

Article

The Exercise of Legal Capacity, Supported Decision-Making and Scotland’s Mental Health and Incapacity Legislation: Working with CRPD Challenges

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Abstract: Article 12 of the UN Convention on the Rights of Persons with Disabilities, particularly as interpreted in the Committee on the Rights of Persons with Disabilities General Comment No. 1, presents a significant challenge to all jurisdictions that equate interventions permitted under their mental health and incapacity laws with mental capacity. This is most notable in terms of the General Comment’s requirement that substitute decision-making regimes must be abolished. Notwithstanding this, it also offers the opportunity to revisit conceptions about the exercise of legal capacity and how this might be better supported and extended through supported decision-making. This article will offer some preliminary observations on this using Scottish mental health and incapacity legislation as an illustration although this may also have relevance to other jurisdictions.

Keywords: Article 12 CRPD; exercise of legal capacity; supported decision-making; will and preferences; human rights; Scottish legislation

1. Introduction

One of the World Health Organisation’s (WHO) *Mental Health Action Plan 2013/2020* Global Targets is that by 2020 fifty per cent of states will have developed or updated their mental health laws in line with international and regional human rights instruments ([1], pp. 8, 12, 20). Given that internationally identified human rights standards remain aspirational only unless they are implemented nationally these

objectives are welcome. The realisation of such objective is, however, clearly not without a number of different challenges.

The *Action Plan* specifically mentions the United Nations Convention on the Rights of Persons with Disabilities (CRPD) ([1], p. 10). A particular challenge that arguably affects all jurisdictions is that presented by recent interpretation by the Committee on the Rights of Persons with Disabilities (the Committee) of the right to equal recognition before the law identified in Article 12 UN Convention on the Rights of Persons with Disabilities (CRPD) in its General Comment No.1 [2]. Its reaffirmation that legal capacity is a universal attribute and all, regardless of disability, have an equal right to legal capacity at all times. This has far reaching implications for mental health and incapacity laws that justify the use of involuntary measures on the basis of mental capacity [3].

What is particularly unique about the situation is that it also confronts those jurisdictions that pride themselves in adopting a broad interpretation of personal freedom even when limitations of such freedom is considered to be legitimately. Scotland, as a devolved region within the United Kingdom, falls within this category.

This article will note some aspects of the developing discussion surrounding Article 12 CRPD, particularly as interpreted by the General Comment [4]. Its purpose is not, however, to provide a comprehensive critique of this. Nor is it to second guess the outcome of the Committee's review of the United Kingdom's (including Scotland's) compliance with the CRPD, following submission in 2013 of its first periodic report under the treaty [5]. It will instead proceed from the position that, whatever opinion one may hold on Article 12 and the General Comment, they offer the opportunity to revisit existing conceptions of legal capacity and to consider how it might be more extensively exercised by persons with mental health issues. Using the broad framework of Article 12 and the General Comment it will make some preliminary observations about the extent to which it may be possible to maximise primacy for the will and preferences and respect for all the human rights of persons with mental health issues even within situations that are possibly more restricted than the General Comment advocates. To this end it will concentrate on Scottish mental health and incapacity legislation [6] although some elements of this may have relevance for other jurisdictions.

In order to place these observations in their proper context it is necessary to first look at Article 12 CRPD and the Committee's requirements regarding the exercise of legal capacity. This will then be followed by a discussion of the constitutional and human rights framework within which devolved Scottish legislation exists before, finally, a consideration of Scottish mental health and incapacity legislation and any support they identify to assist the exercise of legal capacity.

2. United Nations Convention on the Rights of Persons with Disability

The CRPD represents a marked departure from the approach adopted in previous human rights treaties, moving away from the traditional medical model of disability towards a more socially engaged and empowering model of disability. Often referred to as representing a "paradigm shift" in terms of its approach, the CRPD developed in response to the increasing awareness that, regardless of the universality of existing human rights instruments, "people with disabilities had not shared equally in the rights created by those treaties" ([7], p. 3; [8]).

In calling for international human rights protection, many persons with disabilities highlighted their persistent physical and symbolic exclusion from society ([9], p. 133). The CRPD thus endeavoured to address such “invisibility” [9] by proactively illuminating and reinforcing their status as subjects of rights. The issue of equal capacity identified predominantly in Article 12 is central to this as it is viewed as foundational to the exercise of other rights [10]. However, notwithstanding the consensus that a disability convention was needed, the drafting of Article 12 identifying the right to equal recognition before the law and thus the equal capacity of all was highly contentious [11]. The text ultimately adopted has also continued to be the source of much debate.

2.1. Article 12 CRPD—The Right to Equal Recognition before the Law

On initial reading, it is certainly arguable that Article 12 CRPD could be construed as not envisaging an entirely unrestricted right to exercise legal capacity. Article 12(1) reaffirms that persons with disabilities have the same right as everyone else to recognition before the law and Article 12(2) calls on state parties to “recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”. Article 12(3) goes on to direct states parties to take appropriate measures “to provide access by persons with disabilities to the support they may require in exercising their legal capacity” and Article 12(5) equality in terms of managing financial and property affairs. Article 12(4), however, might well be interpreted as recognising that the exercise of legal capacity may occasionally be limited in that it requires safeguards to ensure that the exercise of legal capacity respects:

“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.”

It became clear to the Committee that there was wide misunderstanding about what Article 12, and the CPRD, were seeking to achieve in pursuing the human rights-based model of disability ([2], para. 3). It therefore sought to clarify this in its General Comment although arguably with mixed success and significant debate has persisted concerning the scope and fitness for purpose of the General Comment interpretation of Article 12.

2.2. General Comment No. 1 (2014) Article 12: Equal Recognition before the Law

As already stated, the CRPD itself represents a marked change in approach to that of previous human rights treaties. However, the Committee’s General Comment interpreting Article 12 brought the issue of possession of legal capacity and its exercise into even sharper relief for persons with mental health issues.

The General Comment once again affirms the universality of the right to legal capacity, the need to actively protect this and support the exercise of legal capacity, as required by Articles 12(1) and 12(2). Moreover, it distinguishes between legal capacity, being the ability to hold rights and duties (legal standing) and exercising such rights and duties (legal agency), and mental capacity, being a person’s decision-making skills which vary according to the person and their situation ([2], para. 12). Noting that it is legal agency that is often denied or diminished in the case of persons with disabilities ([2], para. 12) it accordingly directs

that perceived or actual defects in mental capacity must not be used as justification to deny legal capacity ([2], paras. 12–13) thus invalidating the “status approach” to the removal of legal capacity ([2], para. 15). In the Committee’s opinion, to adopt such an approach is to constitute discrimination on the basis that such justification would not be employed in the case of others without perceived or actual mental impairment ([2], paras. 12–13). The functional approach to capacity is also therefore refuted for the same reason ([2], para. 12) despite its endorsement by the World Health Organisation and European Court of Human Rights ([12], pp. 39–40; [13]) and, as Lewis observes, its widespread use across Europe [14].

Noting the tendency to assess mental capacity in subjective and abstract terms, the Committee states:

“The concept of mental capacity is highly controversial in and of itself. Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.” ([2], para. 14).

Capacity is thus seen as a continuum meaning that legal agency must never therefore be denied on the basis of mental disability, an individual’s personal will and preferences only must be given effect and substituted decisions, including those made in that person’s best interests, are not permitted ([2], paras. 14–18 and 37–38).

In adopting this approach the Committee appears to endorse the personhood approach to legal capacity which favours the underpinning notions of dignity and equality—both of which terms are prevalent throughout the CRPD ([9], p. 136)—rather than ascribing value to an individual’s cognitive functioning, and recognises that the ability to control one’s life is difficult, if not impossible, where access to one’s legal capacity is denied or restricted ([15]; [16], pp. 136–37). Moreover, such recognition of personhood allows for diversity in decision-making and acknowledges that individuals rarely make decisions independently and that we are all to varying degrees influenced by our surroundings often looking to others to assist us with our decision-making [17]. The notion of personhood also encompasses the fact that little is understood about how exactly decisions are made and what influences our choices [15,18].

In furtherance of such primacy afforded to universal autonomy the Committee directs that laws permitting substitute decision-making (for instance, in the form of guardianship or trusteeship) and involuntary psychiatric treatment must be abolished ([2], paras. 22–24 and 36–38). It defines substitute decision making regimes as those that possess three main characteristics namely:

“...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 (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” ([2], para. 27).

Whilst this possibly requires formal clarification by the Committee, it would appear that it views these requirements as disjunctive, as opposed to conjunctive [19,20], which clearly considerably widens the scope for incompatibility with Article 12 of the laws of many, if not all, jurisdictions. If any more evidence is required of the paradigm shift represented by the CRPD this must be it given that no jurisdictions currently operate systems of supported decision-making which fully accord with these

requirements ([19]; [21], p. 139). However, as previously mentioned, despite this requirement to remove substitute decision-making regimes, the wording of Article 12(4) itself could equally be interpreted as implicitly permitting substitute decision-making within a framework of supported decision-making that respects the rights, will and preferences of the person. Nevertheless, the General Comment views substitute decision-making as antithetical to giving effect to an individual's will and preferences so as to enable them to fully exercise their legal capacity and actively promotes support for decision-making in recognition of its role in ([2], paras. 16–18).

3. Supported Decision-Making: Within or without a Framework?

Article 12, as interpreted by the General Comment, thus has the potential to radically transform and reform our understanding of disability and capacity ([21], p. 98) so that legal standing and legal agency are not separated ([2], para. 14) and no questions therefore arise as to an individual's ability to hold or exercise their right to legal capacity. Indeed, as Dhanda states:

“Fundamentally, there are two choices before humankind. One recognizes that all persons have legal capacity and the other contends that legal capacity is not a universal human attribute.” ([11], p. 457).

Whilst Dhanda clearly supports [11] the latter choice there is, at present, no general consensus amongst scholars and, indeed, human rights bodies on whether the former choice actually requires a universal acceptance of the complete absence of substitute decision-making regimes. Aligned to this is the role of supported-decision and where such support ought to be located and here there are two alternative approaches. On the one hand, and more in line with the Committee's explanation, supported decision-making can be conceptualised as “both a process and an end, which legally recognises the process of supporting decision making and the legal standing of decisions reached as part of this process” ([22], p. 37). On the other, provided respect for the will and preferences of the individual is placed at the centre of the decision-making process then the presence or absence of substitute decision-making regime is immaterial. However, we must be clear here and accept that whilst support increases participation this nevertheless occurs within a substitute decision-making framework ([22], pp. 36–37).

Support for this second alternative could be advanced on the premise that the CRPD requires the recognition of the right to legal capacity “on an equal basis with others” and this would permit removal of legal capacity if it applies to all persons *on an equal basis* ([23], p. 15). However, this is to deny the reality that persons with mental health issues tend to be disproportionately affected by laws that authorise the removal of legal capacity ([23], pp. 16–20). A perhaps more compelling endorsement of the second approach is the requirement to respect not only an individual's right to exercise their legal capacity but also their other rights. Indeed, it has been argued that to regard respect for legal capacity as being absolute would lead to inconsistencies with other CRPD provisions, namely the obligation for states parties to take measures to ensure the effective enjoyment of the right to life (Article 10, CRPD), and the obligation to take measures to ensure the protection and safety of persons with disabilities *in situations of risk* (Article 11, CRPD) ([23], pp. 38–40).

A More Holistic Approach to the Exercise of Legal Capacity?

It is therefore worth considering whether by moving away from an absolutist approach to the exercise of legal capacity to one that adopts a more holistic approach to the exercise of legal capacity and respect for human rights—an approach that prioritises respect for an individual’s will and preferences and for all of their human rights—such rights being interpreted in the least restrictive manner.

Support for such a contention can certainly be found in paragraph 29 of the General Comment which provides some accepted characteristics for supported decision-making. It commences with the statement:

“A supported decision-making regime comprises various support options which give primacy to a person’s will and preferences and respect human rights norms. It should provide protection for all rights, including those related to autonomy (right to legal capacity, right to equal recognition before the law, right to choose where to live, *etc.*) and rights related to freedom from abuse and ill-treatment (right to life, right to physical integrity, *etc.*)”

Article 29 also states that supported decision-making systems must not overregulate the lives of persons with disabilities and stipulates nine key provisions that are required to ensure compliance with Article 12. Essentially, such key components support the giving of primacy to a person’s will and preferences and respect for their human rights in the widest sense and, to this end, require universality of access to supported decision-making, that provision to such support should not hinge on assessments of mental capacity, an absence of best interests assessments and safeguards to ensure respect for will and preferences.

How would Scotland’s mental health and incapacity laws and available modes of supported decision-making achieve the objective of an alternative model seeking to give primacy to a person’s will and preferences and respect for their human rights in the broadest sense? In order to consider this it is pertinent to first appreciate the constitutional, human rights and legislative framework within which such laws operate.

4. Scotland: Policy, Legislation and Practice

4.1. Scotland’s Human Rights Framework

For Scotland the reflection of the CRPD in domestic law is not altogether straightforward. The United Kingdom has ratified the CRPD. It has also ratified the European Convention on Human Rights (ECHR). However, although it has obligations under international law under the CRPD and, owing to the absence of enabling legislation, it is not given legal effect within the United Kingdom.

By contrast the ECHR is given legal effect in Scotland through the Human Rights Act 1998 and Scotland Act 1998. Indeed, within Scotland not only must public authorities respect ECHR rights¹ (and the courts must interpret the law in accordance with the jurisprudence of the European Court of Human Rights² but devolved legislation of the Scottish Parliament and actions of the Scottish Government may be declared invalid if found to be ECHR incompatible³. It is also possible to prevent devolved Scottish legislation and actions of the Scottish Government where they are believed to be incompatible with the

¹ Human Rights Act 1998, s6.

² Human Rights Act 1998, s2.

³ Scotland Act 1998, ss29(1)(d) and 57.

United Kingdom's CRPD obligations but this is in the discretion of the United Kingdom government⁴. This presents difficulties because each of these treaties adopt somewhat different approaches to the recognition and exercise of legal capacity by each of these treaties.

The CRPD has the potential to influence the interpretation of ECHR rights, and thus have indirect effect within the United Kingdom (including Scotland) legal framework, in that the European Court of Human Rights must have regard to the CRPD as a higher source of international law. However, whilst there has been increasing reference to CRPD rights [24], including Article 12, in ECHR jurisprudence such reference has been somewhat cursory to date. Moreover, the fact remains that it is the ECHR, because of its formal incorporation within the legal framework, that takes precedence in Scotland and Scottish legislation must first and foremost reflect this.

4.2. The European Convention on Human Rights and Respect for Legal Capacity

The right to legal capacity is not expressly identified in the ECHR but its closest equivalent can be found in the right to respect for private and family life (Article 8(1)) to the extent that it has been interpreted as encompassing the right to respect for a physical and moral integrity and autonomy ([25], para. 46). Article 8 and its interpretation by the European Court of Human Rights is less expansive than the interpretation of Article 12 in the CRPD and by the Committee.

The European Court has found that a deprivation of legal capacity may amount to an interference with the right to private life in Article 8(1) ([23], para. 83; [26], para. 35; [27], para. 77) even where it is partial ([28], para. 144) and that measures removing legal capacity are “a serious interference” with a person’s private life” ([29], para. 102). There also appears to recently have been a discernible movement in the Court’s jurisprudence towards a stance that is not completely incompatible with the “paradigm shift” presented by the CRPD in relation to legal capacity. In addition, it has found that the indiscriminate and all-encompassing denial of legal capacity and the imposition of guardianship for persons with mental health issues violates Article 8 [13,29]. The Court has adopted the presumption of capacity approach and whilst this also encompasses the functional approach to the assessment of capacity [13] it has emphasised the requirement for proportionality when restricting this right ([28], paras. 140–43) and necessity for the presence, and strict following, of procedural safeguards in such situations ([26], para. 36). It acknowledges that, given the complexity of determining a person’s mental capacity, state authorities should enjoy a wide margin of appreciation given their direct contact with the individual but has stressed that stricter scrutiny is required where serious limitations to a person’s private life are contemplated ([28], para. 142; [26], para. 37; [30], para. 97). Moreover, similar to that noted in the General Comment, the Court has also acknowledged the consequences for the exercise of other rights resulting from the denial, even where it is partial denial, of legal capacity such as the rights to liberty (Article 5 ECHR) [13], inhuman institutional conditions (Article 3 ECHR) [31], proper access to the courts when attempting to restore one’s legal capacity (Article 6 ECHR) [32] and denial of the right to vote (Article 3, Protocol 1 ECHR) [33].

However, Article 8 does envisage limitations to the right to exercise legal capacity in that Article 8(2) permits the lawful and proportionate restriction of private and family life [34]. Despite what arguably

⁴ Scotland Act 1998, ss35 and 58.

appears to be an increasing vigilance regarding its limitation in the case of persons with mental health issues there is no suggestion this right is absolute.

In light of the aforementioned priority afforded to the ECHR within Scotland it would therefore appear that the environment would be most receptive to the holistic approach to the exercise of legal capacity suggested earlier.

5. Scottish Mental Health and Incapacity Legislation

Both the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and the Adults with Incapacity (Scotland) Act 2000 (AWIA) pre-date the UK's ratification of the CRPD. Both have been commended for their human rights based approaches ([35], p. 175) but even such legislation must constantly address developments in international human rights law.

Whilst apparently ECHR compatible each piece of legislation immediately run into General Comment difficulties. Both Acts adopt status-based approaches to the interventions—criteria for justifying interventions including a person being “incapable”⁵ or having significantly impaired decision-making ability by virtue of mental disorder⁶ and their respective underlying principles whilst promoting presumptions of capacity also adopt a functional assessment test. Additionally, and inescapably, both Acts authorise substitute decision-making regimes, namely involuntary psychiatric treatment and guardianship, that appear to fall within the definition of that outlawed by the General Comment ([2], para. 27). However, notwithstanding this, the extent to which the principles-based approach adopted by each Act and forms of support they identify (admittedly within the context of interventions being the consideration or effected) give primacy to the will and preferences of the individuals and respect for human rights of persons with mental health issues is worthy of consideration.

The Adults with Incapacity and Mental Health Acts and Underlying Principles

The AWIA and MHA both set out principles that must applied when interventions are being considered and effected. Such principles are based on recommendations in Scottish Law Commission and Millan Committee reports that preceded the introduction of each Act and are designed to ensure a person-centred and human rights compliant approach to such interventions [36,37].

Notably, both Acts highlight the requirement for intervention to the least restrictive option⁷ and for that any proposed measure must benefit the individual concerned⁸. A very definite decision was taken in the drafting of the AWIA to include the term “benefit” in preference to “best interests” on the basis of the Scottish Law Commission's opinion that “best interests” gives insufficient weigh to the adult's views, particularly their wishes and feelings expressed whilst they were capable of expressing them ([37], para. 2.50). Similarly, the Millan Report recommended that benefit be one of the MHA's underlying principles ([37], pp. 58–59). Moreover, the participation of the individual, insofar as this is possible, in the decision-making and implementation process is promoted in the requirement to taken into account

⁵ AWIA, s1(6).

⁶ MHA, ss36(4)(a), 44(4)(a) and 64(5)(a).

⁷ AWIA, s1(3); MHA, s1(4)(c).

⁸ AWIA, s1(2).

their present and past wishes and feelings⁹. The MHA also emphasises the need for the necessity for longer term treatment under a compulsory treatment order (in terms of preventing the mental condition from worsening or to alleviate its symptoms)¹⁰, non-discrimination and respect for diversity¹¹.

Although not included as a general principle in the AWIA directs that anyone responsible for implementing an intervention authorised under it must encourage the exercise and development of skills of the adult where reasonable and practical to do so AWIA, s1(5)). This been noted as “surely one of the most important statements of ethos underlying the [2000] Act” ([38], p. 229). In apparently recognising the interdependence and relational nature of capacity it could be regarded as means by which the adult is supported to exercise their legal capacity possibly even extending such exercise.

The requirement to adhere to the underlying principles of each piece of legislation, if implemented in accordance with the spirit of the legislation, play a role in maximising the autonomy of the individual concerned and their ability to exercise their legal capacity. However, what is unavoidable is the fact that whilst this may potentially result in avoidance of or delayed intervention there is no express statutory requirement in either Act to actively support the expression of the individual’s wishes and preferences in the decision-making process in advance of the intervention being effected. In addition, the identified participation and support take place within the confines of a substitute decision-making regime. Nor are such wishes and feelings specifically afforded primacy in the legislation although, of course, arguably this may of itself not be fatal if the overall objective is to achieve full and effective respect for human rights.

That being said, within the confines of substitute decision-making regimes both pieces of legislation identify specific means by which individuals may potentially be supported and/or enabled in the participation process that the legislation promotes. The AWIA obligation to encourage and develop skills has already been mentioned. Additionally, advance planning mechanisms, such as powers of attorney and psychiatric advance statements, and independent advocacy have all been identified [39].

6. Supported Decision-Making in Scotland: If not Full Article 12 CRPD Compliance then Promoting Respect Will and Preferences and Human Rights?

To what extent can it be said that the identified forms of support adequately give primacy to a person’s will and preferences and respect human rights within the confines of existing Scottish legislation?

The following consideration of the statutorily recognised forms of advance planning and independent advocacy is, of course, somewhat limited in its scope. Other forms of supported decision-making exist that are informal or not recognised in the legislation [40]. Difficulties in measuring the effectiveness of the support is also hampered by the fact that the terms “will and preferences” are somewhat ambiguous in nature and the Committee has not defined them ([23], pp. 41–42). It is nevertheless submitted that it is possible to make some general observations by way of contribution towards the consideration of what constitutes effective support arrangements.

⁹ AWIA, 1(4); MHA, ss1(3)(c)–(d).

¹⁰ MHA, s64(5)(b).

¹¹ MHA, ss1(g)–(h).

6.1. Advance Planning: Powers of Attorney and Advance Statements

Advanced planning is explicitly encouraged in the General Comment as an important form of support which should enable individuals to state an individual's will and preferences ([2], para. 17) provided that such arrangements do not enter into force based on assessment of the person's mental capacity ([2], para. 17). Additionally, autonomy will only be preserved where such measures are created and operate in the absence of undue influence ([20], para. 55) and, indeed, the Committee has noted this requirement for supported decision-making arrangements ([2], para. 22).

6.1.1. Powers of Attorney (AWIA)

Powers of attorney permit any individual with capacity to put in place arrangements for the organisation of their financial (continuing) and/or welfare affairs by appointing an individual or organization to act on their behalf.

The AWIA stipulates that certain conditions must be fulfilled for the power to be valid¹² largely obligating solicitors acting for granters to be satisfied that the granting of the power is the result of an autonomous decision. However, there are virtually no limitations placed on the choice of attorney or the powers conferred. Importantly, any limitations or questions arises as to the extent of attorneys powers again suggest the objective of protection of the granter's autonomy. For example, a welfare attorney may not place the granter in hospital for treatment for mental disorder against their will, consent to medical treatment excluded from the scope of the Act's general power to treat¹³, request that the granter's body or body parts be used after death for anatomical/post-mortem examination or use of the granters' body parts, tissue or organs during their life. It is also currently unclear whether welfare attorneys can be empowered to place the granter *in* situations where they will be deprived of their liberty [41]. Equally unclear is whether a welfare attorney may consent to drug treatment for the first two months of a Compulsory Treatment Order, as well as nursing care, psychological and rehabilitation support under the MHA¹⁴ (although they are able to consent¹⁵ to such treatment where the granter is not subject to compulsory provisions). The Act's Code of Practice also encourages the person granting the power to discuss "feelings and wishes regarding the exercise of the powers" ([42], para. 2.18). Additionally, the Act's Code of Practice recommends that detailed discussions between the granter and the attorney take place so as to ensure the attorney has an in-depth knowledge of the granter's likes, dislikes and values ([42], para. 2.19).

Continuing powers of attorney may become operational at any time whereas welfare attorneys' powers only become effective once the granter has lost capacity. The granter can determine in the document the extent of an attorney's powers and, in the case of welfare attorneys or continuing attorneys that are to come into effect upon incapacity, how incapacity will be determined¹⁶. It is noted that the General Comment expressly prohibits mental capacity assessments as being determinative of advance planning

¹² AWIA, ss15 and 16.

¹³ AWIA, s47.

¹⁴ MHA, s242.

¹⁵ AWIA, s50.

¹⁶ AWIA,ss15(3)(ba) and 16(3)(ba).

arrangements coming into effect but it is perhaps worth emphasizing that in the case of powers of attorneys it is the granter themselves who has the opportunity to direct the determination ([2], para. 17).

Whilst, in the case of powers of attorney the risk of undue influence cannot realistically be completely avoided it will be ameliorated to some extent by the aforementioned duty placed on solicitors at the time of creation of such powers¹⁷. This is now reinforced by professional guidance published in 2013 [43]. The fact that attorneys are statutorily required to exercise their powers in accordance with the Act's underlying principles¹⁸ constitutes a further check on the exercise of such powers and requires the assessment of the proportionality and necessity of any interference. The extent to which attorneys are aware of this obligation and adhere to it are, however, unknown.

6.1.2. Advance Statements (MHA)

Advance statements, or advance directives as they are alternatively known, are widely acknowledged as a way in which to respect autonomy and allow individuals to be self-determining ([44], pp. 381–82). Despite their relative over-use in mental health settings terms they undoubtedly play an important role in recognising choice and thus protecting personal integrity and even for the protection of a person's human rights generally ([45], p. 217). Certainly, studies have reportedly found that the making of advance directives has numerous therapeutic benefits including empowering the individual, enhancing capacity, improving the patient/clinician relationship and, most significantly, reducing the need for involuntary detention ([46], p. 23).

However, the legal weight given to the wishes and preferences contained in such statements may vary between and within jurisdictions ([47], pp. 55–78). In Scotland, there is an absence of relevant case and statute law but it seems likely that the English approach will be followed ([37], para. 5.46) in that advance refusals regarding treatment relating to physical health will be upheld by the English courts—and, indeed, are recognised in the Mental Capacity Act 2005¹⁹—although specific treatment preferences will not [48]. There is an absence of relevant case or statute law in Scotland but the approach is likely to be the same. However, whilst those deemed to have capacity may consent to and refuse medical treatment, no matter how irrational such a decision may appear to others [49], the position of those considered to lack capacity is much more tenuous.

The MHA, as previously stated, specifically acknowledges written *psychiatric* advance statements and contains provisions concerning their application²⁰. Made at a time when the patient has capacity²¹, the Act provides that an advance statement—which takes effect when the patient's ability to make decisions becomes significantly impaired because of mental disorder²²—may specify the way the person wishes to be treated, and how they do not wish to be treated, for their mental disorder²³.

¹⁷ AWIA, ss15(3)(c)(iii) and 16(3)(c)(iii).

¹⁸ AWIA, s1.

¹⁹ Mental Capacity Act 2005, ss24–26.

²⁰ MHA, ss275–276.

²¹ MHA, s275(2)(a).

²² MHA, s276.

²³ MHA, s275(1).

Of course, the equating of capacity with the creation and operation of the advance statement is problematic in General Comment terms. More problematic, from a safeguarding the patient's will and preferences perspective, is the fact that the Act provides that the Mental Health Tribunal of Scotland, and any person giving medical treatment under the Act are only required to "have regard"²⁴ to its contents, and may decline to follow the provisions when making treatment orders provided they apply the Act's aforementioned principles²⁵.

The issue of the ability to override advance statements has been identified as a factor contributing to the relatively low numbers of statements being made in Scotland ([45], p. 213)) and on how they are perceived amongst those individuals who are being encouraged to make them ([50], pp. 11–12; [51], paras. 3.43–3.44). It should also be noted that at present it is not possible to ascertain the extent to which wishes and preferences in advance statements are in fact being overridden [52] as there is no central register of such statements. The Mental Health (Scotland) Bill currently being considered by the Scottish Parliament proposes, however, that such a register be established and held by the Mental Welfare Commission for Scotland. That being said, from the information available it does appear that overrides and patient concerns do seem to relate to the more severe and intrusive forms of treatment such as ECT and the prescription of depot medication ([50], p. 39).

It would appear that such psychiatric advance statements will not meet General Comment requirements and more research, monitoring and consideration is clearly required into just how effective they are in terms of supporting individuals' will and preferences. The support that advance statements can provide must not, however, underestimated in terms of enabling individuals to express their will and preferences in psychiatric care and treatment situations. Moreover, it is submitted that there is some strength in the argument that a failure to genuinely consider the Act's underlying principles and relevant human rights in potential override situations may result in claims of breach of statutory and human rights obligations [45].

6.2. *Independent Advocacy*

Access to independent advocacy services is acknowledged as a mechanism through which individuals with mental disorder, whether subject to compulsion under the Act or not, can be supported to make their own decisions ([53], p. 275). Recognising the importance of advocacy the Millan Report recommended that, in order to advance the fundamental principle of participation, the right to access advocacy services should constitute a statutory obligation so as to enable individuals to communicate their preferences and have these taken account of ([37], pp. 182, 186). This recommendation was realised in section 259 of the 2003 Act which provides for the right of access to independent advocacy services for any person with mental disorder, whether or not they are subject to compulsory measures.

The Mental Health Act Code of Practice also states that "Independent advocacy can enable a patient to express their needs and thoughts and to make these known to those who are making decisions about the patient's care and welfare" ([54], para. 97). This approach accords with the "will and preferences" paradigm set forth in Article 12 as the Committee has repeatedly reiterated in its concluding observations that regimes of supported decision-making must respect the will and preferences of the person.

²⁴ MHA, ss276(1) and (3).

²⁵ MHA, s276.

The provision of advocacy services and the role advocacy workers is not further regulated in the legislation and the full extent to which independent advocacy can actually result in the realisation of will and preferences has not been explored. However, the standards and principles set by, for example, the Scottish Independent Advocacy Alliance (SIAA) and guidance produced by the Mental Welfare Commission for Scotland and Scottish Government provide some further clarity on how independent advocacy should operate [55–57]. The SIAA, for example, specifies that a principle of independent advocacy is that services should be directed by the individual concerned and should assist the person in exercising control over their life ([55], pp. 14–16). Scottish Government guidance provides that independent advocacy has two main themes—“speaking up for and with people who are not being heard, helping them to express their views and make their own decisions and contributions” and “safeguarding individuals who are at risk” [57].

As the provision of advocacy is not dependent on, or influenced by, the mental incapacity of the person, it is a support mechanism consistent with the General Comment requirement that support must not hinge on the assessment of mental capacity ([2], para. 29(i)). It is questionable, however, whether the requirement for an individual to have a mental disorder as a prerequisite for being a holder of the right under s.259 represents a “non-discriminatory indicator” which is contrary indicated in the General Comment ([2], para. 29(i)). The fact that there is no similar provision under the Adults with Incapacity Act also excludes those deemed incapable for reasons other than mental disorder ([53], p. 277) which may also present difficulties in terms of the General Comment’s requirement of the availability to all of modes of supported decision-making. That being said, the emphasis of independent advocacy is squarely on determining, expressing and achieving the individual’s choices although, in reality, the extent to which this can be achieved is restricted by inadequacies in provision across Scotland and funding [58,59].

7. Conclusions: An Opportunity Presented

At present, the Committee’s Concluding Observations and indeed its statement on Article 14 CRPD (the right to liberty) [60] appear to indicate that little quarter is being given in terms of Article 12 [61]. However, one might reflect on whether whilst national legal frameworks must, of course, give proper effect to human rights the real essence of the Committee’s concern lies not with the laws themselves but the assessments of capacity that so often act as a catalyst for involuntary measures.

Discussion on whether or not legal capacity can be fully exercised within status-based mental health and incapacity laws and substitute decision-making frameworks, and whether this is actually what the CRPD requires, will doubtless continue for some time. However, alongside this, it must be acknowledged that Article 12 and the General Comment do provide an opportunity to carefully review whether our current legal frameworks and their implementation genuinely afford sufficient primacy to the will and preferences, and human rights, of individuals generally, including those with mental health issues. We need to ask ourselves whether they are genuinely non-discriminatory. We also need to consider whether they allow for people with mental health issues to make their own decisions, including those that may be considered by others to be injudicious or mistaken, about their lives in the same way as everyone else. This, in turn, will delay the use of involuntary interventions and extend the period during which the person can exercise their legal capacity.

Modes of supported decision-making such as those available in Scotland as identified above, despite the noted difficulties facing them in terms of meeting the General Comment's demands, have the potential—admittedly with improvement in some respects—to assist and extend the exercise of legal capacity by persons with mental health issues. However, further legislative and operational changes indisputably will have to be effected in order to support greater and more effective autonomous decision-making within a framework that also safeguards the whole range of an individual's rights.

As discussed, to adopt the universal approach to legal capacity may create a situation of valuing the protection of autonomy over other human rights leaving potentially vulnerable individuals exposed to harm and lead to possible violations of other rights identified in the CRPD and other human rights treaties. Amongst other things, it is perhaps worth reflecting on, for example, how the question that is also currently facing Scotland about how to achieve Article 5 ECHR compatible legal and procedural safeguards for persons with incapacity who may be deprived of their liberty in social care settings might be viewed from such a universal approach.

Supported decision-making can and does operate both within and outside of substitute decision-making frameworks. Provided that it can operate so as to give primacy to an individual's will and preferences of persons with mental health issues and ensure respect for all their human rights, interpreted in a way that is least restrictive of those rights, this would possibly ameliorate some of the concerns that the General Comment seeks to address.

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Conflicts of Interest

The author declares no conflict of interest.

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