Substituted Decision-Making, Deprivation of Liberty and Human Rights

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Abstract

Scotland has a widely respected mental health and incapacity regime, based on the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

It faces a potential crisis, following the UK Supreme Court decision in the Cheshire West case. The court took a broad approach to the definition of ‘deprivation of liberty’ in ECHR Article 5, finding that the test was the same, regardless of the degree of disability, turning on whether the person is ‘under continuous supervision and control’.

This ruling means that thousands of informal care arrangements and placements may be unlawful – possibly even if authorised by a legal guardian.

The Government is shortly to respond to proposals from the Scottish Law Commission, and the paper will consider how far its proposals are practical, and resolve tensions between the principle of ‘least restrictive alternative’ and the need for judicial protection against deprivation of liberty.

The paper will also consider the General Comment on Article 12 of the UN Convention on the Rights of Disabled Persons, which calls for substituted decision making and forcible treatment to be abolished.
Introduction

This talk will discuss a tension which has been at the heart of mental health and incapacity law for at least 50 years, both in terms of legal principle of how best to respect the rights of people with impaired decision making capacity, and the practical question of how to do so proportionately.

The tension is whether treating people with impaired decision making capacity as rights-bearing citizens is best done by minimising the extent to which there is formal legal intervention in their life, or whether the de facto intervention which happens routinely in the lives of people should always require judicial authorisation.

Although not new, it is manifested in differing approaches of ECHR and UNCRDP. ECHR emphasis judicial oversight, and UNCRDP emphasises autonomy and discourages any attempt to use legal processes to substitute for the decision making of the individual. I’d argue that neither, if applied to the extent some have argued, provides a balanced and comprehensive answer to the issues we face.

In UK, to date, ECHR has held most sway, as Human Rights Act and, in Scotland, Scotland Act, make it effectively part of domestic law. The Cheshire West judgement of the Supreme Court has resulted in a crisis – in England that is playing out in Court of Protection, which is now being overwhelmed with cases. In Scotland, crisis has been deferred to some extent, but only because our system is operating in a way which does not fully accord with the Convention.

Development of AWI

Scots mental health and incapacity law underwent major change in early 2000s with Adults with Incapacity (Scotland) Act 2000 and Mental Health (Scotland) Act 2003. But both adhered to a principle that had been apparent since at least Mental Health (Scotland) Act 1960.

The 1960 Act was at the time a “liberalising measure” brought about by the Dunlop Committee in Scotland (following on from the Percy Commission (1954 – 1957)), which tried to ensure that those with mental disorders would not automatically be detained and to protect the rights of those with mental disorders. The 1984 consolidation of the Act specifically provided (s17(2)):
Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or to accommodation provided by a care home service for that treatment in pursuance of arrangements made in that behalf without any application, recommendation or order rendering him liable to be detained under this Act, or from remaining in any hospital or in any such accommodation in pursuance of such arrangements if he has ceased to be so liable to be detained.

Compulsory treatment was only justified where necessary – in effect, when the patient refused or resisted the treatment.

While mental health law had been updated, until the AWI Act, Scots law regarding other decision making for people with impaired decision making was, in many respects, literally medieval.

Financial affairs could be managed by a court appointed curator bonis – a complex, inflexible and expensive system, largely geared to protecting the assets of the person to pass on to their relatives on their death. It was unclear who could make welfare and medical decisions on behalf of an adult, although of course this was done routinely. In the late 90s, a solicitor succeeded in reviving an ancient appointment of tutor dative, who could be appointed to make welfare decisions. But it was clear that this could not stand as a modern approach, and there was a consensus that what was needed was a new system of substituted decision making, for financial, welfare and medical decisions.

Following a detailed review by the Scottish Law Commission, the Adults with Incapacity (Scotland) Act 2000 was passed. This was a major advance, not least in its articulation in the first section of a key set of principles to guide the operation of the legislation, namely [emphasis added]:

(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 subsection (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.

The Act introduced a new and comprehensive form of substituted decision making, including authority to court appointed guardians or attorneys appointed by the person to act on their behalf.

However, the principles, and the definition of incapacity, if not fully reflecting the supported decision making paradigm of the UN Convention, did seek to maximise the autonomy of the adult.

It is also clear from the SLC report that it was anticipated that guardianship would not be needed for everyone who lacked capacity, and that informal arrangements could continue to be made to provide care and support. However, the lack of a legal basis for such arrangements has become increasingly apparent.

It can be argued that the operation of the AWI Act has not turned out quite as anticipated. Advocacy groups of and for people with learning disabilities have argued that courts are too ready to authorise guardianship in favour of family members; and the MWC has criticised the development of a standard and comprehensive list of guardianship powers, which too often is granted when a more focused list of powers or a one off intervention order might have been adequate. So legislation which was
intended to protect adults with impaired capacity is perceived by some as oppressive and keeping them under the control of their families.

There has also been a sharp and steady rise in guardianship cases (up 58% in the last four years), which has placed severe strains on the social workers who have to provide reports to the court; and has arguably compromised the safeguards in the Act of supervision by the local authority and Mental Welfare Commission. Both agencies now have to be highly selective in overseeing the operation of welfare guardianship.

So after the first decade of operation of the Act, pressure was building for a more streamlined regime, which would allow for administrative authorisation of less controversial cases, such as where an adult with dementia needed to be placed in a care home following admission to hospital, and all parties involved were agreeable to the move.

In 2007, the Scottish Parliament amended the Social Work (Scotland) Act, adding a new section 13ZA providing that, where a local authority has, following an assessment of the adult's needs, concluded that the adult requires a community care service, but is not capable of making decisions about the service, they may take any steps which they consider necessary to help the adult benefit from that service, without further judicial authorisation. But even then, it was apparent that this procedure would not meet the requirements of s5 of the ECHR, if the circumstances amounted to a deprivation of liberty.

That risk was highlighted by the English Bournewood case, which was eventually adjudicated on by the European Court of Human Rights, as HL v UK, in 2004. The adult in that case was treated, supposedly informally, but against the wishes of his carers, who were denied access to him. The court found there had been a breach of the European Convention, in that the applicant had no procedure available to him which satisfied the requirements of Article 5, which prohibits detention without a proper process of law.

In England and Wales, that led to the introduction of ‘DOLS’ or Deprivation of Liberty Safeguards, in the Mental Capacity Act 2005. No such procedure was introduced in
Scotland, but the Scottish Law Commission decided that the implications for Scots law needed to be examined.

Unfortunately for them, before they could conclude their work, there were two major developments in April 2014, both of which reflected a wish to advance the human rights of people with mental illness and intellectual impairments, but which pushed in completely different directions. One was the General Comment of the UN Committee on Article 12 of the UN Convention on the Rights of Persons with Disabilities, discussed later, and the other was the judgement of the UK Supreme Court in the Cheshire West case.

Cheshire West

The Bournewood decision concerned a case where there was a substantive dispute about what was in the best interests of an incapable adult. Cheshire West ventured into new territory – considering whether a deprivation of liberty had occurred in the case of an incapable adult even where it was accepted by all sides that the care on offer was the most appropriate and least restrictive that could be devised for that individual.

[What follows is an edited extract from the Scottish Law Commission discussion of the two cases which were combined in the Cheshire West judgement.]

The first case, Surrey County Council v CA, LA, MIG and MEG, involved two young women in the care of a local authority. They were sisters, each suffering from moderate to severe learning difficulty of unknown origin. When the case began, MIG was 18 and was living with a foster carer in the carer’s home. MEG was 17 and living in a residential home for those under the age of 19; the home was small, with only four residents. Both sisters attended the same further education unit daily.

The second case, Cheshire West and Chester Council v P, involved a man who had cerebral palsy and Down’s Syndrome and required 24 hour care. He lived in a bungalow with two other residents and attended a day centre during the week. Because of challenging behaviour, he required certain forms of restraint, including the wearing of a special garment.
In each case, the Court of Appeal had determined that the care arrangements did not result in deprivation of liberty. In the case of MIG and MEG, the court was influenced by the “relative normality of the living arrangements”, where the two young women could for example go to school or college, and contrasted that with people living in a hospital designed for compulsory detention like Bournewood. In P, the Court of Appeal was particularly influenced by the reason and the purpose, assessed objectively, underlying the care regime, and by a notional comparison between P’s situation and that of any other person with his disabilities receiving necessary care.

The decision of the Supreme Court

The decisions in both these cases were appealed to the Supreme Court.

Lady Hale, who gave the leading judgement, rejected the idea that the concept of deprivation of liberty was different for the appellants, because of their disabilities and their consequent need for care:

“45. In my view, it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities.”

The “relative normality” approach was also rejected, although Lady Hale expressed “much more sympathy” with the comparison between MIG and MEG and other teenagers living at home with their families than with the comparison between P (the individual in the Cheshire case) and another person with the same level of disability.

Turning to consider how to obviate “the minute examination of the living arrangements of each mentally incapacitated person for whom the state makes arrangements which might otherwise be required”, Lady Hale wondered if there is “an acid test” for deprivation of liberty in these cases. Her view was that the key element is that the person concerned is “under
continuous supervision and control and [is] not free to leave”. Freedom to leave was explained as the ability “to move away without permission”.

Applying this analysis to the case of P, Lady Hale concluded that the judge at first instance had in substance applied the correct test. It therefore followed that his judgement should be restored. In relation to MIG and MEG, the life lived by MEG was very similar to that of P in Cheshire. By contrast, MIG was living in an ordinary family home, but the reality was that her situation was very similar to that of her sister: her foster mother and others responsible for her care exercised complete control over every aspect of her life. For MIG and MEG, therefore, a declaration that they were being deprived of their liberty fell to be made.

Lords Neuberger, Kerr and Sumption agreed with Lady Hale. Lords Clarke, Carnwath and Hodge agreed with Lady Hale in relation to P, but dissented on whether MIG and MEG were deprived of their liberty. Lords Carnwath and Hodge noted that there was no Strasbourg case in which detention had been found in circumstances comparable to the present. They did not consider that the cases in which the European Court had considered deprivation of liberty in the context of mental disorder provided sufficient support for the general test proposed by Lady Hale. They were concerned that “nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty”. Moreover, it was noteworthy that the suggestion had not been made by anyone (including the court) in the case of HL that HL was deprived of his liberty when he was in the care of his foster parents.

For Lord Clarke, the European Court had not held that there was only one question (or acid test). Its approach was more nuanced. He expressed particular agreement with the views of Lords Carnwath and Hodge that “nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty”.

On the face of it, then, we have a resounding statement of the inalienable and equal human rights of disabled persons. Why might this be a problem?
The answer is that there are many thousands of people in care settings who have not been placed there by a court or by a welfare guardian. Seeking the authority of the Scottish sheriff court for every such case would cost millions and require professional input into the court process which is simply not available. The relevant procedure under the Adults with Incapacity Act requires two medical reports and a report by a specially qualified social worker.

Furthermore, we have the paradoxical situation that people may spend longer in hospital instead of a less restrictive setting, awaiting legal authority to move the person from hospital.

Indeed it is not even clear that some placements which may have been authorised by a welfare guardian or welfare attorney are lawful. The Commission has expressed doubts about the ability of a welfare attorney to authorise a deprivation of liberty, particularly if this was not expressly authorised in the document setting out their powers.

In England, their Law Commission is due to produce detailed proposals for consultation on 7th July. In Scotland, the Scottish Law Commission adapted their developing proposals to take account of the Cheshire West case, and reported in October 2014.

*SLC report on Adults with Incapacity*

The SLC were clearly aware of the practical problems posed by Cheshire West, and have sought to provide a proportionate response which meets the demands of Article 5.

Firstly, they argue that the case may not be as far reaching as some assume. They suggest that voluntary informal arrangements, as envisaged by s13ZA, are still lawful. The SLC also suggest that one can separate issues of where someone should live from authorisation for the conditions under which they live. The latter may amount to deprivation of liberty, but that does not mean that a court order is required every time someone moves from one setting to another.

The basic proposals are as follows:
Firstly, doctors should have a new authorisation process to prevent a person leaving hospital. The doctor can do this at their own hand, without court approval, although there is an appeal to the court. The process is loosely comparable to the existing procedure under s47 of the AWI Act which allows a doctor to authorise medical treatment where the patient cannot consent.

Secondly, the sheriff court, a guardian or a welfare attorney should authorise ‘significant restriction of liberty’ in community settings. The SLC have not used the phrase ‘deprivation of liberty’, but their term is effectively intended to address cases where deprivation of liberty may be said to exist.

Thirdly, there is a new safeguard of an application to the sheriff by the adult or any interested party to cease de facto detention.

In order for ‘significant restriction of liberty’ to exist under the SLC scheme, two of the following three must apply

- The adult is not allowed or is unable to leave the premises unaccompanied
- Barriers are used to limit the adult to particular areas of the premises
- The adult’s actions are controlled by physical force, restraints, or medication.

In my view, the Scottish Law Commission has sought heroically to address an almost unsolvable problem. However, there are a number of difficulties with their scheme.

It may result in both too much judicial oversight and too little, partly because Cheshire West was more concerned with the objective situation of the person than how the person felt about their situation.

So many people who are apparently happy with their situation, and whose family and care providers are also happy, will require a court to rubber stamp a deprivation of liberty. The number of cases where the court might actually turn down such an application, based on the experience of AWI hearings to date, is likely to be negligible, but the amount of time and effort expended in servicing the process will be enormous.
On the other hand, there may be people whose situation is concerning, who do not meet the test set out by the SLC. Understandably, they have sought to produce a process which is simple for care providers to understand, but inevitably that oversimplifies the circumstances which may seriously interfere with a person’s liberty. Examples include CCTV, close observation, temperature control, access to friends or relatives, access to phones and IT, distance from home, restricting correspondence.

And surely we must be particularly concerned with a person who is saying, in whatever way, that they do not wish to be where they are, and want to be somewhere else. That is the essence of de facto detention, but it is only indirectly taken into account in the SLC scheme. Certainly such a person can go to court if they have the wherewithal to do so, but if they lack capacity to instruct a solicitor, and have no-one acting on their behalf, it is not clear how this will come about.

**UNCRDP**

And as if the ECHR issues were not complicated enough, we must somehow address the requirements of the UNCRDP, and particularly the radical shift that the General Comment on Article 12 demands, in respect of the requirements that State parties recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life, and that States Parties shall take appropriate measures to provide persons with disabilities with the support they require in exercising their legal capacity.

The radical shift is that the General Comment goes further than requiring that disabled persons have the same legal ability to, for example, hold property. It argues that any form of substitute decision making is inherently discriminatory, and must be replaced by supported decision making. Furthermore, there must be no forced treatment.

So, while ECHR Article 5 accepts mental disorder as a basis for deprivation of liberty, the General Comment would argue that this is both discriminatory and illegitimate in terms of the UN Convention. No-one should be able to deprive a person with a mental disorder of liberty, except on the same basis as they could do so for a person without a mental disorder.
This can be seen as a reversion to the voluntary or informal approach, but with the difference that de facto decision making by carers or other third parties is to be wholly replaced by decision making by the person, with appropriate support.

This has been criticised, particularly by professional groups, as utopian and potentially discriminatory against those with severe or profound disabilities. The General Comment is in effect calling for the immediate introduction of a regime which does not currently exist anywhere in the world, with only glimmers of how it could be made a reality. It is also far from clear that the General Comment fully addresses the real risks of vulnerability and exploitation – which can be experienced even by those who have some degree of decision making capacity.

Ultimately, Cheshire West and the General Comment contain important challenges about how we should move forward to strengthen respect for the rights and choices of people with mental health problems and intellectual disabilities. But they drive us in different directions. It can also be argued that both proceed from different notions of formal equality which fail fully to recognise some important practical realities and genuine ethical dilemmas.

Conclusion – what needs to be done?

I suggest that, in Scotland and across Europe, we urgently need to seek to develop a consensus about how to respond to these challenges in a way which supports better care and treatment, protection and empowerment for people with impaired decision making ability. For me, the following are the key components of an ethical and proportionate framework for decision making in relation to people with impaired capacity:

- A greater legal recognition of how supported decision making can operate alongside existing substituted decision making regime. At present, the law alludes to the idea, without saying how it can work
- A process which allows family and carers to stay involved with a person, rather than feeling that without taking out guardianship, they lose all rights in relation to that person. In effect, this could be a new first tier of authorised supporter, who can act alongside the adult in making choices. Ideally this process would not require court authorisation except where a dispute exists
- A second tier, which allows for a simple but robust process of appointment or decision making on key welfare and financial decisions. To avoid expense and delay, this second tier need not be judicial, although there must be easy access to a judicial body; and some form of independent protection (such as local advocacy or oversight by a body such as the Mental Welfare Commission) to ensure that cases are escalated to the judicial level when necessary.

- A third judicial tier to authorise major (significant?) restrictions of liberty, or resolve disputes. One option would be to transfer this from the courts to the existing mental health tribunal, which has been widely praised for the development of a therapeutic jurisprudence. Although courts and court-like bodies tend to be privileged by the ECHR as the gold standard for protecting citizens, I suspect they are not well suited to non-binary, complex decisions which change over time – which is the essence of many issues around welfare and incapacity.

- Whatever the forum, we should certainly be doing more to increase the participation of the adult in the process. At the moment, the adult may be told little of the application, and may never be seen by the judge, or independently represented.

- In the longer term, consideration should be given to a consolidation of mental health and incapacity law, which should reconcile, as far as it is possible to do so, the approaches of the ECHR and UNCRPD, and which pays attention to issues of vulnerability as well as to capacity.