions got underway at a later date than those within the remit of DHSSPS. Following consultation (DoJ, 2012) and equality screening (DoJ, 2013), the Department of Justice decided to include those subject to the criminal justice system within the scope of the proposed new framework. In May 2014, a public consultation was launched on draft civil provisions (along with an updated Equality Impact Assessment) and on policy proposals on the criminal justice aspects of the Bill.¹¹

In addition to formal public consultation, both DHSSPS and DoJ ran Legislative Reform Reference Groups to engage with key stakeholders throughout the policy development process. The DHSSPS 'Mental Health and Mental Capacity Reference Group' ran over 16 meetings in the policy development phase from October 2009 until drafting work on the Department's policy positions started to take precedence over the development of policy positions. The Department of Justice conducted a similar engagement exercise once it started its work on the Bill. The DoJ 'Mental Capacity Legislation and Criminal Justice System Project Reference Group' met five times between January 2012 and January 2014.

⁹ See DHSSPS website at <http://www.dhsspsni.gov.uk/>

¹⁰ See DoJ website at <https://www.dojni.gov.uk/>

¹¹ The Consultation Document, Annex A with the Draft Mental Capacity Bill (Civil Provisions) and the Summary of Responses received are all available at: <http://www.dhsspsni.gov.uk/showconsultations?txtid=68523>. The full set of consultation responses received are available at: <http://www.dhsspsni.gov.uk/index/consultations/mental-capacity-bill-responses-2014.htm>

The Mental Capacity Bill entered the Northern Ireland Assembly on 8 June 2015. The text of the Bill as introduced to the Assembly¹² and the accompanying Explanatory Memorandum¹³ are available on the Assembly Website. The Second Stage plenary debate of the general principles of the Bill took place on 16 June 2015.¹⁴ An Ad Hoc Joint Committee to Consider the Mental Capacity Bill was established on 15 May 2015 to consider the Bill.¹⁵ The Ad Hoc Committee received written submissions over the summer of 2015¹⁶ and through September and October 2015 took oral evidence on the Bill from a wide range of groups¹⁷. The Ad Hoc Committee agreed its Final Report¹⁸ on the legislation on the 25th of January 2016 with the Bill then returning to the Assembly. It completed its Final Stage on 15 March 2016¹⁹ and received Royal Assent on 9 May 2016.

Throughout the policy development process a series of key issues attracted substantial debate. Such issues were often initially formulated within the Departmental Reference Groups and then expanded upon in written and oral evidence to the Ad Hoc Committee. Key issues included:

- The recurring use of mental disorder (as out of keeping with the fusion approach);
- The possible separation of processes by type of decision (e.g. having separate authorisation processes for mental health and physical health);
- Professional roles (whether health professionals beyond doctors and social workers should be able to fill key roles within the Bill);
- Independent advocacy (what constitutes effective independence and whether an independent advocate should be involved in forming best interests decisions);
- Inclusion of clauses on advance decisions in the Bill (including the implications of providing a statutory basis for binding advance decisions with respect to mental health treatment);

¹² See <http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity---as-introduced.pdf>

¹³ <http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity-bill---efm---as-introduced.pdf>

¹⁴ The Official Report of this debate is available at: <http://aims.niassembly.gov.uk/officialreport/report.aspx?&eveDate=2015/06/16&docID=238200>

¹⁵ The archived material relating to the work of the Ad Hoc Committee is available at: <http://www.niassembly.gov.uk/assembly-business/committees/archive/ad-hoc-joint-committee-to-consider-the-mental-capacity-bill/>. It was a joint Committee made up of members of the Committee for Health, Social Services and Public Safety and the Committee for Justice.

¹⁶ The written submissions are available at: <http://www.niassembly.gov.uk/assembly-business/committees/archive/ad-hoc-joint-committee-to-consider-the-mental-capacity-bill/written-submissions/>

¹⁷ The Minutes of Evidence are yet to become available.

¹⁸ The Report of the Ad Hoc Committee raised five key issues: the lack of codification of advance decisions within the Bill; the complete replacement of Enduring Powers of Attorney by Lasting Powers of Attorney; the conditions for detention under a Public Protection Order; the extent to which the Department was granted power to make further provision by secondary legislation; and the lack of certainty that resources will be made available to meet implementation costs. The Report is available at: <http://www.niassembly.gov.uk/globalassets/documents/ad-hoc-mental-capacity-bill/report-on-the-mental-capacity-bill.pdf>

¹⁹ See Report on the Final Stage at: <http://aims.niassembly.gov.uk/officialreport/report.aspx?&eveDate=2016/03/15&docID=263222#2103963>

- The application to the criminal justice system (particularly whether a capacity-based approach can sufficiently protect public safety);
- The lack of engagement by key stakeholders (whether the Bill has been sufficiently formed by the perspectives of physical health professionals);
- The compliance of the Bill with the UN Convention on the Rights of Persons with Disabilities; and
- The inclusion of children under 16 within the provisions of the Bill.

IV. OVERVIEW OF THE CONTENT OF THE ACT

The Mental Capacity Act (Northern Ireland) 2016 is one of the largest and most complex pieces of legislation to have been passed by the NI Assembly. The Act has 15 Parts consisting of 308 sections and 11 Schedules. The Act contains around 100 enabling powers for either the DHSSPS or the DoJ, to introduce subordinate legislation. It is clear that extensive secondary legislation is required, although this is still in development and it is not yet entirely clear yet what form this will take.

Part 1 of the Act sets out the key principles which must be complied with where a determination has to be made as to whether a person lacks capacity (sections 1(2)-(5) and also the principle that where a substitute decision is being made, that it must be in the best interests of the person who lacks capacity (sections 2 and 7). There is also a definition of the meaning of lack of capacity. Lacking capacity as defined in clauses 3 and 4 is, in general, the only gateway into the provisions of the Act.²⁰ These principles and definition largely match those of the England and Wales Mental Capacity Act 2005, as was proposed by the Bamford Review (Bamford, 2007). Clause 1(4) requires that a person is not to be treated as lacking capacity ‘unless all practicable help and support to enable the person to make a decision about the matter have been given without success’. This is then amplified by section 5, ‘Supporting person to make decision’, which specifies the steps which must be taken

²⁰ The exception is when the Court makes a ‘Public Protection Order’ (Sections 167 to 173) which is a Court power (which does not require a lack of capacity to be present) to detain people who are not culpable for their actions, but cannot be released because they pose a danger to others. This Court power only exists where a person is convicted of an offence punishable by imprisonment. Such an Order requires that the person convicted of the offence be admitted to and detained in an appropriate establishment, which is a hospital or care home. The core requirements that must be met for a Public Protection Order as laid out in Section 168(2) are:

- “(a) that there is an impairment of, or a disturbance in the functioning of, the offender’s mind or brain;
- (b) that appropriate care or treatment is available for the offender in the establishment;
- (c) that dealing with the offender in any way not involving his or her detention would create a risk, linked to the impairment or disturbance, of serious physical or psychological harm to other persons; and
- (d) that detaining the offender in the establishment in circumstances amounting to a deprivation of liberty would be a proportionate response to—
 - (i) the likelihood of the harm concerned; and
 - (ii) the seriousness of that harm.”

Decision-making with respect to health and welfare for those subject to a Public Protection Order remain subject to the core provisions of the Act. Such an Order does not in itself serve a health interest, but rather seeks to serve a public protection interest. Thus, in Northern Ireland it has indeed proven the case that a measure primarily aimed at reducing harm was necessary as ‘a basis for society to take action’ even within a fusion law. (Gledhill, 2010). However, such circumstances are extremely limited and there is not universal agreement on the need for the Public Protection Order in practice nor on its acceptability in principle

for the purposes of section 4(1). This section thus provides detail on the face of the Act of the support which must be provided before a finding of a lack of capacity can be made. The 'support principle' has the potential to be a central and progressive aspect of the new legislative framework and provides the opportunity for the evidence based for the range of possible supports to be further explored (Davidson et al., 2015). The Act both accepts a necessary connection between mental capacity and legal capacity and requires support for decision-making capacity to ensure that legal capacity is not unduly restricted. It does not simply adopt a substitute decision-making approach over a supported decision making approach, but rather sees support for decision-making as being necessary precisely because a person may lack the mental capacity to make a particular decision.

Part 2 of the Act lays out the core of the legislation which is the availability of a possible protection from civil and criminal liability for an intervention or substitute decision if certain conditions are met. Unlike the Mental Health (Northern Ireland) Order 1986 which conferred powers on substitute decision makers, the Act does not in general do so. Acts have the potential to be lawful through the availability of a defence; they are not lawful because they involve the exercise of a legal power. The Act puts the common law doctrine of necessity into the statute. For certain **kinds of intervention**, or in certain **circumstances**, one or more of a set of additional safeguards must also be in place for the defence to be available. The 'additional safeguard provisions' of Part 2 relate to:

- Conditions for any act of restraint (section 12);
- Formal assessment of capacity (sections 13 & 14);
- Consultation with nominated person (section 15);
- Second medical opinion required for certain treatment (section 16-18);
- Independent advocate must be in place (section 35-36);
- Authorisation by a Health and Social Care Trust of certain interventions (section 19-23); and
- Right to review of such an authorisation by a Tribunal (section 45-51).

The basic approach of the Act seeks to legislate for a 'hierarchy' of interventions where the more serious the intervention, the more significant the safeguards which must be in place to protect the rights and interests of the person who lacks capacity. In practice this means the more serious the intervention, the more onerous the obligations on a substitute decision maker should they wish to have available the possible protection from liability enacted in clause 9. The key distinction with respect to the **kind** of intervention is whether the intervention is a 'serious intervention'. The Act defines this pivotal concept of a 'serious intervention' in section 60(1) and (2) as follows:

- 63.—(1) In this Part "serious intervention" means an intervention in connection with the care, treatment or personal welfare of P which (or any part of which)—
- (a) consists of or involves major surgery;
 - (b) causes P serious pain, serious distress, or serious side-effects;
 - (c) affects seriously the options that will be available to P in the future, or has a serious impact on P's day-to-day life; or
 - (d) in any other way has serious consequences for P, whether physical or non-physical.
- For all serious interventions the required safeguards are: a formal assessment of capacity; the involvement of the nominated person; and, for certain interventions, a second opinion.

There are also specific serious interventions which require the additional safeguard of authorisation by a panel. These include where the 'nominated person' is objecting to the intervention; any deprivation of liberty; and the imposition of an attendance or community residence requirement.

Part 3 makes further provisions relating to the role and appointment of nominated persons and Tribunal powers with respect to nominated persons. This role replaces the role of nearest relative who, under the current Mental Health (Northern Ireland) Order 1986, was identified through a set order of relatives, and was able to act as applicant for compulsory admission. The previous role created concerns about: nearest relatives' knowledge and understanding of the law; the implications for the future relationship between the applicant and the service user; and the potential additional distress for those involved. The new role does not involve acting as applicant for compulsory admission and allows the person to nominate the person they would like to be involved although how this will be done in practice has yet to be detailed. If a nominated person is not in place then the default will still be the nearest relative.

Part 4 lays out when an independent advocate must be in place, procedures for their instruction and obligations on Health and Social Care Trusts to make provision for such advocates. It had been hoped that Northern Ireland might follow Scotland and create a duty to provide independent advocacy for all using services but the statutory duty in this Act is restricted to those subject to interventions that require authorisation.

Currently in Northern Ireland there is a system of Enduring Power of Attorney which relates to decisions about finances.²¹ Part 5 provides for a Lasting Power of Attorney which will include decisions on health and welfare matters in addition to financial decisions.

Part 6 of the Bill covers the powers of the High Court to make decisions and to appoint deputies as substitute decision makers. Part 7 makes provision for the creation of a Public Guardian to maintain registers of Lasting Powers of Attorney and Court appointed Deputies and to supervise Deputies. Part 8 makes provisions relating to research involving people who lack capacity to consent to participate in it. It clarifies what general safeguards from the Bill must be in place and provides for specific safeguards in research situations.

Part 9 retains powers for police officers to remove a person from a public place to a 'place of safety' where the person appears to be in immediate need of care or control. The conditions for the police powers are now that the person is unable to make the relevant decision about going to a place of safety, it would be in their best interests, failure to do so would create a risk of serious harm and removal is a proportionate response. The purpose of the police powers are to enable examination by a medical practitioner and interview by an Approved Social Worker. The maximum period of detention has been reduced from 48 to 24 hours.

²¹ Enduring Power of Attorney (NI) Order 1987. Available at: <http://www.legislation.gov.uk/nisi/1987/1627/contents>

Part 10 of the Act creates court disposals to send persons on remand and convicted offenders to healthcare facilities for medical treatment. The general approach of the Act in terms of respecting decision-making capacity with respect to healthcare decision-making will continue to apply even in the circumstances of these court disposals.

Part 11 covers transfer of persons who are deprived of their liberty in a hospital between UK jurisdictions and a power to create regulations for transfers, including to and from jurisdictions outside the UK. Part 12 Provides for additional safeguards for children subject to the Act and the Mental Health (Northern Ireland) Order 1986 which is being retained and amended for children under 16. (See section 5 below.) Part 13 sets out offences specific to the Act. Part 14 sets out miscellaneous provisions, including giving effect in Northern Ireland to the Hague Convention on the International Protection of Adults. Finally, Part 15 makes provisions relating to codes of practice and other matters.

The Act also has 11 Schedules which provide some more detail about implementation. These include Schedule 2 which sets out the process for authorisation for short-term (up to 28 days, which is an extension of the current 14 days) detention in hospital.

V. KEY ISSUES ARISING IN THE DEVELOPMENT OF THE ACT

There was an extended and somewhat diffuse process over 14 years (from the commencement of the Bamford Review), involving sustained work on the part of many stakeholders, in getting to the point where legislation was actually introduced to the NI Assembly. In contrast, the available legislative timetable of nine months proved to be a challenging one, especially given the ongoing specific political challenges faced by Northern Ireland as a post-conflict society. In particular, there were two key contentious issues which emerged in the policy development process which also posed challenges for the enactment of the Bill.

A. Human Rights

The initial discussions around the reform of the Mental Health (Northern Ireland) Order 1986 took place very much in a context of concern for human rights and the need for new legislation to not only comply with human rights standards, but to promote them and be a model of best practice. (Davidson et al., 2003; Bamford, 2006). In 2008 the United Nations Convention on the Rights of Persons with Disabilities came into force and the United Kingdom ratified the Convention in 2009. As Bartlett (2009) has highlighted, a major implication of the UNCRPD, as set out in Article 14, is that disability, including mental disability, should no longer be a criterion for detention as it is in most mental health laws including the current Mental Health (Northern Ireland) Order 1986. One of the drivers for the new Act was to develop a law which no longer discriminated against those with any form of mental health problems and/or intellectual disabilities. The implications of the Convention were discussed extensively in the DHSSPS Reference Group, initially with a focus on the requirement for support for decision-making capacity. With the publication by the Committee on the Rights of Persons with Disabilities of its General Comment No. 1

on article 12 of the Convention on Equal Recognition before the Law (2014)²², the debate shifted with increasing questioning of the substantive compatibility of the Bill with the approach of the Convention and thus with human rights standards. However, the literature also contains cogent arguments which see great difficulties in the interpretation of the Convention being put forward by the Committee and suggestions that a more realistic approach is needed (Freeman et al., 2015; Dawson, 2015).

There is not space in this general article to engage with these issues in the depth they require²³, but several comments can be made about the proper context for any such assessment:

- To date, debate about the human rights implications of the Northern Ireland law reform process have focused almost exclusively on the UNCRPD (McSherry, 2015). However, the NI Act does not just apply to persons with disabilities and thus assessment of its compliance with international human rights law requires that it be viewed in the context of the human rights system as a whole, including the European Convention on Human Rights as the relevant regional instrument. Fennell and Khalqi (2011) have highlighted some of the potential conflicts between the UNCRPD and the European Convention on Human Rights although these have yet to be tested.
- The focus of debate has also been narrow in a further respect in terms of being conducted almost exclusively with respect to article 12 of the UNCRPD. (Flynn, 2013) However, the correct interpretation of article 12 can only be established in the context of that broader set of human rights treaties and the jurisprudence they have generated.
- Article 12 has been presented as containing a new paradigm which wholly rejects substitute decision making. However, the text of the article itself is clear that it envisages no such shift. This is clearly seen in the use of 'reaffirm' and 'recognise' in articles 12(1) and 12(2) respectively.²⁴ An interpretation of article 12 which sees it as requiring a 'paradigm shift' continues to be consistently rejected by the State Parties to the UNCRPD.²⁵

It is only on the basis of a debatable interpretation of the UNCRPD, and in particular of its article 12, that the Northern Ireland Act seems incompatible. With the United Kingdom now expected to be examined by the UN Committee on the Rights of Persons with Disabilities in 2017, it is likely that the compatibility of the Act with human rights standards will continue to be a matter of deep dispute.

²² Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>

²³ See Colin M Harper, "The Mental Capacity Act (Northern Ireland) 2016 and the human rights of people with intellectual disabilities". *Advances in Mental Health and Intellectual Disabilities* (Forthcoming, 2017).

²⁴ Art. 12/ 1. "States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law."

Art. 12/2. "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."

²⁵ See the reservations and interpretative declarations entered by State Parties to the UNCRPD available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=en. Most recently, that entered by the Netherlands on its ratification on 14 June 2016: "Article 12. The Kingdom of the Netherlands recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Furthermore, the Kingdom of the Netherlands declares its understanding that the Convention allows for supported and substitute decision-making arrangements in appropriate circumstances and in accordance with the law. The Kingdom of the Netherlands interprets Article 12 as restricting substitute decision-making arrangements to cases where such measures are necessary, as a last resort and subject to safeguards."

B. Children under 16 years old

Concerns about the impact of the reform of mental health law on children and young people in Northern Ireland were expressed at an early stage, mainly with respect to insufficient attention being given to the requirements of the UN Convention on the Rights of the Child and to the need for appropriate services (Niwa, 2007). Whilst this early commentary was supportive of the fusion approach, the Act as passed does not in general apply to children under 16. The Bamford Review had suggested that consideration might be given to a rebuttable presumption of capacity between 12 and 16 (Bamford Review, 2007). However, the lobby from the children's sector was focused on the full inclusion of children under 16 in the Bill, rather than calling for the more limited Bamford proposal. In the absence of substantive legal reform for under 16s, the Mental Health (Northern Ireland) Order 1986 is being retained and proposed amendments to this are contained in Part 12 and Schedule 12 of the Act. It is clear that the concerns about the discriminatory nature of the Mental Health Order expressed by the Bamford Review have not yet been addressed by the law reform process. In many ways the legal situation of younger children has not yet received the attention it deserves in discussions of the fusion approach to mental health law.

VI. CONCLUSION

The Mental Capacity (Northern Ireland) Act 2016 legislates one potential approach to fusing mental health and mental capacity legislation. The process of its development has been inclusive and the small size of the jurisdiction has meant that it has perhaps been easier to establish and maintain good working relationships amongst key stakeholders over a sustained period through the Bamford Review, the Mental Health and Learning Disability Alliance and the Departmental Reference Groups. There is no doubt that taking about 12 years to get a full draft of the legislation to the Assembly has helped ensure continuing broad support for the majority of policy positions taken. Northern Ireland has also benefited from very substantial investment from the Atlantic Philanthropies Foundation in policy work in the areas of mental health and the human rights of people with disabilities which has undoubtedly helped to build expertise and sustain engagement over the period of development of the Act. With policy development coming a sufficiently long time after legislation had been enacted in England and Wales and in Scotland has meant that Northern Ireland has been able to learn from the experience of these jurisdictions. The coming into force of the UN Convention on the Rights of Persons with Disabilities has reinforced a proper focus on the need for legislation to be progressive in human rights terms and in particular has drawn attention to the need to legislate for support for decision-making and to seek to ensure proportionate respect for the wishes of a person who has been found to lack capacity.

One of the conclusions of the recent House of Lords post-legislative scrutiny of the England and Wales Mental Capacity Act 2005 was:

We acknowledge the wide-spread support which the Act enjoys among stakeholders. It is described in unusually enthusiastic language. It is disappointing therefore that the implementation of the Act has yet to receive the same acclaim. (House of Lords, 2014: 50)

Challenges to full and effective implementation of the Northern Ireland Act remain, the more so in that it represents the first attempt at implementing a fusion approach. The NI Assembly Research Service has published a series of reports which seek to critically analyse estimates of the cost of implementing the Bill, with particular consideration given to the likely costs of training staff across the criminal justice and health and social care sectors and the costs of implementing the safeguards the Act requires for deprivations of liberty.²⁶ Concern about the cost of implementing the Act has also been expressed by the Ad Hoc Committee. It is not yet clear what implications cost considerations will have for the implementation of the Act. Whether the Committee will seek to amend the legislation to make it less costly to implement and whether this can be done in a manner which does not undermine the principles of the legislation or the effectiveness of its safeguards remains to be seen.

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²⁶ These reports are available at: <http://www.niassembly.gov.uk/assembly-business/committees/ad-hoc-committee-to-consider-the-mental-capacity-bill/research-papers/>

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