Additional Support Needs Tribunals for Scotland Members' Newsletter

Issue 6
June 2017

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Additional Support Needs Tribunals for Scotland

Included in this issue

President's address

ASNTS President **May Dunsmuir** welcomes you to the latest edition of the newsletter.

Dear members,

Photograph by David Murray

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I hope you are in good health and enjoying the occasional sunshine and warm temperatures of May and June.

Applications to the Tribunal

Many of you will be aware that, like the surge in temperature, we have seen an unexpected surge in applications to the Tribunal since April. There appears to be no particular trigger for this and it may simply reflect a growing awareness of our jurisdiction.

We continue to receive a consistent number of applications from Glasgow and Edinburgh education authorities but we are seeing a rise, year on year from West Lothian.

I have engaged in a cycle of meetings with education authorities across the year for the purpose of exchanging information and to identify only local issues which might impact on the potential for applications to the Tribunal. This year, I have met with Edinburgh, Fife and Perth and Kinross and I will shortly meet with the new Head of Inclusion at Glasgow City Council.

The Tribunal Forum

In addition to these meeting, I host the annual Tribunal Forum, which is an excellent opportunity to share the work and developments of the Tribunal whilst responding to enquiries from the range of attendees. This year's Forum was again very well attended and the materials from this are available on our website. Derek Auchie, our Training Committee Chair attended and provided a presentation on the 2016 Act and the new tests of capacity and wellbeing. I am sure you will find the material from the Forum interesting and I recommend them to you.

Member recruitment in 2017

In light of the continuing surge in business and the need to recruit more 'ordinary members' in particular, the Judicial Appointments Board for Scotland (JABS) has been invited to run a recruitment later in 2017 for legal and ordinary members for our new Chamber. This is likely to commence in September. **Until we have more members I would be grateful if those who have the capacity to sit more often could make Hugh Delaney aware. We are very thin on the ground at the moment for non-legal members.**

Health and Education Chamber

Preparations for the transfer of the Tribunal into the new Health and Education Chamber of the First-tier Tribunal continue at a pace. Given the range of regulations which need to be laid (which include those in relation to the 2016 Act) the date for our transfer has been changed from 20 to **30 November 2017**.

Judicial Oath

I will shortly take the judicial oath, having received confirmation from the Scottish Ministers that I can do so prior to the date of transfer. You will be invited to take the oath or affirmation at our training on 13 September 2017, which I will administer. Those members and conveners who are already in the First-tier Tribunal and have taken the oath or affirmation will not require to repeat this, however, I will require a copy of the record they have from their other jurisdiction for our own member files. Only those who have taken the oath or affirmation can sit.

September Training

Our training in September is to be treated as mandatory training as this will equip us for our new responsibilities under the 2016 Act. The Training Committee are working hard to develop an interesting programme and I am delighted to advise that Adrian Ward, who is an expert in incapacity law, will be addressing our whole membership on 13 September. Adrian's knowledge in this field in second to none and his expertise is recognised not only in Scotland but across international borders. He is regularly called upon for a view by the Scottish Government and he acts as Consultant to Council of Europe.

Supported Decision Making

Adrian will undoubtedly refer us to the importance of 'supported decision making', which is concept flowing from the UN Convention on the Rights of Persons with Disabilities (CRPD). This will be a familiar concept to us, as we regularly endeavour to overcome difficulties in communication in order to hear the voice of the child and as we endeavour to ensure consistency and compliance with the UNCRC. We now need to place this within the concept of capacity, to explore whether all that can be done to support the child to make their own decision, has been done.

Capacity

We are shortly to become the first jurisdiction in Europe to have such a range of rights provided to children. It is crucial that we understand the trajectory of these rights and developing concepts around capacity. With this in mind, this newsletter edition is focused on capacity and you will read a range of member, education and expert views. I hope you find this helpful.

Young People and Adults

It is worth remembering that a person becomes as adult in Scottish law at the age of 16 years, so, a young person for the purposes of the 2004 Act who is aged 16 to 17 years, will also be considered in law to be an adult. The 2016 Act will remove the upper age limit, which means that a young person aged 16 years or above who remains in school education will have rights under the 2004 Act. In practice, this may mean that a young person could be subject to more than one jurisdiction - for example, they may be subject to guardianship under the *Adults with Incapacity (Scotland) Act 2000*, and our 2004 Act, when an application is before our Tribunal.

Terms and Conditions

You will be provided with new terms and conditions upon transfer. I am pleased to advise that the question of member immunity from civil suit will be addressed, with a specific condition to place this beyond doubt. This would mean that if civil legal proceedings are brought against you by a third party in consequence of the exercise of any of the functions of your appointment; the Scottish Ministers would meet any civil liability arising from such a claim.

Senior Salaries Review Board

In addition to your new terms and conditions, the Senior Salaries Review Board (SSRB) has agreed to include in its review the fees of legal members of Scottish tribunals. The Scottish Government has expressed a commitment to reviewing the fees of non–legal members at a later date. I and other Presidents have asked that pension provision be included within the SSRB's considerations.

Code of Practice

The Code of Practice is being amended to incorporate the 2016 Act provisions. This has recently been circulated and a link to the consultation on The Supporting Children's Learning Code of Practice (third edition) and associated regulations, is provided here: https://consult.scotland.gov.uk/supporting-learners/code-of-practice The Code is enormously helpful and is regularly referred to by parties in our proceedings, I urge you to take time to read this over and to respond to the consultation.

Timescale for Decisions

Conveners who have sat on recent hearings will be becoming familiar with the decision timescale prompt which case officers send as a reminder that the decision will be delivered within 10 working days, following from the last hearing day. For the avoidance of doubt, the last hearing day will be either the last oral hearing day or the last day on which written submissions are lodged.

Our Last Edition

This is our last ASNTS Members' Newsletter. I wish to extend my thanks to previous and current editorial teams for the development of this. It has been an undoubted success and a very useful means of communication across the membership. Irene Stevens has been the editor since 2014 and she has been ably assisted by Lynsey Brown since the end of 2015 - my thanks to them both for their hard work and commitment to the production of a very polished and interesting Newsletter.

Best wishes,

Chatter BOX

Julie Burton

After 23 years of working with HMCTS (Her Majesty's Courts and Tribunal Service) Julie decided to move to pastures new and joined the Private Rented Housing Panel in August 2015.

Julie currently works within the scheduling team arranging inspections and hearings across Scotland.

Recently an opportunity arose for a part-time caseworker within the ASNTS jurisdiction and Julie was very fortunate to be selected. Julie is coming towards the end of her ASNTS training and she is enjoying the challenge of learning about the type of work involved. Julie recently attended the all members training event which provided her with a useful insight into the role of the conveners and members.

Julie will be working at least 1 day per week with ASNTS and providing cover during leave periods etc. and she looks forward to developing her knowledge, with the help of Hugh and Megan.

In her spare time, Julie likes to travel (mostly to Cyprus where she owns an apartment) and loves spending time with her young nieces. She also has a very energetic dog who takes up the majority of her time!

TRAINING IN SEPTEMBER

ABODE Hotel

129 Bath Street

Glasgow, G2 2SZ

13 September 2017

Education (Scotland) Act 2016 (all members)

14 September 2017

Education (Scotland) Act 2016 (conveners only)

BOOK NOW to secure a room @ the ABODE Hotel for £75 per night. Booking must be made by 9 AUGUST. Email sales@abodeglasgow.co.uk or call 0141 221 6789. Quote training dates.

Task Specific Capacity

by Deirdre Hanlon, convener

"A PERSON'S *CAPACITY* IS DIRECTLY RELATED TO THE SPECIFIC DECISION THEY ARE MAKING"

A person's capacity is directly related to the specific decision they are making. **This fundamental concept underpins incapacity law in Scotland; it encapsulates what capacity means to me as a solicitor with 17 years experience in the voluntary sector**. Capacity is ordinarily presumed in law. As adults, we are allowed to make our own decisions, however unwise, provided those decisions are within the parameters of the law. Whilst many with acute mental illness will retain the necessary legal capacity to make decisions, there are times when a person's ability, and therefore capacity, to make decisions can be impaired by mental disorder. Legal mechanisms, developed significantly over the past 15 years, exist to protect people in this position.

Adults with Incapacity (Scotland) Act 2000

In 2000 the Scottish Parliament introduced its first major piece of legislation, the *Adults with Incapacity (Scotland) Act 2000*. It brought with it a new framework for safeguarding and decision-making in relation to the welfare and finances of adults who lacked capacity due to mental disorder or an inability to communicate. 'Adults with Incapacity' were defined in statute for the first time and a set of general legal principles were introduced to be applied in any intervention in their affairs. The changes were largely positive and significantly increased rights of review and legal redress for those who become 'incapable adults' by virtue of mental disorder. If someone seeks to intervene in the affairs of an adult with incapacity who has not previously granted a valid power of attorney, a Sheriff Court order, whether for a Welfare Guardian or Financial Guardian, is normally required and there has been a huge increase in litigation in this area.

Often an adult's incapacity to make decisions around their care needs or finances is clear to those involved and the court. However, some cases are more complex. What of adults with learning disability who seek to form partnerships, engage in physical relationships or even have children? Unless a court intervenes, such adults have the same rights and expectations here as anybody else.

> **"Unless a court intervenes, such adults have the same rights and expectations here as anybody else…"**

However, depending on the severity of their disability, they may have a limited understanding of the risks of exploitation or consequences of such actions. Establishing capacity can be fraught with difficulty here: when does an unwise choice in a relationship, not uncommon among us all, become one where an adult lacks capacity? In resolving these difficult legal and ethical dilemmas, courts will consider evidence from a variety of professionals and carers who work with the adult. Regard must be had to the adult's own cultural, religious and individual beliefs. It is not uncommon for professionals working with an adult to disagree on capacity or the requirement for court intervention. The general principles of the 2000 Act have assisted courts a great deal in determining whether to intervene in the affairs of an adult.

Lessons I've Learned

Capacity cannot be judged by a person's diagnosis. Evidence from relevant professionals can assist in assessing capacity, but it is a legal test at the end of the day.

Capacity can sometimes be enhanced or diminished. Advocacy working to support and prompt someone to engage with a decision-making process may enhance capacity. Familiar surroundings, and other factors, can also sometimes enhance capacity. Fear, stress, pressure or the undue influence of others can diminish someone's decision-making ability. A well-meaning family member may, quite unintentionally, act in a manner that diminishes further a vulnerable adult's capacity to make decisions.

Acting for clients where capacity is an issue requires a degree of flexibility. Incapacity in decision-making in one area does not necessarily mean incapacity in others. An adult may lack capacity in certain decisions about their welfare, but retain the necessary capacity to instruct a solicitor to oppose the legal process that they are involved in. Such is the task-specific nature of capacity.

Preparing for assessing capacity

Adam O'Brien: City of Edinburgh Council, Maura Kearney and David Patrick: Glasgow City Council

The Interview REPORT

Under the Education (Scotland) Act 2016, local authorities have been given the responsibility of assessing the capacity of a child (aged 12 to 15 years) to exercise their extended rights. To explore how local authorities are approaching this, we interviewed some local authority staff who may be playing a key role in the delivery of this responsibility.

Adam O'Brien, from the City of Edinburgh Council, works as the Council's parent and pupil support manager. Adam has a key role in relation to additional support for learning and represents the Council at ASNTS hearings. In relation to the assessment of capacity, he said that it would be their intention to use the Council's educational psychology service and to involve speech and language therapy, according to existing protocols and procedures. He felt that the Act will operate to strengthen what should be good practice in local authorities. As Adam said,

> ***"Here, we routinely seek the views of the child as part of GIRFEC. The Act highlights what good local authorities should be doing in line with the UNCRC as best practice."***

Adam agreed that capacity is not a one-off measurement. As he said,

> ***"The needs of children change with time and best practice is that we remain mindful of this."***

Given that the new responsibility does not apply to placing requests, Adam is not anticipating a high volume of work relative to the responsibility of assessing capacity; however, he does anticipate that some CPD may be required, particularly for teachers.

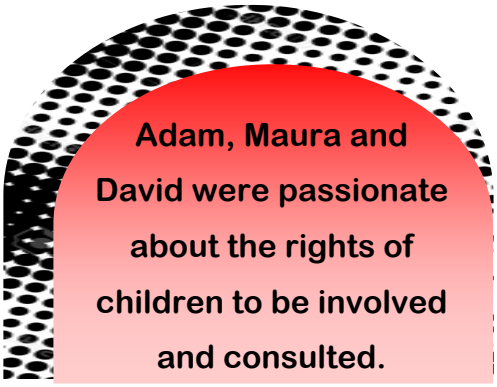
David Patrick and Maura Kearney work for Glasgow City Council as Depute Principal Psychologists for the North West and the North East of the city. In relation to the ASNTS, they help support the educational psychologists who can sometimes be asked to attend the hearings. David advised that Glasgow Psychological Service (GPS) has a strong commitment to ensuring that all professionals within education appreciate the need to actively seek and document the views of the children and young people they work with.

> ***"...strong commitment to ensuring that all professionals within education appreciate the need to actively seek and document the views of the children and young people they work with…"***

For some children and young people there can be additional barriers, such as issues linked to capacity, where staff require to be even more mindful of how important it is for children and young people to be heard. Both David and Maura agreed that capacity has different dimensions, which include cognitive, social and emotional functioning. Maura explained that capacity is not a single, absolute and concrete entity. It is domain-specific; so, within the determination of capacity, much attention should be paid to context. Maura was also quite clear that it would be wrong to think that you can determine capacity in a one-off, cold and clinical fashion. She felt strongly that determination of capacity had to be done in the context of a trusting relationship and using a multi-disciplinary approach.

David and Maura commented on how they had developed two tools which may have some relevance to the new Act. These are the '*Glasgow Wellbeing and Motivation Profile'* (which assesses the child's *affiliation, agency and autonomy*) and '*Nurturing Me'* which enables a child to express how they feel about their family and close supports. Both tools have very strong links to the GIRFEC wellbeing indicators. Both Maura and David felt that this type of approach, which helps children to articulate areas of their life and wellbeing which can be quite complex, was a way forward. This was particularly true of children with additional support needs and communication challenges.

The issue of assessing capacity and preparing for the new responsibilities under the Act will require some thought and care, particularly in looking at exactly what is meant by capacity. It will also be a developing area, as with any new piece of legislation.



Capacity: a psychiatrist's perspective

by Pradeep Pasupuleti, member

"*Capacity* is the ability to understand information relevant to a decision or action and to appreciate the reasonably foreseeable consequences of taking or not taking that action or decision"

Capacity is the ability to understand information relevant to a decision or action and to appreciate the reasonably foreseeable consequences of taking or not taking that action or decision.[1] It is not an all or nothing concept; it is **task and time specific**. One must work on a presumption that all adults, 16 and above, have the capacity to make decisions on their own behalf. 'Incapacity' is simply the term which refers to the lack of such an ability. *In this article, I will explore some of the issues and guidance which has helped healthcare staff to manage this complex area.*

A diagnosis is not the same as an assessment of capacity. A person should not be assessed as lacking capacity solely on the basis of their appearance or the presence of a disability or physical or mental disorder. Someone who cannot make a complex decision may be able to make a simpler one. The capacity assessment must relate to the decision that needs to be made, at the specific time that it needs to be made.

Lack of capacity to make a specific legal decision may arise because of mental disorder. Almost a decade ago it was estimated that some 100,000 Scots may lack the capacity to make some financial or welfare decisions.[2] In 2015/16 the number of existing guardianship orders (10,735) had risen by 15% since the previous year (9,333). The rate in Scotland for approved welfare guardianship applications has increased again in 2015/16 from 55 to 60 per 100,000 in the over 16 age group population[3].

Issues with capacity and consent to treatment generally arise either from a developmental disorder, causing generalised intellectual disability or a degenerative disorder, such as dementia. In these cases, it is unlikely that capacity will be regained. However, in functional illnesses such as depression, mania or psychosis, incapacity could be transitional, directly related to a remitting and relapsing mental disorder. In all cases, every effort should be made to maximise decision-making ability before concluding that the person lacks capacity.[4]

> **"In all cases, every effort should be made to maximise decision-making ability before concluding that the person lacks capacity.[4]…"**

Assessment of capacity, primarily to consent to the treatment offered, is an essential ethical and legal question that must be confronted by healthcare staff in the delivery of care to some of the most vulnerable individuals in society. These assessments are a common and necessary part of caring for individuals with cognitive impairment. It is estimated that between 30 to 52% of people admitted to hospital in the UK will lack capacity to consent to treatment.[5] Assessing the capacity of patients to make decisions about their functional problems has substantial ethical, clinical, and financial implications. The growing population of older adults with cognitive impairment either in the community or in long-term care and medical facilities increases the importance of adequately assessing capacity.

The ***Adults with Incapacity (Scotland) Act 2000*** ("the 2000 Act") has provided a comprehensively principled framework in protecting the interests of the adults with incapacity. Section 1 of the Act provides **five underpinning and guiding principles** which shall be followed in relation to any intervention in the affairs of an adult pursuant to or under the Act. These are

1. Beneficence;
2. Minimum intervention;
3. Consideration of the wishes of the adult;
4. Consultation with relevant adults; and
5. Encouraging the adult to exercise residual capacity.

The 2000 Act refers to 'Incapacity' rather than 'capacity' and defines 'incapable' as meaning incapable of:

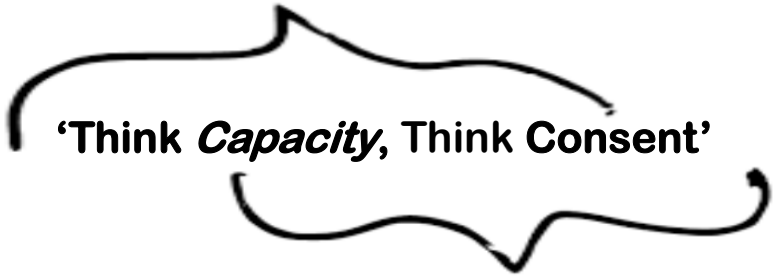
> **'a. Acting; or**
>
> **b. Making decisions; or**
>
> **c. Communicating decisions; or**
>
> **d. Understanding decisions; or**
>
> **e. Retaining the memory of decisions.**

The decision-making in question is broadly based, relating to any sort of decision regarding any aspect of life for an adult. In most cases, when assessing whether an individual has decision-making skills, it first has to be established whether a mental disorder is responsible for the deficiency in decision making.[6]

An amendment to the 2000 Act extended the provision for practitioners who may issue a 'certificate of incapacity' under section 47. The Act now included a registered medical practitioner, a dental practitioner, ophthalmic optician or registered nurse with the relevant qualifications, experience and competence on the assessment of incapacity as prescribed in the 2000 Act. It is expected that the practitioner who has the 'overall responsibility' for the treatment conducts the assessment and completes a certificate relating to the specific treatment proposed. The 'authority to treat' is however restricted to health professionals authorising treatment within their own specialty or offering instruction to others involved in the care and treatment of the person. For example, under this provision a nurse can authorise nursing interventions and/or take instructions from a doctor prescribing medication to administer them.

Within healthcare, a well-recognised practice is for a medical practitioner to conduct assessment and decide if an individual is incapable. In some cases, this would involve a psychiatrist or a specialist in the psychiatry of the elderly or people with an intellectual disability. In most cases it will be the general practitioner who carries out the assessment of capacity. Assessing capacity is a basic medical skill and all medical practitioners should be familiar with it.

'Think Capacity, Think Consent' is an excellent free online learning resource developed by NHS Education for Scotland (NES), which provides essential information about the application of Part 5 of the 2000 Act to ensure healthcare staff safeguard the rights of people who lack capacity to *consent* to treatment.[8] It may also be useful to refer to the Mental Welfare Commission guidance on '*Consent to Treatment*'.[9]



Finally, the General Medical Council has developed a free online interactive tool as a guidance for medical practitioners to help them decide what to do when in doubt about a patient's capacity to make healthcare decisions.[10]

References

1. Scottish Government, *Adults with Incapacity (Scotland) Act 2000: Communication and Assessing Capacity: A guide for social work and health care staff,* February 2008

2. Scottish Executive, *Making the right moves: Rights and protection for adults with incapacity,* 1999, p.4.

3. Mental Welfare Commission, *Annual overview of the use of the Adults with Incapacity (Scotland) Act 2000, Monitoring report,* September 2016

4. Dr J Crichton and K Campbell QC, The Adult with Incapacity. Chapter 7 in *Mental Health and Scots Law in Practice* (Eds. Thomson and Cherry), 2nd edition

5. NHS Education for Scotland, *Think Capacity Think Consent*, educational and training resource, September 2012

6. Dr J Crichton and K Campbell QC, The Adult with Incapacity. Chapter 7, page 215, in *Mental Health and Scots Law in Practice* (Eds. Thomson and Cherry), 2nd edition

7. https://www.bma.org.uk/advice/employment/ethics/mental-capacity/assessing-mental-capacity

8. http://www.nes.scot.nhs.uk/media/1557644/capacity_and_consent-interactive.pdf

9. http://www.mwcscot.org.uk/GoodPractice/Publications/Guidance_documents.asp

10. General Medical Council (GMC), *Consent: patients and doctors making decisions together.* www.gmc-uk.org/Mental_Capacity_flowchart/

Comhairle nan Eilean Siar

By Tim Langley,

Solicitor

Comhairle nan Eilean Siar is the smallest local authority in Scotland. However, like all other local authorities, it is considering the implications of the **Education (Scotland) Act 2016**. In this article, this authority's consideration of these implications will be explored. Section 3 sets out the test for capacity, and s3A sets out the circumstances (the child's right to do something, or the authority's right or obligation to do something in relation to the child) in which the education authority is required to be satisfied as to the child's capacity. If the authority, having carried out an assessment of the child's capacity and having considered the effect of the action on the child's wellbeing under s3A(3), is satisfied that the child lacks capacity or that the proposed action would adversely affect the child's wellbeing, the child or the authority may not take the action.

On paper this places a significant burden on the authority. How often it occurs in practice will of course vary across the country; in this authority it is not expected to be especially onerous. This is because the authority has the benefit of being small and in a close-knit community, and hence the number of affected children is low. It is likely that affected children will have been identified by the authority as it carries out cognitive assessment tests as a matter of course, and expects that any issues concerning capacity would be identified by those tests. If so, further standardised tests are available and they would all form the evidential basis of an assessment of capacity. However, the authority will refer each assessment to mental health professionals for their view. It is this authority's experience that health professionals are not inclined to conclude that a child lacks capacity if there is doubt about the matter.

Therefore, for the moment, this authority's approach is to wait and see how often the issue will arise, and because of the relatively small numbers of children within the authority's area, it is not considered necessary to put in place specific measures. Having said that, it does foresee some areas of potential difficulty.

As was previously the case, care will need to be taken to make good, where possible, any limitation in the child's ability to communicate, so as to ensure that the assessment of capacity is not affected by that limitation.

The authority expects to have to work with speech and language therapists in this regard, and to use visual symbols and assessments to ensure understanding, where the child is likely to benefit from these.

Some children may exercise their new rights in order to obtain support under the Act in cases where their parents either do not consider that support is necessary or are resistant, for social or cultural reasons, to the authority's intervention. The authority is concerned at the friction which might arise between it and parents when the child has exercised a right under the Act against the wishes of the parents. It is also possible, particularly in a small authority area such as this one,

> **"…friction which might arise between it and parents when the child has exercised a right under the Act against the wishes of the parents…"**

that there will be a perceived stigma in having to undergo an assessment of capacity in order to exercise a right under the Act. It may be, therefore, that a child will decline to exercise his or her rights for fear of having his or her capacity called into question. Careful management of these situations will be required.

The outcome of the authority's assessment of capacity and wellbeing may be a cause for dispute. Advocacy services may take up the cause of children who wish to exercise their rights. While their support is generally to be welcomed, as it ensures that the child's voice is heard, there is some concern as to what influence parents may exert over the arguments raised on behalf of the child.

There is also a concern that the assessment of capacity and wellbeing should not be unduly influenced by any history of poor decision-making by the child. The temptation is to assume that if a child has made poor choices in the past, or is vulnerable, then his or her capacity is in doubt. Previous poor decision-making may be a factor in assessing the maturity of the child, but that is only one aspect of the test for capacity in the Act. The ability to make responsible decisions is however a relevant aspect of SHANARRI for the purpose of the assessment of wellbeing (s3B).

If it is the child who is proposing to take the action, the Act requires the authority to notify the parents of its need to carry out an assessment of capacity and wellbeing, and then to notify them of the results of that process (s3A(6)). This raises issues of confidentiality as it involves the sharing of sensitive personal data relating to the child. Although it is arguable that the Data Protection Act 1998 ('DPA') allows the sharing of such data by the authority in the exercise of its functions under the Act, this is open to question. If the child were to object to the assessment being shared with the parents then a difficulty would arise: on the one hand the Act requires the authority to notify the parents, but on the other the authority must respect the wish of the child data subject (who, having reached 12 years of age, is deemed to be able to give or withhold consent under the DPA).

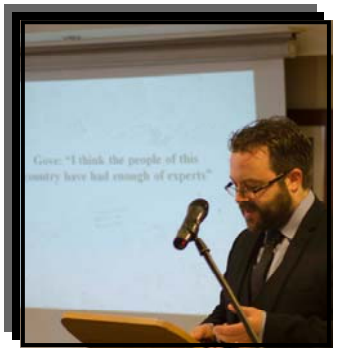
THE EXPERT TRIBUNAL

All members' conference

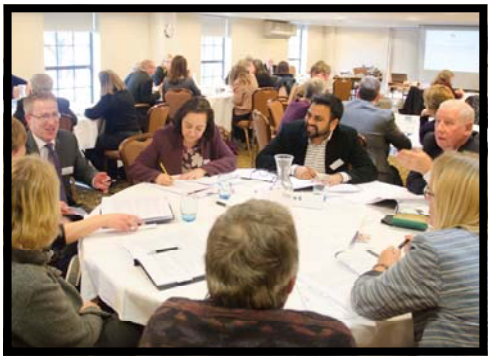
The Members' Conference took place on 22 March 2017 at the Hallmark Hotel in Glasgow and the theme for this year was 'The Expert Tribunal.'

by Irene Stevens, editor and member

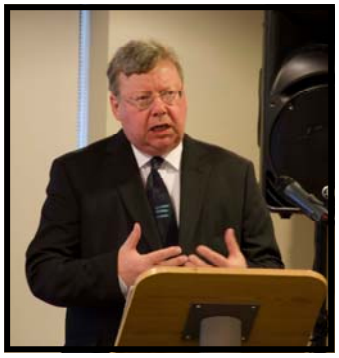
The programme for the day started with Mr **Iain Nisbet**, who gave his views as a representative. This was an excellent introduction to the day. We then heard from **Judge Jane McConnell,** via Skype, who is the judicial lead for the English version of our jurisdiction; and her input about the workload and the process of the English system was well received. The only complaint from those in attendance was that they had no opportunity to ask questions. This is something the training committee will keep in mind for the future. We then heard from Mr **John Swinney MSP**, who is the *Deputy First Minister for Scotland and the Cabinet Secretary for Education and Skills*. He gave a very helpful talk on his remit in relation to additional support needs and some members commented later on his authenticity and his willingness to listen and answer questions.



In the afternoon, we had some groupwork on using expertise within the hearing and this was very ably led by two of our members, **Jimmy Hawthorn** and **Hazel McKellar**. Members evaluated this session very highly and it confirmed that groupwork is one of the best ways to share experience and practice.

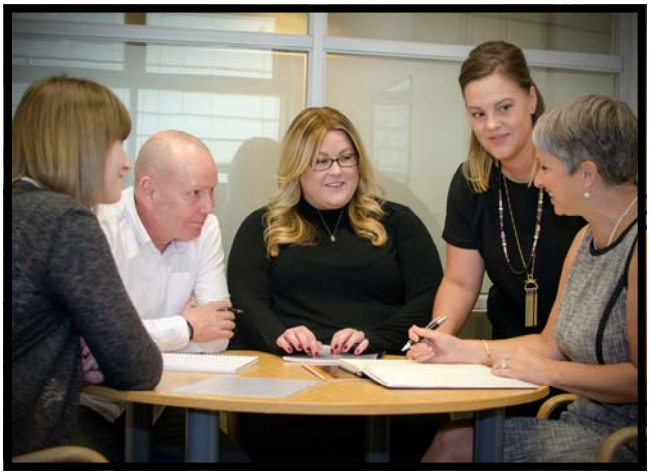


This was followed by a session from **Who Cares? Scotland**, which is a national organisation representing care-experienced children and young people. We heard from a young person about her care journey and the challenges she had faced. She pointed out that education was one of her only safe anchors. This was a hard-hitting and thought-provoking session. It was the most highly evaluated of all the sessions and confirmed the value of hearing the voice of the child as a key part of our training events.



The final speaker of the day was the **Right Honourable Lord Carloway**, the **Lord President**. It was a fitting end to a day which helped all of us to reflect on the nature and agency of expertise. Overall, the conference was evaluated positively and the venue once again proved popular for its central location and food.

The conference would not have been such a success without the help and assistance of a range of people. The training committee would like to thank our speakers and members who contributed so helpfully, particularly Jimmy and Hazel. As always, the events could not have progressed without the staff of the ASNTS, who were on hand to help things run smoothly. Special mention goes to Lynsey Brown, our Member Liaison Officer, for the excellent work in preparing the training packs, which were much appreciated by the membership. Our thanks once again go to our President, for opening and closing the conference, and for providing leadership and ideas to consider. Finally, the training committee would like to thank our members and conveners. The evaluation forms which you submitted will once again provide the basis for further training. **Finally, if you have any ideas in the meantime, please get in touch with Lynsey, who will forward your emails to the training committee.**



The year ahead for the Tribunal Administration

The team have spent the first part of the year working with the President to identify key areas of any administrative processes that will need to be in place in order to support the new **First-tier for Scotland Health and Education Chamber structure**. We are also considering changes required as a result of the *Education (Scotland) Act 2016*.

We have a lot to deliver over the remainder of 2017 but the team are excited to be part of the upcoming changes. We are working on updates to our case management system, template letters, application forms, naming conventions and the ASNTS website.

The ASNTS website has recently been reviewed by a legal member of the Tribunal to ensure accuracy but will undergo a number of other changes this year. The website will be updated to reflect the new naming convention but we also aim to implement improvements to increase accessibility and to include a children's section. As you can imagine, this is not a simple task but the team are currently gathering requirements for the website and once approval has been given we hope to have this ready for testing after the summer.

There is currently a "pulse survey" live on the website. It would be of great assistance to the team if you could take a moment to review the current website and provide us with feedback or suggested improvements. The survey is available until the end of July here: https://www.asntscotland.gov.uk/content/pulse-survey-2017

The team are also committed to assisting our training liaison officer, Elaine Forbes, in the creation of a suite of training materials for the jurisdiction.

I would like to take the opportunity to express my thanks to the team for their continuing hard work. I also welcome Julie Burton who has joined the team this year. Julie is currently in training and will be assisting the team one day per week. She will also provide cover during leave or busy periods.

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A major step forward in CRPD compliance by the German Federal Court?

When forced treatment complies with UN CRPD, the status of the views of the UN Committee on the Rights of Persons with Disabilities, the role of a constitutional court.

The following article was originally published in the Mental Capacity Law Newsletter, now the Mental Capacity Report, published by 39 Essex Chambers and generally issued monthly. Adrian is one of the Scottish contributors. Subscriptions are free, and may be obtained at http://www.39essex.com/resources-and-training/mental-capacity-law/. This article is reprinted here with kind permission of 39 Essex Chambers. It has also been published on the German judicial internal website.

Introduction

Legislatures and courts worldwide, when they consider medical treatment and other measures in the context of intellectual disabilities, will require to take account of a decision dated 26 July 2016 and published 25 August 2016 by the First Senate of the German Federal Constitutional Court (Bundesverfassungsgericht). This decision by eight justices, without any dissenting opinion, has significance beyond the 80,000,000 population within the jurisdiction of that court. The impressive and careful reasoning of the court could well be referred to comparatively if similar issues were to arise in any other jurisdiction. The decision has the potential to contribute significantly to any assessment, in relation to the UN Convention on the Rights of Persons with Disabilities ("the CRPD"), of the role played by the practice of contracting states in the interpretation of international treaties, accorded by Article 31 of the Vienna Convention on the Law of Treaties; and to any assessment of the relative weight to be given to the views of committees which have competence to offer interpretations of human rights treaties, including the UN Committee on the Rights of Persons with Disabilities ("the UN Committee").

At national level, the decision remedies a lacuna in German law by permitting medical treatment of people in the situation of a woman who opposed it. At international level, it is ground-breaking in claiming that her situation fell also within a lacuna in the reports, guidelines and recommendations of the UN Committee, and that the court's decision is accordingly not inconsistent with that of the UN Committee in terms of those documents. Those of us who have engaged with the UN Committee, and who have benefited from the willing availability of its members to discuss, cannot doubt that the UN Committee regards its published views as explicitly prohibiting an outcome such as that in this German case. Another view, however, would be that the German court has identified and addressed a blind spot in the Committee's understanding of the realities of some intellectual disabilities. Two opposing and irreconcilable interpretations of the CRPD have now been authoritatively placed in the international public domain.

The full citation of the decision is "Bundesverfassungsgericht, Beschluss (des ersten Senats) vom 26. Juli 2016 - 1 BvL 8/15". A press release in English which describes the decision in a helpful degree of detail uses "custodianship" to translate the German "Betreuung" (and "custodian" for "Betreuer"). It would be wrong to see Betreuung as implying a form of custody, and a more traditional translation would be "guardianship" and "guardian". Thus the title in English of the "Weltkongress Betreuungsrecht", reported on by Alex in the October 2016 Newsletter, was "World Congress on Adult Guardianship". However, the glossary on the Congress website offered "court-appointed legal representative", reflecting an increasing international move away from the sometimes unacceptable connotations of the traditional terminology.[1] In this report I use "Betreuung" and "Betreuer". Some case names and citations are given as they appear in the published decision of the First Senate.

[1] Thus the revised Yokohama Declaration (see [Newsletter link, please, Alex]) no longer contains those traditional terms.

The decision uses the terms “free will” and “natural will”. The former is understood to mean an exercise and expression of will by a person with competence in relation to the matter in question, and thus being legally valid where it is capable of having legal significance. The latter is understood to be any wish or will that is consciously and wilfully expressed or made known to others, notwithstanding that it might lack legal validity because it was not capably formulated and communicated. The decision also refers to “original will” and “when necessary supported will”. In the penultimate section of this report I describe further, and comment upon, aspects of the decision as to the description, use and considerable significance of these terms.

Facts and procedural history

The woman concerned in the proceedings suffered from a “schizoaffective psychosis”. In consequence, a Betreuer[2] had been appointed to her in April 2014. In September 2014 she was briefly admitted to a care facility. While there, she declined to take medications prescribed to treat an auto-immune disorder. She refused to eat. She expressed the intent to commit suicide. In accordance with various orders of the court, she was transferred to a closed dementia unit at a clinic, and treated with medication “through coercive medical measures”.

Further examination showed that the woman also suffered from breast cancer. She was described as being by then severely weakened physically, and unable to walk or even to move around with a wheelchair by herself. She was described as being mentally capable of expressing her “natural will”. In response to questions from the court, she repeatedly stated that she did not wish to be treated for her cancer. Her Betreuer then applied to the court to authorise extension of her placement in her current accommodation, and to approve coercive measures, particularly to treat her breast cancer.

The court refused that application. It held that the legal requirements to permit placement in accommodation “associated with the deprivation of liberty” and for coercive medical treatment were not satisfied. The Betreuer appealed unsuccessfully to the regional court, and then on points of law to the Federal Court of Justice. The Federal Court of Justice stayed the proceedings and referred to the Federal Constitutional Court the question of whether relevant legislation was compatible with the German Basic Law (Grundgesetz – “GG”).

Issues and decision: German law

The point of law at issue was that the law of Betreuung under the German Civil Code provides that coercive medical treatment may only be given to persons who have a Betreuer if they are accommodated in a closed facility “associated with the deprivation of liberty”. The First Senate described as “constitutionally unobjectionable” the intention of the legislature in establishing a legal basis for coercive medical treatment that is applicable only to persons placed by their Betreuer in a closed facility.[3] Persons, such as the woman at the centre of this case, who have a Betreuer, who are already within in-patient treatment, and who are factually not capable of physically removing themselves, cannot be placed in accommodation “associated with the deprivation of liberty”. In consequence, they cannot be subjected to coercive medical treatment under the provisions described above. Accordingly, even if such persons would otherwise undoubtedly meet all of the substantive conditions for treatment, in that situation they could not be treated coercively. I refer to such persons as “persons in the woman’s situation”. It was argued, successfully, that this situation contravened the state’s duty of protection under the GG. The GG also contains a general equality and anti-discrimination clause, which was referred to by almost all of the interveners in the case before the First Senate: disability groups, lawyers, charities, psychiatrists and so forth. The Association of Psychiatry Users was an exception. It argued that the problem was that the relevant provisions permitted deprivation of liberty and compulsory medical treatment at all. The court did not address the discrimination point. It determined that there was unconstitutionality based on the state’s positive obligation to protect the health of persons in the woman’s situation.

[2] See explanation of “Betreuer” above.

[3] Or, though not mentioned by the First Senate, persons so placed by an attorney acting under an enduring power of attorney.

The woman to whom the proceedings related was deceased by the time the decision was made. The First Senate held that the referral to the Constitutional Court was not rendered inadmissible by her death. It held that the function of judicial review, directed to clarifying the law and bringing about satisfaction, can in exceptional circumstances justify answering a referred question even after an event that would normally resolve the matter, if a sufficiently weighty and fundamental need for clarification persisted. The First Senate did however sound the warning that the question of when an interest in legal protection survived such an event would depend on the circumstances of each individual case.

The court held that it violated the state's duty of protection under the GG that persons who have a Betreuer, who are not capable of forming a "free will", should be entirely excluded from necessary medical treatment if giving that treatment should conflict with their "natural will", where they cannot be placed in accommodation "associated with the deprivation of liberty" because the requirements for placement in such accommodation are not satisfied, and where such placement is a precondition for giving treatment contrary to the "natural will" of the person. The First Senate ruled that this deficit was unconstitutional. It would be within the discretion of the legislature how to remedy the deficit, but the court ordered that it must promptly be remedied. It further ordered that in the meantime, because the current legal situation in effect entirely denied the possibility of treatment for persons in the woman's situation even in the face of the threat of serious or life-threatening damage to their health, the existing provisions permitting non-consensual treatment should apply to this group of people. "The state community cannot simply abandon helpless persons to their own devices".

In reaching this decision, the First Senate acknowledged that giving treatment against the "natural will" of a person who has a Betreuer conflicts with the person's right of self-determination, and with the fundamental right to physical integrity. Under the GG, all persons are, as a rule, free to make their own decisions regarding any interferences with their physical integrity, and how to deal with their own health. In deciding whether and to what extent to allow an illness to be diagnosed and treated, they are not required to follow a standard of objective reasonableness. However, the state's duty of protection takes on special weight in the case of a serious threat to the health of a person who is unable to protect himself or herself. The state's duty of protection outweighs the person's right to self-determination and to physical integrity, where the following criteria apply: (a) no special treatment risks are associated with the medical measure necessary to avert the threat to health, and (b) there is no viable reason to believe that the refusal of treatment reflects "the original free will" of the person who has a Betreuer (which I interpret as meaning the competent will of the person, prior to loss of relevant competence).

Issues and decision: international obligations

In a passage commencing at paragraph 90 of the decision, the First Senate concluded that no international obligations conflicted with the state's obligation to provide protection to a person who has a Betreuer and who is vulnerable and unable to form a "free will", in the circumstances addressed in the case. Coercive treatment in such circumstances, the court held, was consistent with the CRPD, the European Convention on Human Rights ("ECHR"), and the case-law of the European Court of Human Rights.

In Germany the CRPD has the force of law, and can be used as an interpretative aid when defining the content and scope of basic rights under the German Constitution. The Federal Constitutional court on 23 March 2011 had held that the CRPD did not suggest a different outcome. The CRPD includes provisions (notably in Article 12) aimed at guaranteeing and strengthening the autonomy of persons with disabilities. However, in the court's understanding of these provisions, they did not impose any general prohibition of measures which are taken against the "natural will" of a person with a disability, where that is done on the basis of the person's limited ability to make decisions, and where that limitation of ability is the result of an illness.

The court held that: "The context of Art. 12(4) CRPD, which relates to measures which limit the exercise of a person's legal capacity, shows that *the Convention does not impose a general prohibition of such measures*, but rather limits their admissibility, inter alia by requiring the contracting states to develop feasible safeguards against conflicts of interests, abuse, and to guarantee proportionality" (para 88 of the decision, again in informal translation, with emphasis added).

Since the decision of 23 March 2011 had been issued, the UN Committee had promulgated various reports, guidelines and recommendations regarding the interpretation of the CRPD and the legal situation in Germany. As to the effect of such reports, guidelines and recommendations upon the decision of 23 March 2011, the court opined that they "do not lead to a different conclusion". The court pointed out that the views of a committee that has competence to interpret a human rights treaty are to be given significant weight, but they are not binding on international or national courts under international law.[4] On the views under the additional protocol to the ICCPR, the court noted General Comment No 33 of the Human Rights Committee.[5] The court held that such committees do not have the competence to develop international treaties beyond the agreements and practice of the contracting states, having regard to Art. 31 of the Vienna Convention on the Law of Treaties, which codifies customary international law.[6] The court conceded that it was an open question whether principles which have been developed in the context of other international treaties apply to all declarations of the UN Committee. It is however clear, the court found, that Article 34 of the CRPD does not confer on the UN Committee a mandate to provide a binding interpretation of the CRPD. When interpreting a treaty, the court held that a national court should nevertheless engage in good faith with the views of a competent international treaty body, but it is not obliged to adopt them.[7]

In any event, the court held that, as regards the substance of the views of the UN Committee, those views would not exclude medical treatment without a person's consent where this is required under German constitutional law. The Committee had in its concluding observations on the first German state report of 13 May 2015 (UN Doc. CRPD/C/DEU/CO/1) criticised the provisions of the law on Betreuung in the German Civil Code, by referring to the UN Committee's General Comment No. 1. In particular, in General Comment No. 1 the Committee demanded the abolition of all substitute decision-making, and replacement with a system of supported decision making. However, the court considered that the UN Committee's criticism "remains unspecific" with regard to the issues in this case concerning medical treatment without consent. In particular, the court considered that the UN Committee remained silent with regard to the question that was relevant in the present case, namely medical emergencies in which the "free will" of a disabled person is completely absent.

The court took the view that a corresponding approach applied to the guidelines of the Committee regarding the interpretation of Article 14 of the CRPD (of September 2015). In those guidelines the Committee had emphasised that no healthcare measures should be taken in respect of persons with disabilities that are not based on the free and informed consent of the person concerned. The Committee asserted that states should refrain from any form of compulsory treatment.

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[4] The court referred to ICJ, Ahmadou Sadio Diallo [Republic of Guinea v Democratic Republic of the Congo], I.C.J. Reports 2010, S. 639, <663-664>, para. 66; Supreme Court of Ireland, Kavanagh v Governor of Mountjoy Prison and the Attorney General, [2002] IESC 13 March, S. 14 f.; Tribunal Constitutional [Spain], STC 070/2002, recurso de amparo num. 3787-2001, Decision of 3 April 2002, II. Para. 7 a); Conseil d'état [France], Juge des référés of 11. October 2001, No. 238849, ECLI:FR:CEORD:2001:238849:20011011, S. 4.

[5] UN Doc. CCPR/C/GC/33 of 5 November 2008, para 13, which reads "The views of the [Human Rights] Committee under the Optional Protocol represent an authoritative determination by the organ established under the Covenant itself charged with the interpretation of that instrument. These views derive their character, and the importance which attaches to them, from the integral role of the Committee under both the Covenant and the Optional Protocol".

[6] And ICJ, LaGrand [Germany v USA]. I.C.J. Reports 2001. S. 466 <501> para. 99; Mark Villiger, Commentary on the 1969 Vienna Convention on the Law of Treaties, 2009, Art. 31 Rn. 37.

[7] See – though with reference to decisions of international courts – BverfGE 111, 307 <317 f.>; 128, 326 <366 ff., 370>; Christian Tomuschat, Human Rights Committee, The Max Planck Encyclopaedia of Public International Law, Bd. IV, 2012, S. 1058 <1061> Rn. 14.

However, the court held that here also the Committee had not provided an answer to the question of what, according to its understanding of the treaty provisions, should happen to persons who cannot form a "free will" and who are in a vulnerable position. The court held that, even taking into account the views of the UN Committee, there were no good reasons under the text and spirit of the CRPD to abandon such persons to their fate, and to conclude that the Convention is opposed to compulsory medical treatment where this is constitutionally required under strictly regulated circumstances. The court held that this was so, in particular, because the requirements of German constitutional law and of the law on Betreuung, in compliance with the CRPD, give precedence to the will of the disabled person, and where necessary to the will to be determined with support.

The court considered relevant provisions of the ECHR, and in particular Article 8, which, according to the jurisprudence of the European Court of Human Rights, guarantees the right to determine for oneself how to live one's life, including the possibility to engage in activities that are physically harmful or dangerous. With reference to these provisions, the court held that the medical treatment of competent adult patients against their wishes would amount to an interference with the person's physical integrity, and therefore with their Article 8 rights, even where refusal would lead to the person's death. The court referred to Lambert v France[8]; and Pretty v United Kingdom.[9] However, also by reference to Lambert v France, the court noted that states have a margin of appreciation in this respect.

The court held that it is a prerequisite for the obligation of the state and of society to accept a decision that is objectively unreasonable, and which could result in death, that the decision is based on the "free will" of an adult person who has mental capacity. If, on the other hand, a person does not take a decision voluntarily and with full understanding of the circumstances, the court held that the European Court of Human Rights imposes an obligation on states (under Article 2 of ECHR) to prevent the person from putting his or her life at risk[10]. Where a patient refuses a medically indicated treatment with the consequence that his or her life is put at risk, the European Court of Human Rights imposes on the state the obligation to take adequate precautions to ensure that – in cases where there is reason to believe that the person lacks "free will" – the relevant medical practitioners investigate further the capacity of the person concerned[11]. The court concluded that compulsory treatment required by the German Constitution under the conditions addressed in the decision, of persons who are vulnerable, does not conflict with obligations under Articles 2 or 8 of ECHR.

Comment: "free and informed consent"

In a crucial sentence, the decision of 26 July 2016 describes the view of the UN Committee as to the effect of Article 14 of the CRPD thus (in informal translation): "As regards persons with disabilities, no measures for the protection of health may be undertaken unless they rest on the free and informed consent of the person concerned". That could mean two things, in relation to millions of people in the world who, because of their intellectual disabilities, are not capable of "free and informed" consent or dissent. Firstly, it could mean that those people, because they are incapable of "free and informed consent", should not be provided with any healthcare. That however would contravene the right of persons with disabilities under Article 25 of the CRPD "to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability". That cannot therefore be the correct interpretation if another interpretation not inconsistent with the provisions of the CRPD is possible. Secondly, it could mean that the requirement for "free and informed consent" applies only to people capable of giving it. If they are capable of such consent to a proposed "measure for the protection of health" (or refusing it), then that measure may not be imposed without consent. But if they are not so capable, the stipulation does not apply to them.

[8] [2015] ECHR 545, § 120 ff.

[9] [2002] ECHR 427, § 62 f.

[10] Lambert v France, § 140; Haas v Switzerland, [2011] ECHR 2422, § 54; Arskaya v Ukraine, [2011] ECHR 1735, § 69 f.

[11] Arskaya v Ukraine, §§ 62, 69, 70, 88.

It is unsurprising that the German court should opt for the latter approach. It is also perhaps unsurprising that this outcome should be identified in the context of German language and usage. In English, the meaning of "free … consent" is not obvious: not "free from" something specified, simply "free". The meaning identified above (and discussed further below) of "free will" does point to a clear meaning: "free" means competent, and legally effective. It must surely be common ground that, in the context of the CRPD of all places, a disability preventing a person from giving competent consent to healthcare treatment, or preventing exercise of legal capacity in any other way, should not disqualify that person from receiving healthcare treatment, or from the benefits and protections of any other exercise of legal capacity.

In the CRPD, "free and informed consent" appears not in Article 14, but in Article 25, part of the first sentence of which is quoted above. The particular requirements of Article 25 include that States Parties should "d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent …". Here again the method of reasoning of the German court is relevant. Healthcare cannot be provided "of the same quality … as to others" if people incapable of giving free and informed consent because of their disabilities should be excluded from receiving it. "Others", if taken to hospital unconscious following an accident or sudden onset of illness, receive treatment notwithstanding their inability at the time to give "free and informed consent". If that inability is the consequence of a disability, treatment should still be given.

A key word in this discussion is "include" in the second sentence of Article 1 of the CRPD: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". People with disabilities across the world still face such barriers, in various ways and degrees. The sustained energy of the UN Committee in confronting reluctance to remove those barriers – wherever it is encountered – is to be absolutely commended, driven as it is by personal experience of their own disabilities. Those are disabilities, the disadvantages of which could ultimately be removed substantially if not entirely by the elimination of such barriers. That holds good for physical, sensory and many intellectual disabilities. In the legal sphere, the support provisions of Article 12(3) of the CRPD should be applied to the maximum extent to enable as many people with intellectual disabilities, in as many matters, as possible to exercise their legal capacity themselves. There will always be people, however, for whom measures relating to the exercise of legal capacity referred to in Article 12(4), will be necessary if (in the words of the German court, translated): "helpless persons" are not to be abandoned "to their own devices".

It is here that the word "include" in Article 1 is so significant. Persons with disabilities, for the purposes of the CRPD, are not limited to those whose full and effective participation in society is limited by barriers. It also includes those, albeit a minority, who are in some respects limited by the very nature of their intellectual disabilities. That, for some, means in relation to the exercise of legal capacity. If that were not so, and if they were not included within the provisions of the CRPD, then - as the German court identified – there would be no place for the safeguards in Article 12(4).

Comment: The four concepts of "will"

I return to the four concepts, to be found at various points in the decision, of "free will", "natural will", "original free will" and "the when-necessary-supported-will of the person with a disability". The decision does not set out clear definitions of any of them. It is understood that the core meanings of the first two are however well established in German law, though there is some marginal ambiguity and scope for debate. As indicated above, and put simply, free will means a competent formation and expression of will, sufficient for a legally valid action or transaction. An action could be consent to (or refusal of) healthcare treatment, or making a Will. A transaction could be entering a contract.

Also as indicated above, and again put simply, natural will means any wish or will that is consciously and wilfully expressed or made known to others, notwithstanding that it might lack legal validity because it was not capably formulated and communicated. It could be expressed as an acceptance or refusal of healthcare, but might lack validity as such. Likewise, a purported Will or contract could lack validity.

With these two concepts defined with a degree of confidence, one can move forward to suggest, also with some degree of confidence, that "original free will" means a competent formation and expression of will in the past of a person who may no longer retain such competence, but which remains decisive.

Two aspects of the court's treatment and use of these three concepts are significant and fascinating. Firstly, the court appears to accept a reality which has always been readily apparent to anyone with experience of engaging with people with even some of the wide and diverse range of intellectual disabilities. The court appears to accept that humanity does not divide neatly into people capable of "free will", on the one hand, and those incapable of "free will" and able only to communicate expressions of "natural will", on the other. These concepts are at two ends of a spectrum. The formation and expression of will by different people, by the same person at different times and in different circumstances, or by the same person in relation to different matters, can all be at different points along that spectrum, as well as at one end or the other. Thus, for example, the court refers to "the quality of the natural will": a particular formation and expression of natural will may be at some point closer to, or further from, the "free will" end of the spectrum.

This leads to the even more significant aspect in the decision, which is the apparent synthesising of these different categories of "will" into a single overall concept of "will", particularly in a passage where the court elaborates how the legislature must resolve the question of proportionality and give the highest possible weight to the person's will. My interpretation of that requirement is this. The principle of proportionality must be applied to the question whether, in a particular case, the presumption in favour of a person's expressed will should be applied and should be decisive, or whether – exceptionally – a person's expressed will should be overridden. The requirement is that the legislature should provide methodologies for carefully determining whether a person's "free will" can be identified, or even constructed, so that such "free will" will be decisive.

This echoes the process of "constructing decisions" which I described in the final chapter (Chapter 15: "Constructing Decisions") of *Adult Incapacity*, W Green, 2003. That chapter offered a description of the decision making process required by the newly enacted Adults with Incapacity (Scotland) Act 2000. I described a hierarchy of elements ranging from, at one end, an adult's present competent decision, through past competent decisions, decisive or at least significant choices, current wishes and feelings, past wishes and feelings, information about the adult from persons closest to the adult, and widening beyond there to significant personal or professional input about the adult, the shared views and ethos of the adult's family and background, and so forth. Generally, an element earlier in that list should prevail over a later element, unless later elements strongly and persuasively indicate that it would be appropriate for them to prevail. Different aspects of a decision might be derived from different points on the hierarchy. However, while other people may play a role in this process of constructing a decision, the purpose of such a process is to construct the adult's decision in the matter, not to impose a decision made by someone else.

I write "echoes" advisedly. There is a quantum leap from a process of constructing a decision, to transferring a somewhat similar methodology to a process of identifying and perhaps constructing what is a person's will, and assessing the quality of that will, in relation to a particular purpose and at a particular time.

Constructing a person's will can be equated with the recommendation in paragraph 21 of General Comment No. 1 that: "Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the 'best interpretation of will and preferences' must replace the 'best interests' determinations". An assessment of the quality of the will thus interpreted or constructed is necessary when there is conflict among a person's rights, will and preferences in the context of the requirement of Article 12(4) of the CRPD that safeguards must "respect the rights, will and preferences of the person"[12].

On this view, one could see this decision of the German Federal Constitutional Court as a significantly progressive step in carrying forward the task of implementing and operationalising the key requirement of Article 12(4) to respect a person's rights, will and preferences. If respect for a person's will is to be elevated from "something that is good" to an element actually to be delivered in the world of hard reality, the only way of maximising that respect requires something more than defining ways to travel as far as possible in the direction of identifying or even constructing "will" that in particular circumstances can be categorised as decisive "free will". If we accept that the purpose here is to set the potential boundary of decisive "free will" as widely as possible, and if doing so is to become effective not only in theory but in day-to-day practice, it becomes all the more important that this boundary be clearly defined. It becomes essential to define the boundary up to which "will" is decisive, and beyond which, for a particular purpose and in a particular situation, that "will" is of such a quality that respect for a person's rights, or addressing a situation where there are various incompatible preferences, may require that the person's will be overridden.

It is in the context of this interplay of the flexible concepts of will, and the need to assess whether identified or even constructed will should be decisive, that the court said that the free will of the person needs to be respected even if it can only be determined by reference to previously expressed views of the person, or based on the quality of the natural will. The court went further when (in Sabine's translation – see above) it said that: "This can, *inter alia*, require differentiation as to how much weight should be given to the natural will of the person, depending on how close it comes to the person's free (or presumed free) will after providing due support".

We have only this one tantalising reference to this significant further step forward to the concept of "the when-necessary-supported-will of the person with a disability". Article 12(3) of the CRPD requires states parties to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". The proper route towards satisfying this requirement has been the topic of considerable discussion. The formula used by the court suggests that the route to providing the support required by Article 12(3) must include strategies for supporting the person's will. Much work remains to be done to create and operationalise such strategies.

If the above analysis is correct, then the German Federal Constitutional Court is to be congratulated for signposting this significant step forward in the task, shared by the worldwide community, of fulfilling in day-to-day practice the aspirations and promise of the CRPD.

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[12] An exploration of how the drafting committee for the CRPD intended that "will" should be understood in this phrase would be valuable, but is beyond the scope of this report, as it would appear to require further research into the travaux préparatoires. This would appear to be a situation where resort to the travaux would be appropriate in terms of Article 32 of the Vienna Convention on the Law of Treaties (see §2 of the Essex Autonomy Three Jurisdictions Report referred to in footnote 1 above).

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