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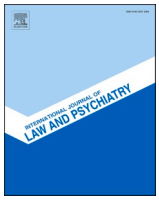

Capacity and incapacity: An appropriate border for non-consensual interventions?

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ABSTRACT

Those who support decision-making capacity as a criterion for non-consensual interventions for persons with mental disabilities (mental illness, learning disability, neurodivergence, acquired brain injury and dementia) argue that it creates parity between physical and mental health approaches to care, support and treatment. It is also argued that such an approach aligns with European Court of Human Rights direction relating to restrictions of a person with a mental disability's rights under Articles 5 and 8 of the European Convention on Human Rights. Indeed, the presence or absence of decision-making capacity has been adopted as a criterion for non-consensual intervention under mental capacity legislation across all UK jurisdictions. Decision-making capacity has also been adopted as a criterion for psychiatric treatment interventions under the Mental Capacity Act (Northern Ireland) 2016 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

More recently, however, the use of decision-making capacity as a determining factor for intervention has been challenged on human rights, particularly following the adoption of the Convention on the Rights of Persons with Disabilities, and on practical support grounds. This was considered by the Scottish Mental Health Law Review (2019–2022) which recommended an alternative, arguably more human rights compliant and support effective, Autonomous Decision-Making test.

This article will consider the use of mental capacity as an appropriate border for non-consensual interventions under mental health and capacity law. In doing so, it will consider the wider arguments for and against such use, how this was addressed by the Scottish Mental Health Law Review and what lessons may be learned from this exercise.

1. Introduction

Ethical and human rights-based approaches generally require clear determining criteria for non-consensual interventions involving our freedoms because of the resultant implications for all or many aspects of our lives. This includes where a person with a mental disability (mental illness, learning disability, neurodivergence, acquired brain injury and dementia) is unable or unwilling to provide consent to an intervention at a given time. In such cases, the presence of, or potential for, risk, either to the person themselves or to others, is often used as a determining factor.

Mental, or decision-making, capacity tests have also been held out as a legitimate means by which to establish the threshold between respect for autonomy and non-consensual intervention. It has been established for some time that refusals of physical health treatment by an individual with mental capacity must be respected. Some commentators also argue in favour of this approach being applied in relation to mental health treatment on the basis that it creates parity between physical and mental health treatment.[1] This accords with the direction of the European Court of Human Rights relating to restrictions of the Articles 5 (the right to

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[1] J Dawson and G Szmukler, 'Fusion of mental health and incapacity legislation' (2006) 188(6) *British Journal of Psychiatry* 504–509; G Szmukler, R Daw and J Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation' (2010) 20 *Journal of Mental Health Law* 9–22.

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liberty) and 8 (respect for private and family life) European Convention on Human Rights (ECHR) rights of a person with mental disability which are justified where the person lacks capacity as a result of a diagnosis of mental disability.[2] Indeed, the presence or absence of decision-making capacity has been adopted as a criterion for non-consensual intervention under mental capacity legislation across all UK jurisdictions.[3] It has also been adopted as a criterion for psychiatric treatment interventions under the Mental Capacity Act (Northern Ireland) 2016 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

However, challenges to the decision-making, or mental, capacity-based approach have arisen since the adoption of the Convention on the Rights of Persons with Disabilities 2006 (CRPD) and, in practical terms, regarding the use of mental capacity assessments to determine whether and what intervention is required. It has been argued that justifying intervention on the basis of a lack of mental capacity associated with a diagnosis of mental disability is in fact discriminatory and, given its binary nature, may either inappropriately restrict a person's freedoms[4] or, conversely, deny a person vital support.[5]

Between 2019 and 2022 the independent Scottish Mental Health Law Review[6] was charged with making recommendations on how to ensure that Scotland's mental health, capacity and adult support and protection legislation, can better align with developing and current international human rights standards, notably the ECHR and CPRD. An important consideration for the Review was the use of capacity-based tests for intervention under mental health and capacity law and the Review's Final Report in September 2022[7] recommended an Autonomous Decision Making, within a wider human rights and supported decision-making framework, as a more human rights aligned approach to determining the threshold for involuntary interventions.

This article will consider the use of mental incapacity as an appropriate border, or threshold, for non-consensual interventions under mental health and capacity law and associated resource allocation. In doing so, it will consider the wider arguments for and against such use, how this was addressed by the Scottish Mental Health Law Review in its recommended Autonomous Decision Making test and what may be usefully taken forward from this exercise.

2. Decision-making capacity as a gateway to interventions

2.1. Case law

Whilst only binding in the English and Welsh courts other English-speaking jurisdictions have been strongly influenced by the 1993 *Re T*[8] and 1994 *Re C*[9] rulings which established that incapacity is a gateway to interventions in that a person with capacity is entitled to consent to or refuse medical treatment relating to their physical health and that such consent or refusal must be respected. Echoing this, Lady Justice Butler-Sloss subsequently stated in *Re MB*:

> "A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death…".[10]

Moreover, the case law is clear that no automatic assumptions of incapacity must be made simply because a person has a diagnosis of mental disability.[11]

These principles tend to be faithfully followed in relation to physical health, and property and financial matters, but less so in the case of psychiatric care and treatment, leading to calls for parity, particularly through the vehicle of unified mental health and capacity legislation[12] and, indeed, resulting in such legislation being enacted in Northern Ireland.

2.2. Human rights: ECHR

The European Court of Human Rights has reinforced the principle that non-consensual interventions engaging Article 5 and/or Article 8 which deprive a person of their ability to exercise their autonomy, including their legal capacity, must be a last resort and always accompanied by strong procedural safeguards. The greater the intrusion the more rigorous these must be.[13] The Court has reiterated on several occasions that removal of a person's ability to exercise their legal capacity must be proportionate to their ability to make decisions in relation to the specific matter being considered.[14] It has also stated that the existence of even a serious 'mental disorder' is of itself insufficient justification to fully deprive a person of their legal capacity[15] and that assumptions of consent allowing authorities to restrict rights without safeguards, for example through a deprivation of liberty, must not be made.[16] The Court has further stressed that whilst a person who lacks capacity may be subject to measures under the law this does not necessarily mean that such person is unable to understand their situation. A person may have strong opinions about whether or not they are happy with the decision and actions taken by others. This strongly suggests that sensitivity a person's feelings transcends an incapacity assessment.[17] Article 14 ECHR does require that a person's rights must be enjoyed without discrimination based on various characteristics, including disability.[18]

However, the Court's jurisprudence on Articles 5 and 8 continues to

[2] For example, *Shtukaturov v Russia* Application no 44009/05, Judgment, 27 March 2008 at paras 87–89; *Sykora v Czech Republic* Application No 23419/07, Judgment 22 November 2012 at paras 101–103; *X v Finland* Application No 34806/04,Judgment, 3 July 2012 at para 220, *HL v UK* Application No 45508/99, Judgment, 5 October 2004.

[3] See Scotland's Adults with Incapacity (Scotland) Act 2000, the Mental Capacity Act 2005 in England and Wales and the Mental Capacity Act (Northern Ireland) 2016 in Northern Ireland.

[4] Committee on the Rights of Persons with Disabilities, General Comment No. 1 - Article 12: Equal recognition before the law (adopted 11 April 2014), CRPD/C/GC/1, 19 May 2014 (General Comment No. 1).

[5] Scottish Mental Health Law Review, *Final Report*, 28 September 2022, available at: https://webarchive.nrscotland.gov.uk/20230327160315/https:/www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-final-report/

[6] The author was a member of the Scottish Mental Health Law Review Executive Team. However, this article represents the author's views only and not necessarily those of the Executive Team.

[7] Scottish Mental Health Law Review (2022), ibid.

[8] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

[9] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819

[10] *Re MB* [1997] EWCA Civ 3093, per Lady Justice Butler-Sloss at para 17(2).

[11] *Re C (Adult: Refusal of Treatment)* ibid.

[12] J Dawson and G Szmukler, op cit; G Szmukler, R Daw and J Dawson, op cit; Bamford Review (a) *Human Rights and Equality of Opportunity*, Report, October 2006; (b) *A Comprehensive Legislative Framework for Mental Health and Learning Disability*, Report, August 2007, both available at https://www.health-ni.gov.uk/publications/bamford-published-reports

[13] *HL v UK* (App no. 45508/99) (2004) ECHR 471; *Sykora v Czech Republic* (App no 23419/07) (2012) ECHR 1960, paras 101–103; *X v Finland* (App no 34806/040) (2012) ECHR 1371, para 220; *Salontaji-Drobnjak v Serbia* (App no 36500/05) [2009] ECHR 1526, paras 144–145.

[14] See, for example, *AN v Lithuania* (App no. 17280/08) (2016) ECHR 462, para 111; *Calvi and CG v Italy* (App no. 46412/21) (2023) ECHR 571, paras 90 and 108.

[15] *Nikolyan v Armenia* (App no 74438/14) (2019) ECHR 674, para 122.

[16] *HL v UK op cit*; *Shtukaturov v Russia* (App no 44009/05) (2008) ECHR 223.

[17] *Shtukaturov v Russia* ibid., para 108.

[18] *Glor v Switzerland* (App no. 13444/04) judgment of 30 April 2009, para 80.

accept that clinical diagnosis and related mental incapacity ultimately justify a deprivation of liberty and other restrictions of autonomy.[19] The resultant loss of legal capacity and associated legal agency in situations involving psychiatric care and treatment and other health, welfare and financial decisions potentially has enormous short or long-term consequences for the person involved. This position has been challenged by the CRPD.

2.3. Human rights: CRPD

ECHR jurisprudence and the previously mentioned English case law therefore make it clear that, subject to safeguards, a lack of mental capacity allows others to make decisions for the person concerned, and indeed often a trigger for support. The CRPD, however, represents a change in this approach as it focuses on access to support and empowerment rather than the presence or absence of mental capacity to determine how a person may be treated.

The CRPD's approach is one of dismantling barriers preventing equality in the enjoyment of rights for persons with disabilities, and in pursuance of this support may be required.[20] This applies across the entire range of a person's rights, for example civil rights relating to life,[21] to the exercise of legal capacity,[22] liberty[23] and freedom from torture and freedom from torture or cruel, inhuman or degrading treatment or punishment,[24] and socio-economic rights underpinning realisation of the right to the highest attainable standard of physical and mental health[25] and to independent living.[26]

Article 12 CRPD (equal recognition before the law) is central to this approach and Articles 12(1) and 12(2) require that a disabled person's right to exercise legal capacity – to have one's rights, will and preferences respected under the law - must be enjoyed on an equal basis with those who are not disabled. Article 12(3), reflecting the CRPD message that obstacles to equality in rights enjoyment must be overcome, places an obligation on state parties to provide access to support for the exercise of such legal capacity.

The Committee on the Rights of Persons with Disabilities elaborates on Article 12 in its interpretive General Comment No.1[27] by stating that the use of mental capacity, or decision-making, assessments as a means of determining the extent to which a person is able to exercise their legal capacity is discriminatory.[28] It argues that such assessments tend to be linked to diagnosis of mental disability and, even if confined to individual decisions, are tarnished by a tendency for others to make incorrect assumptions about the competence and authenticity of a person's expressed will and preferences allowing for others to substitute their own decision-making for the person arguing that it is in their 'best interests'.[29] In the words of the Committee:

> '…the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. This is decided simply on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered to have negative consequences (outcome approach), or where a person's decision-making skills are considered to be deficient (functional approach)… This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law. In all of those approaches, a person's disability and/or decision making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law.'[30]

Noting that states' laws often authorise this in the form of non-consensual psychiatric interventions and guardianship the Committee requires that such laws are abolished and replaced by supported decision-making.[31]

There has been some conjecture over the nature and extent of supported decision-making, including over whether it can or cannot exist within substitute decision-making regimes.[32] However, it is clear that the Committee considers that such support, in its various forms, must transcend any decision-making impairment. At the same time, it concedes that there may be situations where, despite all reasonable endeavours to support and discover a person's will and preferences, this proves impossible and a 'best interpretation' of such will and preferences must be made.[33] Some commentators have interpreted 'best interpretation' not as an admission that substitute decision-making has its limitations. They instead argue that by endeavouring to align a 'best interpretation' with the person's will and preferences what is actually happening is a continuance of supported decision-making[34] although this opinion is not shared by all commentators.[35]

There has been a certain amount of push back against the CRPD Committee's approach.[36] That being said, some states have sought in reforms of their mental health and capacity legislation or in

[19] *Winterwerp v Netherlands* (app no. 6301/73) (1979) ECHR 4; *HL v UK* op cit; *A-MV v Finland* (App no. 53251/13) (2017) ECHR 273; *Rooman v* Belgium (App no. 18052/11) (2019) ECHR 105; Strøbye *and Roselind v. Denmark* (App nos. 25,802/18 and 27,338/18), Judgment 2 February 2021.

[20] Committee on the Rights of Persons with Disabilities, *General comment No.6 on equality and non-discrimination*, CRPD/C/GC/6, 16 April 2018.

[21] Article 10 CRPD.

[22] Article 12 CRPD.

[23] Article 14 CRPD

[24] Article 15 CRPD.

[25] Article 25 CRPD.

[26] Article 19 CRPD; Committee on the Rights of Persons with Disabilities, General Comment No.5 on Article 19 - the right to live independently and be included in the community, CRPD/C/ GC/5, 27 October 2017.

[27] Op cit.

[28] General Comment No. 1, op cit, paras 13–15.

[29] Ibid, paras 15 and 21.

[30] Op cit, para 15.

[31] Op cit, paras 5, 7, 15 and 25.

[32] See for example W. Martin et al. (2016) *Three Jurisdictions Project: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK*, available at: https://autonomy.essex.ac.uk/resources/eap-three-jurisdictions-report/#:~:text=across%20the%20UK-,Three%20Jurisdictions%20Report%3 A%20Towards%20Compliance%20with%20CRPD%20Art.,legal%20jurisdictions%20of%20the%20UK

[33] General Comment No. 1, op cit, para 21.

[34] E Flynn and A Arstein-Kerslake, 'The Support Model of Legal Capacity: Fact, Fiction, or Fantasy?', (2014) 32(1) *Berkeley Journal of International Law* 134–153, 141–142.

[35] G Quinn, 'Personhood and Legal Capacity Perspectives of the Paradigm Shift of Article 12 CRPD' (Concept Paper), (2010) HPOD Conference, Harvard Law School; L Series, 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms', (2015) 40 International Journal of Law and Psychiatry, 40, 80–91; K Booth-Glen, 'Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond', (2012) 44 Columbia Human Rights Law Review 93–169.

[36] M C Freeman et al. 'Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2 *Lancet Psychiatry* 844–50; Martin et al., op cit; UK Government (Department of Health and Social Care), *Modernising the Mental Health Act Increasing choice, reducing compulsion: Final report of the Independent Review of the Mental Health Act 1983*, December 2018, available at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review; P Appelbaum, 'Saving the UN Convention on the Rights of Persons with Disabilities – from itself', (2019) 18(1) *World Psychiatry* 1–2.

recommendations of reviews of such legislative, to strengthen the voice of persons with disabilities through principles and recognition of supported decision-making within substitute decision-making regimes.[37] This includes where measures are authorised as a result of the person being assessed as lacking decision-making capacity.[38] The Scottish Mental Health Law Review, however, was amongst the first to consider an alternative to mental, or decision-making, capacity as a trigger for non-consensual interventions.

2.4. Scotland's existing mental health and incapacity legislation: diagnosis and capacity-based intervention thresholds

The Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 both stipulate that incapacity associated with diagnosis is one of a number of criteria which must be present before non-consensual interventions may be considered. Whilst both Acts contain a number of safeguards that a person is deemed to be 'incapable' under the Adults with Incapacity (Scotland) Act,[39] or that 'because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired' under the Mental Health (Care and Treatment) (Scotland) Act,[40] are integral to decisions made about involuntary measures. The principles identified in each Act which underpin decisions to intervene require that regard to be had for the individual's present and past wishes and feelings,[41] the least restrictive option must be employed in the circumstances[42] and for any intervention to provide a benefit to the person not otherwise available to them.[43] The Mental Health (Care and Treatment) (Scotland) Act also contains the criteria for involuntary intervention that a failure to adopt compulsory measures would result in there being significant risk to the individual or others[44] and that the measures are necessary.[45]

These safeguards and principles were designed to be ECHR compliant and, if properly implemented, remain so. The Adults with Incapacity Act also requires that those exercising functions under the Act must encourage the individual to exercise and develop skills concerning one's property, financial affairs or personal welfare,[46] and the Mental Health (Care and Treatment) Act emphasises the need for the individual's participation and for support and information to assist such participation in decisions concerning one's psychiatric care and treatment.[47] The Mental Health (Care and Treatment) Act also recognises psychiatric advance statements[48] and confers a right to independent advocacy.[49]

However, these principles and supports apply at the time decisions are being made about whether and when to intervene without consent. Evidence is not required that these have been applied as a means to enhance decision-making prior to such decisions being made.[50] Moreover, the lack of hierarchy of all the principles allow for the possibility of disproportionately restricting the autonomy of persons with mental disabilities.

2.5. The Scottish Mental Health Law Review and capacity thresholds

The viability of mental capacity thresholds as a criterion for authorising such measures and Article 12 CRPD and General Comment No. 1 were important considerations for the Scottish Mental Health Law Review. At the same time, in light of ECHR rights being legally enforceable in Scotland, it could not ignore the jurisprudence of the European Court of Human Rights around Articles 5 and 8 ECHR, which has been previously discussed.

In its Final Report, the Review acknowledged that establishing greater CRPD alignment meant overcoming the limitations of the existing mental health and capacity legislation in Scotland. Although underpinned by ECHR principles designed to safeguard individual autonomy, such legislation focuses on the authorisation and regulation of non-consensual interventions and related civil rights. There is little attention paid to a person's needs more widely and their underpinning rights which include economic, social and cultural rights.

CRPD compliance requires a repurposing of the law so that it moves away from disproportionate restrictions of the freedoms of persons with mental disabilities towards non-discriminatory meeting of the needs underpinned by the realisation of the whole range of a person's rights. To most effectively achieve this would arguably involve the integration of mental health and capacity issues into general human rights-based legislation rather than there being distinct mental health and capacity legislation.[51] However, although the Scottish Mental Health Law Review acknowledged in its Final Report[52] that some of its recommendations might well be best placed within wider human rights legislation it was also mindful that its remit extended to only mental health and capacity law.

In order to bring about such alignment the Review therefore recommended that the legislation be refocused to ensure that the needs, and underpinning rights, of people with mental and intellectual disabilities are met appropriately and timeously.[53] This would be supported by legally enforceable economic, social and cultural rights, as well as civil rights,[54] and a distinct pathway of reducing non-consensual interventions which necessarily encompasses viable alternatives to such measures.[55] An accompanying framework that includes Human Rights Enablement would provide the mechanism whereby the whole range of an individual's applicable rights are identified, balanced and enabled in any situation to ensure the person's needs are non-discriminatorily met.[56] A supported decision-making approach would also be included in the framework to ensure that the person's will and preferences are respected to the same extent as others.[57]

The Review noted the CRPD Committee's concerns about capacity expressed in its General Comment No 1 and the argument that its use

[37] For example, UK Government (Department of Health and Social Care) ibid.; Mental Health and Wellbeing Act 2022 (Vic).

[38] Mental Capacity Act (Northern Ireland) 2016; Mental Healthcare Act 2017 (India); Scottish Mental Health Law Review (2022), *Final Report,* September, available at: https://webarchive.nrscotland.gov.uk/20230327160315/https:/www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-final-report/

[39] s 1(6).

[40] ss 36(4)(b), 44(4)(b) and 64(5)(b).

[41] s 1(4)(a) Adults with Incapacity (Scotland) Act 2000; s 1(3)(a) Mental Health (Care and Treatment) (Scotland) Act 2003.

[42] s 1(3) Adults with Incapacity (Scotland) Act 2000; s 1(4) Mental Health (Care and Treatment) (Scotland) Act 2003.

[43] s 1(2) Adults with Incapacity (Scotland) Act 2000; s 1(3)(f) Mental Health (Care and Treatment) (Scotland) Act 2003.

[44] ss 36 (5) (b), 44(4)(d) and 64(5) (c) Mental Health (Care and Treatment) (Scotland) Act 2003.

[45] ss 36 (5) (a), 44(4)(c) and 64(5) (e) Mental Health (Care and Treatment) (Scotland) Act 2003.

[46] s 1 (5) Adults with Incapacity (Scotland) Act 2000.

[47] ss 1(3) (c)-(d) Mental Health (Care and Treatment) (Scotland) Act 2003.

[48] ss 275–276.

[49] s 259.

[50] J Stavert, 'The Exercise of Legal Capacity, Supported Decision-Making and Scotland's Mental Health and Incapacity Legislation: Working with CRPD Challenges' (2015) 4(2) *Laws* 296–313.

[51] World Health Organisation, *Mental health, human rights and legislation: guidance and practice*, 9 October 2023, HR/PUB/23/3 (OHCHR)., p2.

[52] Op cit, Chapter 8.

[53] Op cit, Chapter 2 and Recommendation 2.2.

[54] Op cit, Chapter 6 and Recommendations 6.1–6.12.

[55] Op cit, Chapter 9 and Recommendations 9.1–9.34.

[56] Op cit, Chapter 8 (pp227–244) and Recommendations 8.1–8.4.

[57] Op cit, Chapter 4 and Recommendations 4.1–4.12.

linked to diagnosis of a mental disability as a criterion for intervention is discriminatory[58] and that involuntary measures, such as guardianship and non-consensual psychiatric interventions, should be abolished.[59] However, it ultimately decided that provided mental health and incapacity law is reformed to support the needs and rights of persons with mental disabilities in a non-discriminatory manner, and there is a clear pathway towards reducing the use of compulsory measures, then abolition is unnecessary.[60] This was decided on the basis of concerns expressed to the Review, notably including many persons and representation organisations from the lived experience community, that owing to a lack of appropriate support and resourcing at present the removal of non-consensual interventions an immediate removal of compulsory measures may result in more rather than less rights violations. The Review decided that a programme involving focusing more on supporting an individual's needs rather than authorising intervention supported by a Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework, accompanied by adequate and better support and resourcing and enforceable socio-economic rights, cross-sector training, training would ensure that the need for non-consensual interventions would be minimal because even where individuals might be unable to communicate their will and preferences at a given time there would be sufficient information and support to ensure that any intervention was tailored to how the individual wishes to live their life.[61] That being said, it recognised that it was still important to address the thresholds for non-consensual interventions which involved consideration of the use of capacity assessments under the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act. In particular, the Review explored whether it is possible for mental, or decision-making, capacity assessments to be made and used in such a way to ensure greater respect for autonomy, including the exercise of legal capacity, and improve access to appropriate support and services to meet a person's needs more holistically and going beyond involuntary psychiatric and other interventions.

2.6. Autonomous decision making: establishing a non-discriminatory threshold to non-consensual care, support and treatment?

Evidence provided in the course of the Review's stakeholder engagement revealed differing opinions over the use and role of capacity assessments under the Adults with Incapacity (Scotland) Act and the Mental Health (Care and Treatment) (Scotland) Act. Some regarded the current tests as providing a necessary level of objectivity and focus if these tests are applied properly although it was also commented that greater clarity on how the tests should be applied is required so as to ensure consistency in their application.[62] However, largely echoing the CRPD Committee's concerns, others commented that the tests are being applied inconsistently, subjectively and not fully understood thus allowing for misperceptions and biases associated with a person's diagnosis and related abilities and the quality and reliability of their decision-making. It was also mentioned that the tests can often be applied too early, rather than other options being first considered, to facilitate treatment and resource allocation decisions.[63]

The Review accepted the limitations, and discriminatory nature, of decision-making assessments based on mental capacity and that the ability to make autonomous decisions can be influenced by a number of factors. It therefore recommended an Autonomous Decision Making test to replace the existing capacity tests in the Scottish mental health and capacity legislation as a more rights-based criterion for non-consensual intervention.[64]

The Review defined an autonomous decision as one which is free from 'controlling influences'.[65] These influences would be those factors which prevent a person from the making an autonomous, or voluntary, decision and/or or communicating it to others.

A person's ability to make an autonomous decision would have regard to the person's ability to understand information relevant to the decision, to use or weigh the information in order to make a decision, to communicate the decision, to act on their decision, or otherwise act to safeguard themselves from harm. The Review recognised that a person's ability to make and communicate an autonomous decision may associated with but not necessarily entirely restricted to their diagnosed mental, cognitive or intellectual condition. It therefore defined 'controlling influences' as the extent to which a person's decision, or expression of will and preferences, may be undermined by undue influence by another person or persons, and/or the impact of any illness, disability or health condition (including a health care crisis) and/or of any situational or environmental factors, if they cannot be sufficiently mitigated, for example through support. Such support would include supported decision-making which is constructed to avoid undue influence and conflict of interest determined by whether or not the support provided benefitted those providing such support more than the individual in receipt of the support.

The Review envisaged that the Autonomous Decision Making test would not be applied until every support has been provided to maximise the person's ability to make an autonomous decision about a specific matter.[66] Moreover, a finding that a person is unable to make and communicate an autonomous decision would not automatically result in a restriction of the person's rights, for example, detention, involuntary treatment and other measures. Its operation within a Human Rights Enablement (allowing for not only enforceable civil and political rights but also enforceable social, economic and cultural rights) and Supported Decision Making framework would ensure that overall respect for the person's rights and freedoms, including will and preferences, commencing from the premise of as full rights realisation as possible and as little accompanying restriction of autonomy and opportunities as possible. Whether measures are necessary would be decided on a human rights and equality and non-discrimination basis.

This conception of autonomous decision-making does not deny the impact of a person's diagnosed condition on their decision-making, or how it might usefully inform measures ultimately adopted to support the person. However, as already mentioned, it accepts that decision-making can be impacted by matters beyond symptoms associated with diagnosis. It thus accepts that there are internal and external threats to autonomy, and that decision-making may be impacted by a wide range of factors. In this way, it arguably absorbs the CRPD Committee's comment that decision-making skills vary from one person to another and may differ according to many factors, including environmental and social factors.[67] At the same time, it goes some way to addressing criticisms of the limitations of the social model of disability when such model is interpreted as a person's disability being entirely the result of exclusory social attitudes and structures, and takes no account of a person's

[58] General Comment No. 1, op cit, paras 13–15; C McKay and J Stavert, *Scotland's Mental Health and Capacity Law: the Case for Reform,* Mental Welfare Commission for Scotland/ Edinburgh Napier University, 2017.

[59] General Comment No. 1, op cit, paras 7–9.

[60] Scottish Mental Health Law Review, op cit, pp80–81, and Chapter 9.

[61] Scottish Mental Health Law Review, op cit, Chapters 2–4, 6 and 8.

[62] Scottish Mental Health Law Review, op cit, pp248 and 257. See also W Martin et al. 'SIDMA as a criterion for psychiatric compulsion: An analysis of compulsory treatment orders in Scotland' (2021) 78 (Sept-Oct) *International Journal of Law and Psychiatry*101736. doi: https://doi.org/10.1016/j.ijlp.2021.101736. Epub 2021 Aug 24.

[63] Scottish Mental Health Law Review, op cit, pp248–2.

[64] Ibid, Recommendations 8.5–8.8, pp260–2.

[65] Op cit, pp250–2.

[66] Op cit, pp252–6.

[67] General Comment No. 1, op cit, para 13.

experience of their symptoms and impairment.[68]

The Review considered that the Autonomous Decision Making test could be applied to both routine and urgent situations involving care and treatment for a person's mental or physical health conditions, or support with their welfare, financial and property affairs and would not be based on any specific diagnosis but rather on the person's ability to make an autonomous decision, such assessment being made on a non-discriminatory basis. Whilst the Review's remit was in relation to people who traditionally would fall to be supported under mental health and mental capacity legislation, it acknowledged that the Autonomous DecisionMaking test may, given its nature, potentially apply to any person. However, it was clear that Autonomous Decision Making would be, where appropriate, part of the pathway to better rights realisation and support in its widest sense and not confined to psychiatric care and treatment or other interventions currently authorised or regulated under mental health and mental capacity legislation. This would not mean that the net would be cast even wider in terms of individuals without mental disability potentially being subject to mental health and capacity law type interventions. It would instead be a signpost to the more appropriate support for the individual concerned. Relevant support and interventions might be sought through other legislation or services under these circumstances where appropriate. The Review thus accepted that the requirement for Autonomous Decision Making might also be more appropriately be situation in more general human rights legislation but triggering support and interventions under mental health and capacity legislation where this is required.

3. Conclusion: where will we go from here?

Relatively few mental health laws have adopted capacity tests as a criterion for detention and non-consensual psychiatric treatment[69] although they are prevalent in laws determining competence to make other decisions. Moreover, there appears to be little appetite globally for taking such assessments beyond mental capacity or decision-making linked with diagnosis tests.

The CRPD is, however, serious in its requirements of equality in rights enjoyment. It does require states to reconsider authorising measures that single out people with mental disabilities for rights interferences where this would not occur for others. It requires states to implement measures that counter this.

Given the binary nature of and concerns around bias it is clear that mental, or decision-making, capacity tests linked to diagnosis have the potential to result in disproportionate and discriminatory restrictions of the rights and freedoms of persons with mental disabilities. This is the case whether they are associated with authorisation and regulation of non-consensual interventions only or access to support and services more widely. Delinking decision-making ability from diagnosis and considering a person's needs and underpinning rights in their widest context with restrictions on autonomy only occurring where it is essential to achieve the attainment of these needs and rights arguably avoids or reduces such discrimination.[70]

The Scottish Mental Health Law Review acknowledged that the detail and application of the Autonomous Decision Making test concept needs to be further worked to ensure its effective implementation. Issues such as responsibility and accountability for activating and undertaking such a test, balancing rights to ensure that interventions which amount to restrictions of rights and freedoms are a last resort and proportionate in the achievement of the individual's will and preferences and the overall realisation of all the person's rights. Legally enforceable social, economic and cultural rights is integral to achieving this, as is a robust system of monitoring and accountability, accompanied by data designed to accurately assess and evaluate rights realisation, practical and effective judicial and non-judicial routes to justice and, to ensure equality in entitlement and access to support and services, core minimum obligations for rights which the state must adhere to.[71]

That being said, the recommended Autonomous Decision Making test along with the Human Rights Enablement and Supported Decision Making approaches offer a template which might be developed to achieve a less discriminatory and more supportive intervention threshold for persons with mental disabilities. It offers the potential to remove the arguably artificial border created by capacity tests and ensure that necessary support and services are provided where they are actually needed without unnecessary and disproportion restrictions of persons with mental disabilities. However, whether this can be most effectively achieved within the confines of mental health and capacity legislation, rather than wider human rights or other legislation, remains to be seen.

CRediT authorship contribution statement

Jill Stavert: Writing – original draft, Conceptualization.

Declaration of competing interest

None.

[68] J Mulvany, 'Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder' (2000) 22(5) Sociology of Health & Illness 582–601; T Shakespeare and N Watson 'Beyond Models: Understanding the Complexity of Disabled People's Lives' in *New Directions in the Sociology of Chronic and Disabling Conditions*, G Scambler and S Scambler (eds), London: Palgrave Macmillan, pp. 57–76; T Shakespeare, 'The Social Model of Disability' in *The Disability Studies Reader*, 5th edition, ed. LJ Davis, New York: Routledge, 2017, Chapter 13.

[69] For example, India's Mental Healthcare Act 2017, and in Australian Queensland's Mental Health Act 2016 and Victoria's Mental Health and Wellbeing Act 2022.

[70] B McSherry, P Gooding and Y Maker "Human rights promotion and the 'Geneva impasse' in mental healthcare: scoping review". (2023) 9(3) *BJPsych Open* e58; J Stavert and G Szmukler 'Promoting human rights in mental healthcare: beyond the 'Geneva impasse.' (2023) 9(5) *BJPsych Open* e155.

[71] Scottish Mental Health Law Review, op cit, Chapters 6, 11 and 12.