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A comparative analysis of the intersection of mental capacity laws and international human rights law in Northern Ireland and Ireland

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ABSTRACT

This article examines the law on mental capacity in Ireland and Northern Ireland. It sets out key provisions in the Mental Capacity Act (Northern Ireland) 2016 (MCA (NI)) and the Assisted Decision-Making (Capacity) Act 2015 (ADMCA). The slow legislative progress in Ireland and Northern Ireland requires closer examination, particularly due to the unique links between the jurisdictions. Both Northern Ireland and Ireland have ratified the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), and this article considers how both legislative models align with human rights obligations under the CRPD. The 'fusion' model of legislation adopted in Northern Ireland represents an experimental approach, retaining provisions on substitute decision-making but placing a greater emphasis on supporting persons to make decisions. The legislation in Ireland also adopts an experimental approach placing a premium on supported decision-making, while also retaining substitute decision-making provisions. The article evaluates the jurisprudence of the Committee on the Rights of Persons with Disabilities on article 12, using it as a lens to assess the MCA (NI) and the ADMCA. By comparing the principles underpinning the legislative frameworks, best interests in the MCA (NI) and will and preferences in the ADMCA, and the different approaches to capacity assessment, this article argues that the ADMCA aligns better with the CRPD's requirements. The ADMCA in Ireland and the fusion model in Northern Ireland are gaining international attention for their experimental approaches to capacity legislation reform and seeking alignment with article 12 of the CRPD. While these models aim to enhance autonomy, respect human rights and move away from restrictive systems, their effectiveness in practice requires further research to identify operational challenges and ensure alignment with the CRPD. These models offer valuable insights for global capacity law reform initiatives.

Keywords: mental capacity law; CRPD; Northern Ireland; Ireland; legal capacity; article 12; best interests; will and preferences; law reform; equal recognition before the law.

INTRODUCTION

This article examines the law on mental capacity in Ireland and Northern Ireland.[1] It looks at the development of the Mental Capacity Act (Northern Ireland) 2016 (MCA (NI)) and the Assisted Decision-Making (Capacity) Act 2015 (ADMCA). There has been significant legislative development in other jurisdictions in this area, including jurisdictions of the United Kingdom (UK). The delayed legislative development in both Ireland and Northern Ireland demands greater consideration of the respective legal frameworks, especially given the unique relationship between both jurisdictions. The cross-border nature of life for some Irish and British citizens introduces a unique complexity to the application of legal protections for persons whose mental capacity may be in question. This freedom to move, live and work between Ireland and Northern Ireland means that persons could potentially be subject to either legislative regime, depending on where they choose to live or seek services.[2] Consequently, the differences between the legal frameworks in these jurisdictions can lead to varied human rights protections. The ability to navigate between these legal systems becomes crucial. Therefore, this article seeks to develop an understanding of the governing mental capacity in both regions. It has been noted that cross-border healthcare remains a largely neglected aspect of public policy, with limited appetite from authorities on either side of the border to address the issue.[3] The ongoing efforts both in Northern Ireland and the Republic of Ireland to implement new capacity and mental health legislation presents a valuable opportunity for cross-border cooperation to not only facilitate smoother implementation of both models but also to lay the foundation for developing larger, long-term collaboration in cross-border healthcare.

Both Northern Ireland and Ireland have ratified the UN Convention on the Rights of Persons with Disabilities (CRPD), and this article considers whether the law in both jurisdictions complies with obligations under article 12 of the CRPD. The fusion model in Northern Ireland, with its focus on substitute decision-making,

1 Northern Ireland is part of the United Kingdom of Great Britain and Northern Ireland, which consists of England, Scotland, Wales and Northern Ireland. Ireland is a separate jurisdiction created initially under the Anglo-Irish Treaty in 1921, as the Irish Free State in 1922 and as a republic in 1949. For the purposes of this article the law on the island of Ireland, as it relates to Northern Ireland and Ireland, is considered.

2 See Clayton Ó Néill and Andrea Mulligan, 'Health law: convergence and divergence on the island of Ireland' (2023) 34(2) Irish Studies in International Affairs 285–329.

3 Deirdre Heenan, 'Cross border cooperation: health in Ireland' (2021) 32(2) Irish Studies in International Affairs 117–136, 134.

marks an experimental departure in legal and policy frameworks in this area. Meanwhile, Ireland's legislation has introduced a range of supported decision-making components while also maintaining substitute decision-making provisions. This article critiques the delayed enactment of these laws in both jurisdictions and points out the critical differences and similarities. The development of new laws in both jurisdictions has not yet yielded substantial comparative analysis. A more thorough comparative analysis of the legislative frameworks is needed.[4] This article seeks to add to the existing literature in developing this comparative analysis.

NORTHERN IRELAND

The relevant legislation in place in Northern Ireland is the MCA (NI), which received royal assent on 9 May 2016. Despite the lengthy period required to develop and enact the MCA (NI), the legislation is not fully implemented and is being commenced slowly on a phased basis.[5] Given the delayed implementation, the pre-existing legislation, the Mental Health (NI) Order 1986, remains on the statute book and interfaces with the MCA (NI). This will remain the case until such time as the MCA (NI) is fully implemented and repeals the Mental Health (NI) Order 1986. Therefore, at the time of writing this article the two systems continue to operate alongside each other. The approach adopted in Northern Ireland is known as the fusion approach, amalgamating mental health and mental capacity laws in a standalone piece of legislation. It has been suggested that the MCA (NI) represents 'an exciting and innovative development and there are substantial potential benefits, including the reduction of stigma, the protection of patient autonomy and the removal of confusing parallel mental health and mental capacity legislation'.[6] This approach differs from the approaches adopted in other parts of the UK (England and Wales (Mental Capacity Act 2005) and Scotland (Adults with Incapacity (Scotland) Act 2000). The discussion in this section is confined to key issues such as the background to the legislation, the best interest principle, assessing capacity etc, as it

4 See Anne-Maree Farrell et al, 'Mental health policies and laws on the island of Ireland' (Edinburgh School of Law Research Paper 7/2022 2022); and Ó Néill and Mulligan (n 2 above).

5 Phase one implementation took place between October and December 2019. See Mental Capacity (2016 Act) (Commencement No 1) Order (Northern Ireland) 2019, 2019 No 163 (C 5), Mental Capacity (Deprivation of Liberty) (No 2) Regulations (Northern Ireland) 2019, Mental Capacity (Research) Regulations (Northern Ireland) 2019, 2019 No 193 and Mental Capacity (Money and Valuables) Regulations (Northern Ireland) 2019.

6 Gerard Lynch, Catherine Taggart and Philip Campbell, 'Mental Capacity Act (Northern Ireland) 2016' (2017) 41(6) BJPsych Bulletin 353–357, 357.

is not feasible to comprehensively address every aspect of the MCA (NI) within the scope of this article. This approach will facilitate a comparative analysis with key corresponding provisions implemented in Ireland by way of the ADMCA.

Background to the MCA (NI)

The enactment of the MCA (NI) has taken a long and winding path. One of the main drivers for law reform in Northern Ireland was recognition that it was out of step with the developments in the other jurisdictions of the UK (namely England and Wales and Scotland). Therefore, the Department of Health for Northern Ireland commissioned a number of studies and reports into this area of law and corresponding areas of 'mental health' and 'learning disability service delivery'. A report published in 2007 marked the culmination of this lengthy review process and the report made recommendations that ultimately informed the MCA (NI) 2016.[7] This review process is known as the Bamford Review. One of the key recommendations from the report of the Bamford Review was the creation of 'a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern Ireland'.[8] The rationale for this recommendation was that such an approach would support a reduction in stigma and prejudicial attitudes directed towards having separate mental health legislation, while simultaneously augmenting protections for persons considered to lack capacity and support them to make legally effective decisions relating to mental or physical health, personal welfare or financial decisions.[9] The Bamford Review identified that confusion arose as a result of having legislation covering mental illness and another piece of legislation covering mental capacity.[10] Therefore, it considered it desirable for:

> one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust ... Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory.[11]

The approach adopted in Northern Ireland is referred to as the 'fusion' or 'fused' approach as it brings together mental health and

7 Bamford Review, *A Comprehensive Legislative Framework: The Bamford Review of Mental Health and Learning Disability* (Northern Ireland) (2007).
8 Ibid.
9 Ibid.
10 Ibid 36.
11 Ibid.

mental capacity laws into a standalone piece of legislation.[12] The Law Commission for England and Wales defines fusion as 'a single legislative scheme governing the non-consensual care or treatment of people suffering from physical and/or mental disorders, whereby such care or treatment may only be given if the person lacks the capacity to consent'.[13] Dawson and Szmukler are the leading proponents of this model.[14] They argue that it is feasible to conceive a law that merges the advantages of incapacity and civil commitment models, drawing on the intervention criteria set out in the Mental Capacity Act 2005 of England and Wales.[15] Their proposed approach aims to minimise unwarranted legal bias against persons with mental disorders and enforce uniform ethical standards throughout medical law.[16] Essentially, the argument is that the fusion approach to mental health and capacity law suggests that it can enhance the rights of persons subject to the legislation and aligns better with the obligations arising from international human rights law, including the CRPD. However, the approach has proven controversial with many commentators critiquing the approach from a variety of different perspectives. As Campbell and Rix point out, the fusion model has been proposed and rejected in other jurisdictions of the UK.[17] However, recent law review processes in England, Wales and Scotland have shown renewed interest in adopting this model as a replacement for their current legislative approaches.

The approach in England and Wales has been to deal with mental health through the Mental Health Act 1983 and mental capacity through a separate piece of legislation, the Mental Capacity Act 2005. However, there has been an increased interest in fusion as evidenced by the Law Commission for England and Wales' consultation on its work on *Mental Capacity and Deprivation of Liberty*. The Commission's consultation coincided with the enactment of the Mental Capacity (Northern Ireland) Act 2016. The Law Commission in its report emphasised the potential for the fusion model to reform mental health legislation in England and Wales, suggesting that the approach could be the future direction of reform in that jurisdiction. The Commission

12 Gavin Davidson, Tomas Adell and Aine Morrison, 'The development of a non-discriminatory alternative to mental health law, the Mental Capacity Act (Northern Ireland) 2016' (2020) 1 Journal of Elder Law and Capacity 68–78.

13 Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017) 2.

14 John Dawson and George Szmukler, 'Fusion of mental health and incapacity legislation' (2006) 188(6) British Journal of Psychiatry 504–409.

15 Ibid.

16 Ibid.

17 See Philip Campbell and Keith Rix, 'Fusion legislation and forensic psychiatry: the criminal justice provisions of the Mental Capacity Act (Northern Ireland) 2016' (2018) 24(3) BJPsych Advances 195–203.

recommended in its report that the UK and Welsh Governments take that opportunity to consider this approach. Fusion was also recently considered as part of the ongoing review of Scottish mental health law. The review advocated for a gradual process of reform, outlining reforms for the short, medium and long-term.[18] It recommended that merging laws related to mental health and capacity could be a long-term goal, but it would be more beneficial to seek closer harmony between the different pieces of legislation as an initial step. It was suggested that this could be achieved by establishing common principles based on human rights, and by embracing a framework that promotes human rights enablement, supported decision-making, and autonomous decision-making.[19] Additionally, it recommended making immediate, short-term enhancements that do not necessitate changes in the law or complex alterations in policy.[20] This phased approach was recommended, given the vast, intricate and interconnected nature of the fusion approach.

An overview of the MCA (NI)

Northern Ireland was the last jurisdiction in the UK to enact updated legislation regulating the area of mental capacity. Like the corresponding legislation in England and Wales, the Northern Ireland legislation provides for a presumption of capacity in respect of adults (persons aged 16 and over).[21] The legislation also provides for a test of incapacity. In the context of medical decision-making, it provides for the 'doctrine of necessity'.[22] While one of the purported benefits of the fusion approach is to reduce confusion and complexities in the legislation, the MCA (NI) nonetheless is a highly complex statute. Part 1 of the Act sets out the key principles underpinning the legislation. These principles codify and expand the common law presumption of capacity of persons aged 16 and above.[23] In addition, the principle of 'best interests' is placed on a statutory footing in section 2.[24] The principle applies to persons aged 16 and over, who lack capacity in relation to whether the act should be done, or a decision made for or on behalf of a person who is 16 or over and lacks capacity to make

18 See Mental Health Directorate, *Scottish Mental Health Law Review: Our Response* (Health and Social Care, 28 June 2023) 8.
19 Ibid.
20 Ibid.
21 See part 1, MCA (NI).
22 See Explanatory Notes to Mental Capacity Act (Northern Ireland) 2016: Explanatory Notes, para 3.
23 See s 1, MCA (NI).
24 See ibid ss 2 and 7.

the decision.[25] Section 7 outlines the principles to be followed when determining what is in the 'best interests' of a person aged 16 or over under this Act. It emphasises that decisions should not be based solely on age, appearance, or other characteristics that might lead to biased assumptions about their best interests. The decision-maker is required to consider all relevant circumstances and is specifically instructed to assess whether the person is likely to regain capacity regarding the matter in question and to involve the person as much as practicable in the decision-making process. Additionally, section 7 requires special consideration to be given to the person's past and present wishes, beliefs, values and any other factors that they would consider if able.[26]

Importantly, the provisions on the presumption of capacity[27] and the 'best interests' principles[28] emphasise the need to support persons subject to the legislation to exercise their legal capacity and engage in decision-making. This is considered to be an improvement on the existing law. The legislation retains substitute decision-making, which applies in circumstances where a person is considered to lack the mental capacity to make a specific decision at a particular time. The provisions of the MCA (NI) are set out in 15 parts consisting of 308 sections in total. In addition, there are 11 schedules accompanying the legislation. Part 1 of the MCA (NI) emphasises the key principles underpinning the legislation. The principles place on a statutory basis the common law presumption of capacity and the requirement that decisions made by a third party for a person considered to lack mental capacity need to be done in the person's 'best interests'. Part 1 of the MCA (NI) also seeks to recognise the obligations arising from the UK's ratification of the CRPD (which happened after the Bamford Review). In that regard there is recognition of the need to take measures to support persons subject to the legislation to make decisions for themselves. Ó Néill and Mulligan have suggested that the UK's decision to ratify the CRPD in 2009 probably had a more significant impact on the law reform process in Northern Ireland than the theoretical discussions regarding the fusion model, given the requirement in the Convention to move towards a more rights-focused framework.[29]

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25 See ibid ss 2(1)(a) and 2(1)(b).

26 Ibid s 7, also requires consultation with relevant persons, defined broadly to include family, caregivers and legal representatives, in order to ensure a comprehensive understanding of best interests. The decision-making process must also seek to accomplish its goals in the least restrictive manner to the person's rights and freedoms, consider the implications of inaction, and expressly prohibits decisions on life-sustaining treatment from being motivated by a desire to end the person's life.

27 See ibid s 1.

28 See ibid ss 2 and 7.

29 See Ó Néill and Mulligan (n 2 above) 296.

Section 9 of the MCA (NI) is significant as it formally codifies the common law principle, often referred to as the defence of necessity. This section essentially allows persons involved in the care, treatment or personal welfare of someone aged 16 or older, who is unable to make decisions regarding their care, to act on their behalf.[30] The placing of the doctrine of necessity on a statutory basis was considered essential to address the concerns of persons who provide services and support to persons whose decision-making is called into question.[31] The rationale for this provision is that it insulates third parties from both civil and criminal liability when making decisions on behalf of a person. It is subject to the requirement that this protection is only available when that third party makes the decision in the person's best interests.[32] There are additional safeguards provided for in part 2 of the MCA (NI). The legislation provides that where the intervention in respect of the person considered to lack capacity is more significant, the greater level of safeguards applies.[33] Before an intervention takes place it has to be established that the person lacks the mental capacity and that the intervention by the third party has to be in that person's best interests. Therefore, the requirement to undertake a formal assessment of the relevant person's mental capacity and to appoint and consult with a nominated person are seen as core safeguards.[34]

Section 3 outlines the meaning of 'lacks capacity' under the MCA (NI). It states that a person is considered to lack the capacity concerning a specific issue if, at the time when a decision is needed, they are 'unable to make a decision' on their own regarding that issue (as defined in section 4) 'because of an impairment of, or a disturbance in the functioning of, the mind or brain'.[35] Therefore, the reason for the inability to decide must stem from disturbance in the functioning of the mind or brain. Essentially, the definition in section 3 zeroes in on the precise moment a decision is required and the specific issue at hand. It does not evaluate a person's overall decision-making abilities. A person might be assessed as lacking capacity for one issue but not another. The section further clarifies that lacking capacity can apply even if the capacity loss is temporary and irrespective of the

30 However, MCA (NI), s 10, specifies an exception to this rule: acts related to psychosurgery are not covered under this defence. Consequently, psychosurgical treatments for persons who are unable to consent must be authorised by a court.

31 See Explanatory Notes to Mental Capacity Act (Northern Ireland) 2016: Explanatory Notes, para 3.

32 See s 9(1)(d)(ii), MCA (NI).

33 See Explanatory Notes to Mental Capacity Act (Northern Ireland) 2016: Explanatory Notes, 16.

34 Ibid.

35 See s 3(1), MCA (NI).

impairment or disturbance's cause.[36] This cause could be a disorder or disability, but it might also not be.[37] Section 4 is important as it outlines the criteria for determining if a person is unable to decide about a particular issue. A person is deemed unable to make a decision if they cannot: (a) understand the information related to the decision, including understanding the likely outcomes of different decisions or the absence of a decision; (b) retain that information long enough to make a decision; (c) recognise the significance of the information and incorporate it into the decision-making process; or (d) communicate their decision.[38] Therefore, both the diagnostic and functional criteria are connected by the requirement of a causal relationship.[39]

Sections 13 and 14 of the MCA (NI) address the procedures for formally assessing a person's capacity, particularly in situations involving significant interventions. Section 13 stipulates that for actions constituting or forming part of a significant intervention, a detailed assessment of the person's capacity is mandatory, along with the issuance of a statement declaring incapacity.[40] Section 9 also provides that a belief that the person lacks capacity is not reasonable without the completion of a formal capacity assessment. Furthermore, this assessment must be recent enough to be applicable and meaningful.[41] Section 14 defines a 'formal capacity assessment' as an evaluation performed by a professional deemed appropriately qualified as per future regulations. A 'statement of incapacity'[42] is also defined in this section, as a written declaration by the assessor affirming that, in their professional judgement, the person lacks the capacity for a significant intervention. This statement must detail which specific functional aspects of the capacity test, as described in section 4, that the person cannot fulfil due to a mental or cognitive impairment. Crucially, the statement should also document any unsuccessful attempts to provide the person with the necessary assistance or support to make the decision independently.

Hence, the assessment method for capacity provided for in the MCA (NI) differs significantly from the approach in the ADMCA in Ireland. Unlike the ADMCA, which relies solely on a functional assessment of capacity, the MCA (NI) incorporates both a diagnostic

36 See ibid s 3(2).
37 See ibid s 3(3).
38 See ibid s 4(1)(a)(b)(c)(d).
39 See Ó Néill and Mulligan (n 2 above) 297.
40 Without these actions, the person conducting the intervention cannot claim immunity from liability as outlined in s 9 of the MCA (NI).
41 However, this requirement is waived in emergency scenarios, as provided for in ibid ss 65 and 66.
42 See ibid s 14(3).

and functional test. Ó Néill and Mulligan have noted that this dual approach in the MCA (NI) does not align with article 12 of the CRPD.[43]

The fusion model and the MCA (NI)

Dawson and Szmukler argue for a law that applies to all persons who are considered unable to make important decision for themselves, irrespective of the reason for that 'inability'.[44] As mentioned above, the main thrust of their argument for this approach is that it reduces or eliminates discrimination in respect of the persons subject to the legislation. Therefore, one of the main aims of the fusion approach is to eliminate discrimination against persons with a 'mental health disability', through fostering respect for the person's dignity.[45] It is suggested that an appropriate 'capacity' criterion is not discriminatory provided 'certain strict conditions are met' and that it can mean that the domestic law complies with international human rights law.[46] However, Flynn and others have expressed concern about the fusion approach and the potential that the assessment of whether the person has 'functional capacity' to understand and appreciate the nature and consequences of their decision-making can be excessively flexible, resulting in the erosion of the person's rights.[47]

The introduction of the CRPD has ensured that the concept of disability has undergone a 'paradigm shift' in thinking.[48] Traditionally, the response to disability was known as the medical model, which focused on what is 'wrong' with the person and the 'problem' caused by a particular impairment or condition.[49] This shift in thinking is encapsulated in the move from the 'medical model' to the 'social model'

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43 See Ó Néill and Mulligan (n 2 above) 298.

44 John Dawson and George Szmukler, 'The "'fusion law"' proposals and the CRPD' in Michael Stein et al (eds), *Mental Health, Legal Capacity, and Human Rights* (Cambridge University Press 2021) 95–108, 107.

45 Ibid.

46 Ibid.

47 See Peter Bartlett, 'A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention' (2012) 16(6) International Journal of Human Rights 831–844 and Eilionóir Flynn, 'Mental (in)capacity or legal capacity? A human rights analysis of the proposed fusion of mental health and mental capacity law in Northern Ireland' (2013) 64(4) Northern Ireland Legal Quarterly 485–505.

48 Rosemary Kayess and Phillip French, 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8(1) Human Rights Law Review 1–34.

49 Charles O'Mahony and Shivaun Quinlivan, 'The Convention on the Rights of Persons with Disabilities' in Gerard McCann and Féilim Ó hAdhmaill (eds), *International Human Rights, Social Policy and Global Development: Critical Perspectives* (Bristol University Press 2020).

and now to the 'human rights model' of disability.[50] The medical model assumes that any reduction in quality of life, or ability to participate in society, is because of a medical condition intrinsic to the person. Therefore, the focus of the medical model has been on medical solutions such as healthcare and related services. The focus is on addressing the functionality of the person to allow them to live a more 'normal' life, in other words all the failings are with the person.[51] Degener highlights that this has resulted in several assumptions, for example, that people with disabilities need to be minded and protected or are not capable or able.[52] These assumptions have led to the development of segregated or separate law and social policies such as mental health and guardianship laws, special schools and institutions. Therefore, the assessment method for capacity provided for in the MCA (NI) (see discussion above), which incorporates both a diagnostic and functional test, can be seen as embedding the medical model in the legislation, an approach at odds with article 12 of the CRPD and its philosophy.

Series and Nilsson note that functional approaches to determining capacity have been gaining favour due to their perceived respect for individual autonomy and are argued to be non-discriminatory towards disabilities.[53] It is suggested that these approaches, which focus on assessing the process of decision-making rather than the decision's outcomes, offer a more personalised and non-biased method to restrict legal capacity in specific areas, in contrast to traditional guardianship criteria.[54] In that regard Dawson and Szmukler have argued that a carefully designed fusion law, which respects a person's rights, will and preferences, and includes necessary safeguards against abuse, could be compatible with the CRPD.[55] In support of this proposition they identify the MCA (NI) as a close approximation of the fusion approach they advocate for.[56] They argue that the legislation, through combining elements of mental health and capacity legislation, complies with the

50 Anna Lawson and Angharad E Beckett, 'The social and human rights models of disability: towards a complementarity thesis' (2021) 25(2) International Journal of Human Rights 348–379.

51 Shivaun Quinlivan, 'The United Nations Convention on the Rights of Persons with Disabilities: an introduction' (2012) 13(1) ERA Forum 71, 71–85.

52 Theresia Degener, 'Disability in a human rights context' (2016) 5(3) Laws 3.

53 See Lucy Series and Anna Nilsson, 'Article 12 CRPD: equal recognition before the law' in Ilias Bantekas, Michael Ashley Stein and Dimitris Anastasiou (eds), *The UN Convention on the Rights of Persons with Disabilities* (Oxford University Press 2018) 339–382.

54 See Wayne Martin, *Towards Compliance with CRPD Art 12 in Capacity/ Incapacity Legislation across the UK: An Essex Autonomy Project Position Paper* (6 June 2016).

55 Dawson and Szmukler (n 44 above).

56 Ibid.

requirements of international human rights law.[57] However, their argument is not convincing as it does not address the core criticisms of the functional approach made by the Committee on the Rights of Persons with Disabilities in General Comment No 1.[58] The Committee in its General Comment No 1 firmly dismisses interpretations of functional assessments of mental capacity as complying with article 12 of the CRPD. The Committee criticised the functional approach for two primary reasons. First, it is often applied in a discriminatory manner in respect of persons with disabilities.[59] Second, it assumes a flawed ability to accurately evaluate a person's mental processes.[60] Therefore, the Committee has concluded that this approach risks denying fundamental human rights, such as equal recognition before the law, based on a person's disability or decision-making capabilities. Instead of allowing for such discrimination, article 12 advocates for providing necessary support to persons to help them exercise their legal capacity.[61]

In his testimony before the Northern Ireland Assembly regarding the legislation when it was a Bill, George Szmukler described it as 'a ground-breaking step which I strongly support'.[62] Subsequently, Dawson and Szmukler described the MCA (NI) as 'cleav[ing] quite closely to the "fusion" model … an important new development in health law'.[63] Under the MCA (NI) non-consensual treatment for both mental or physical medical conditions is decided on the basis of the person's perceived incapacity to consent in conjunction with acting in a person's 'best interests'. Unlike other jurisdictions, the non-consensual treatment of the person is not based on factors such as mental disorder or risk. The MCA (NI) does, however, require that support has to be provided to the person to make the decision for themselves before a determination of a lack of capacity is made. Section 1(4) requires that '[t]he person is not to be treated as unable to make a decision for himself or herself about the matter unless all practicable help and support to enable the person to make a decision about the matter have been given without success'. Section 1(5) further requires that '[t]he person is not to be treated as unable to make a decision for himself or

57 Ibid.

58 See 'General Comment No 1: Equal Recognition Before the Law (article 12)' (UN Committee on the Rights of Persons with Disabilities 11 April 2014) 4.

59 Ibid.

60 Ibid.

61 Ibid.

62 See George Szmukler, 'Comments on Mental Capacity Bill 2015' (Ad Hoc Committee on the Mental Capacity Bill and Clerk to the Committee for Health, Social Services and Public Safety 7 July 2015).

63 Dawson and Szmukler (n 44 above) 107.

herself about the matter merely because the person makes an unwise decision'.

As discussed above, proponents of the fusion model, such as the one adopted in Northern Ireland, dispute the interpretation of the CRPD as outlined by the CRPD Committee in General Comment No 1.[64] However, it is noteworthy that the fusion model pre-dates the development of the CRPD and the jurisprudence that has emerged on legal capacity (article 12) and the right to liberty (article 14). The discourse surrounding the review of mental health and capacity law in Northern Ireland also precedes the drafting and entry into force of the CRPD. As such the CRPD did not form an important aspect of the initial law reform dialogue on the development of the legislation.[65] However, Flynn has noted that the CRPD became more important and prominent in the development of the new legislation for Northern Ireland.[66]

Szmukler and other supporters of the fusion approach have pointed to some of the conflicting interpretations of the relevant international human rights law in this area as a means of supporting their proposals for law reform.[67] For example, Szmukler has pointed to the statements of other UN human rights bodies such as the UN Human Rights Committee and the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which differ and diverge from the jurisprudence of the CRPD Committee.[68] Notwithstanding the different interpretations, the fusion model does not achieve compliance with article 12 of the CRPD and the requirement for state parties to ensure that their domestic law guarantees that persons with disabilities can exercise their legal capacity on an equal basis with others. Szmukler has not substantially engaged with the Committee on the Rights of Persons with Disabilities' fundamental critiques of the functional assessment approach, choosing rather to challenge the Committee's understanding of the requirements for compliance with article 12 of the CRPD. This approach does not facilitate the resolution of key disputes concerning the interpretation of international law.

The Essex Autonomy Project, commenting on the MCA (NI) when it was a Bill, described it as a 'pioneering piece of legislation'.[69] However,

64 See 'General Comment No 1' (n 58 above).

65 See Flynn (n 47 above) 496.

66 Ibid.

67 See George Szmukler, '"Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) World Psychiatry: Official Journal of the World Psychiatric Association 34–41.

68 Ibid.

69 See W Martin et al, 'Three Jurisdictions Report: Towards Compliance with CRPD Art 12 in Capacity/Incapacity Legislation across the UK' (*Essex Autonomy Project* 6 June 2016) 51.

the centrality of substitute decision-making and the 'best interest' principle underpinning the legislation mean that the MCA (NI) requires significant amendment if it is to comply with article 12 of the CRPD. The CRPD Committee has been clear as to what is required by article 12 of the CRPD:

> State parties must holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an unequal basis with others. Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment. These practices must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.[70]

The UK signed the CRPD on 30 March 2007 and ratified it shortly thereafter on 8 June 2009 and subsequently signed the Optional Protocol (OP) to the CRPD on 26 February 2009 and ratified it on 7 August 2009. The UK entered a reservation in respect of article 12(4) of the CRPD at the time of ratification. However, it is important to note that this was not a reservation as to the substantive provisions contained in article 12 of the CRPD. The rationale for this reservation was that the UK Government was of the view that the system in place for appointing third persons to collect social security on behalf of a person with a disability was not consistent with the CRPD. Once this matter was addressed, the UK withdrew this reservation.[71]

In 2017 the CRPD Committee published its first report on the UK's application of the CRPD to domestic law and policy. The Committee's report was highly critical of a number of areas of government policy. In respect of the UK's domestic laws on capacity, it was not surprising that the Committee expressed its concern about the legislation across the different jurisdictions. The Committee noted that the domestic laws restricted the legal capacity of persons with disabilities based on actual or perceived impairment. The Committee was critical of the 'prevalence of substituted decision-making in legislation and in practice, and the lack of full recognition of the right to individualized supported decision-making that fully respects the autonomy, will and preferences of persons with disabilities'.[72]

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70 'General Comment No 1' (n 58 above).

71 The UK withdrew this reservation, as a result of adopting a new procedure to manage this process in 2011.

72 'Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland' (Committee on the Rights of Persons with Disabilities 3 October 2017) para 30.

The Committee further highlighted the insufficient support to all asylum seekers and refugees with psychosocial and/or intellectual disabilities in exercising their legal capacity. The Committee also focused on the research that reports that a higher number of black people with disabilities are compulsorily detained and treated against their will in the UK.[73] In respect of the UK's compliance with article 12, the Committee recommended that the UK should closely consult with organisations of persons with disabilities, including those representing persons from black and minority ethnic groups and in line with the Committee's General Comment No 1 (2014) on equal recognition before the law.[74] The Committee, in accordance with its existing jurisprudence, recommended the abolition of all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws.[75] In addition, the Committee advised the UK to step up efforts to foster research, data and good practices and speed up the development of supported decision-making regimes. It is regrettable that the Committee did not seize the opportunity to discuss the MCA (NI), especially since this model is being considered for adoption in other jurisdictions. By critiquing the legislation and explicitly addressing its compliance with article 12, the Committee could have significantly contributed to clarification as to compliance of the fusion approach with international human rights law.

The UK's next State Party Report is due, and it remains to be seen how the UK Government will frame its response to the criticisms and recommendations contained in the Committee's Concluding Observations on its divergence from the requirements contained in article 12. The existing legislation in place in Northern Ireland has not been reformed in order to implement the Committee's recommendations in the intervening period nor has the legislation even commenced. This is despite the clear communication from the Committee that the models developed in Northern Ireland, and the rest of the UK, do not comply with the CRPD.

It is important to note some of the important differences in the MCA (NI) and the ADMCA in Ireland. As discussed above, section 3 of the MCA (NI) outlines the meaning of 'lacks capacity' under the MCA (NI). Essentially, a person is considered to lack the capacity concerning a specific issue if, at the time when a decision is needed, they are 'unable to make a decision' on their own regarding that issue 'because of an impairment of, or a disturbance in the functioning of,

73 Ibid.
74 Ibid para 31.
75 Ibid.

the mind or brain'.[76] The approach in the ADMCA is based solely on a functional assessment. Therefore, the approach in the MCA (NI) includes a diagnostic test for determining incapacity, an approach that does not align with article 12 of the CRPD. The manner in which the MCA (NI) addresses 'best interests' also differs from the approach in Ireland's ADMCA, which eschews the concept of 'best interest' in favour of the person's will and preferences, which is the central guiding principle of the legislation. This reliance on a diagnostic criterion and the inclusion of 'best interests' renders the legislation less compliant with the commitments derived from the CRPD, which will be discussed below.

IRELAND

Like the law reform processes in Northern Ireland, the journey to enacting new legislation in Ireland has been long. Until recently the law in Ireland meant that a person's legal capacity could be restricted through the ward of court system, a type of plenary guardianship operating under Victorian era legislation, known as the Lunacy Regulation (Ireland) Act 1871. Before the enactment of the ADMCA, the law in this area was also informed by common law principles developed through case law.[77] The ADMCA, which has recently commenced (April 2023), modernises the law and brings closer compliance with Ireland's obligations under article 12 of the CRPD. The new legislation brings Ireland into closer compliance with the CRPD but, arguably, will still fall short due to the retention of provisions on substitute decision-making. This section of the article will discuss Ireland's road to ratification of the CRPD and provide an overview of the ADMCA, its background and key provisions. The section will also provide a brief overview of the Assisted Decision-Making (Capacity) (Amendment) Act 2022 (ADMCA 2022). The ADMCA 2022 made significant amendments to the principal legislation. It will be evident from the discussion below that the approach ultimately adopted in Ireland differs from the model introduced in Northern Ireland, and it will be argued that the approach in the ADMCA aligns better with the requirements of the CRPD, which will be discussed in greater detail in the next section of this article.

76 See s 3(1), MCA (NI).

77 See Patricia T Rickard Clarke, 'Decision-making capacity: standards required by the constitution' in Mary Donnelly and Caoimhe Gleeson (eds), *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections* (Health Service Executive 2021) and *Fitzpatrick v FK and Another* [2008] IEHC 104.

Ireland and the CRPD

Ireland signed the CRPD in 2007 and ratified it in 2018[78] but deferred ratification of the OP.[79] Ireland adheres to the common law tradition of not ratifying treaties until such time it considers that Irish domestic law is in general conformity with the treaty. This has been the justification for the delayed ratification of the CRPD and the refusal to ratify the OP. When ratifying the CRPD in 2018, Ireland entered a Declaration and Reservation on article 12.[80]

Before ratification the Department of Justice indicated that Ireland, when ratifying the CRPD, would enter an interpretative declaration in respect of article 12 (similar to the declarations of other states parties such as Canada, Australia and Norway).[81] This was not a surprise given that the ADMCA provides for substitute decision-making. It declared its understanding of the CRPD as permitting both supported and substitute decision-making arrangements, subject to appropriate and effective safeguards. It went on to state that 'the extent Article 12 may be interpreted as requiring the elimination of all substitute decision making arrangements, Ireland reserves the right to permit such arrangements in appropriate circumstances and subject to appropriate and effective safeguards'.[82] This understanding of article 12 is clearly at odds with the established jurisprudence of the CRPD Committee.[83] Ireland's Declaration in respect of articles 12 and 14 states that Ireland recognises that all persons with disabilities enjoy the right to liberty and security of person and a right to respect for physical and mental integrity on an equal basis with others. However, it declared its understanding of the CRPD to allow for involuntary care or treatment for 'mental disorders', when circumstances require treatment as a last resort, and the treatment is subject to legal safeguards.[84] Ireland's initial state report under article 35 of the CRPD sets out the domestic

78 Ireland was the last country in the EU to ratify the CRPD largely due to the delay in reforming outdated capacity legislation (Lunacy Regulation (Ireland) Act 1871), which does not comply with international human rights standards. This has been replaced by the ADMCA, which was recently commenced (see discussion below).

79 The protocol allows for complaints to be submitted directly to the CRPD Committee, which is a UN body of independent experts which monitors implementation of the CRPD by countries that have become party to it. A person can make a complaint alleging the violation of rights contained in the CRPD if the state party has ratified the optional protocol.

80 UN, Ireland's 'Declaration: articles 12 and 14' (20 March 2018).

81 'Roadmap to Ratification of the United Nations Convention on Persons with Disabilities' (Department of Justice and Equality October 2015).

82 Ibid.

83 'General Comment No 1' (n 58 above).

84 UN, Ireland's 'Declaration' (n 80 above).

position with respect to each article of the Convention.[85] In the report, Ireland highlighted recent developments in public policy and legislation that it considered to bring the state into compliance with the CRPD. Of particular note, the Irish Government showcased its work on the development of the ADMCA, which provides for a new Decision Support Service to support the rights and interests of people who may need support with decision-making.

As noted earlier, Ireland has not yet ratified the OP. This failure to ratify the OP to the CRPD means that Ireland at the time of writing is an outlier amongst European Union (EU) member states (along with the Netherlands and Poland). The OP to the CRPD essentially provides for two procedures to strengthen it, namely the individual communications procedure and the inquiry procedure.[86] The failure to ratify the OP to the CRPD has been criticised by non-governmental organisations, disabled persons' organisations and the Irish Human Rights and Equality Commission as undermining Ireland's commitment to implementing and realising the rights contained in the CRPD. The ADMCA represents a progressive step towards empowering persons with disabilities, and others, by recognising their legal capacity and promoting their ability to make decisions regarding their lives. However, the commitment to respecting human rights in this area is called into question when international safeguards, like the CRPD's OP, are not in place.[87] Ratifying the OP would allow persons, including those under the ADMCA's purview, to file complaints directly with the Committee on the Rights of Persons with Disabilities if they believe their rights under the Convention have been violated (should they meet the Committee's admissibility criteria). This mechanism is crucial for addressing grievances and ensuring accountability, especially in cases where domestic remedies are unavailable, ineffective or have been exhausted. The absence of this international recourse means that persons who face discrimination or whose rights to legal capacity are infringed upon have reduced avenues for redress. It creates a gap in the protection framework, leaving persons subject to the ADMCA without a critical tool to challenge violations and seek justice.

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85 See 'Initial Report under the Convention on the Rights of Persons with Disabilities: Ireland' (Initial Report to the Committee on the Rights of Persons with Disabilities December 2020).

86 The ratification of the OP is 'optional' in that states are not obliged to become parties to the protocol, even if they are party to the parent treaty (the CRPD).

87 The Minister for Children, Equality, Disability, Integration and Youth recently announced the creation of an 'Inter-Departmental Group to speed up work to ratify the Optional Protocol'. See Department of Children, Equality, Disability, Integration and Youth, 'Inter-Departmental Group to Accelerate Work to Ratify the Optional Protocol to the UNCRPD' (5 March 2024).

Overview of the ADMCA: background and key provisions

The Irish Government accepted for many decades that there were significant deficiencies with the wards of court system and committed to the introduction of new legislation.[88] Despite many commitments, new legislation only commenced in April 2023. Prior to the implementation of the ADMCA, the law governing decision-making capacity was largely shaped by principles established through common law and the evolution of case law.[89] In the landmark judgment of *Fitzpatrick v FK*,[90] the High Court was asked to decide whether a hospital could administer a blood transfusion to a patient who had not given consent. Justice Laffoy's ruling in this case is a seminal judgment as it was the first time that an Irish court had to determine the extent to which it could intervene in medical decisions involving an adult patient who had refused treatment in circumstances where their mental capacity was in dispute. Justice Laffoy formulated what was essentially a functional test.[91] In determining whether a patient is deprived of capacity to decide to refuse medical treatment Justice Laffoy set out a three-stage approach, adapted from the English case of *Re C*.[92] Justice Laffoy's test involved assessing whether the person (a) comprehended the treatment information, (b) believed the treatment information, and (c) weighed the information.

Around the same time as Justice Laffoy issued her judgment in *Fitzpatrick v FK*, the Department of Justice published the scheme of the Mental Capacity Bill in 2008. The 2008 Heads of the Bill were largely based on the Law Reform Commission of Ireland's recommendations in its body of work in this area.[93] It is of note that the approach recommended by the Irish Law Reform Commission, which culminated in the 2008 Bill, was modelled on the English Mental Capacity Act 2005. The 2008 Bill sought to reform the ward of court system in so far as it applies to adults and replace it with a guardianship system that would regulate decision-making of persons considered to

88 See, for example, 'Second Disability High Level Group Report on Implementation of the UN Convention on the Rights of Persons with Disabilities' (June 2009) 96.

89 See Clarke (n 77 above) and *Fitzpatrick v FK* (n 77 above) .

90 *Fitzpatrick v FK* (n 77 above).

91 Justice Laffoy in her judgment acknowledged that an adult patient has the mental capacity to decide to refuse medical treatment, but that presumption can be rebutted.

92 *Re C (Adult: refusal of medical treatment)* [1994] 1 All ER 819.

93 See Law Reform Commission, *Vulnerable Adults and the Law* (LRC (83) 2006), Law Reform Commission, *Consultation Paper on Vulnerable Adults and the Law: Capacity* (LRC (37) 2005), Law Reform Commission, *Consultation Paper on Law and the Elderly* (LRC (23) 2003).

lack mental capacity. The Government at the time considered that the 2008 Bill would 'give effect to the Convention in so far as it applies to the legal capacity issues in Article 12 of the Convention'.[94] The draft scheme of the 2008 Bill sought to strike a balance between autonomy and protection. However, much of the commentary on the scheme of the 2008 Heads of Bill recognised that it fell significantly short of complying with the emerging understanding of the requirements of article 12 of the CRPD.[95]

A range of interest groups, professionals and other stakeholders were centrally involved in the reform process through feeding into the Law Reform Commission's consultation process and subsequently through engaging in discussion with Government on the resultant legislation to repeal and replace the ward of court system. The Government subsequently published the Assisted Decision-Making (Capacity) Bill 2013.[96] There was a consensus amongst civil society organisations that the revised Bill represented a 'significant improvement' on the Mental Capacity Bill 2008.[97] On publication of the 2013 Bill, the then Minister for Justice Alan Shatter considered that the Assisted Decision-Making (Capacity) Bill 2013 was sufficiently 'framed to meet Ireland's obligations under Article 12 of the Convention in line with the Government's commitment in the Programme for Government to introduce this legislation'.[98] However, the 2013 Bill has been described as 'an interesting mix of supports ... and substitute decision-making', falling short of the requirements of article 12.[99]

The debate surrounding article 12 of the CRPD significantly influenced the law reform process in Ireland. This is important context for understanding why it was decided to exclude 'best interests' as a

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94 'Second Disability High Level Group Report on Implementation of the UN Convention on the Rights of Persons with Disabilities' (June 2009) 96.

95 See, for example, 'Submission on Legal Capacity to the Oireachtas Committee on Justice, Defence & Equality' (Centre for Disability Law & Policy, University of Galway August 2011).

96 For a discussion on the Bill, see Brendan Kelly, 'The Assisted Decision-Making (Capacity) Bill 2013: content, commentary, controversy' (2015) 184 Irish Journal of Medical Science 31–46.

97 See, for example, 'Equality, dignity and human rights: does the Decision-Making (Capacity) Bill 2013 fulfil Ireland's human rights obligations under the Convention on the Rights of Persons with Disabilities?' (Centre for Disability Law and Policy, University of Galway et al 2013).

98 See Alan Shatter, 'Speech by Minister for Justice, Equality and Defence at the Assisted Decision-Making (Capacity) Bill 2013' (Consultation Symposium, Printworks Conference Centre, Dublin Castle 25 September 2013).

99 Eilionóir Flynn and Anna Arstein-Kerslake, 'The support model of legal capacity: fact, fiction, or fantasy?' (2014) 32 Berkeley Journal of International Law 124, 134–143.

guiding principle in the ADMCA in favour of respecting the person's 'will and preferences'. Critics of the UN Committee on the Rights of Persons with Disabilities' interpretation of article 12 highlight disagreements within the broader UN system in support of their position.[100] For instance, bodies like the UN Human Rights Committee and the Subcommittee on Prevention of Torture have expressed views that diverge from the CRPD Committee's interpretation of legal capacity (article 12) and involuntary treatment (article 14).[101] These bodies have not yet fully endorsed the Committee's positions. Some academic commentators have also criticised the Committee's absolutist position, questioning the prohibition on substitute decision-making.[102] A lot of the debate revolves around the concept of 'legal capacity' and the principle of respecting the 'will and preferences' of persons with disabilities. Szmukler has argued that the terms 'will and preferences' remain ill-defined, which he sees as problematic.[103] Regardless of the ongoing academic debate, the shift from 'best interests' to 'will and preferences' better respects the principles of autonomy and self-determination, especially for adults with disabilities who have been at increased risk of having their decision-making questioned and denied.[104] The 'best interests' standard relies on the judgement of a third party as to what is best for a person, and this trumps the person's own views and limits their autonomy. This shift from 'best interest' to 'will and preferences' in the ADMCA is consistent with the human rights-based approach under the CRPD, allowing greater potential for persons with disabilities to exercise their legal capacity on an equal basis with others and warding off paternalism and substitute decision-making.

The Bill was enacted as the ADMCA. The ADMCA provides for substitute decision-making but also includes several provisions that support persons to make legally effective decisions. The provisions on substitute decision-making are at odds with the CRPD. Nevertheless, there is explicit recognition in the guiding principles of the centrality of respecting the will and preferences of the person. This inclusion in the guiding principles reflects the paradigm shift in thinking as discussed

100 Szmukler (n 67 above).

101 Ibid. For a discussion on the ethics perspective on the shift from 'best interests' to 'will and preferences', see Wayne Martin, 'Respect for the will of the person' in Michael Bach and Natalia Espejo-Yaksic (eds), *Legal Capacity, Disability and Human Rights* (Intersentia 2023) 31–48.

102 Freeman Melvyn Colin 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(9) The Lancet Psychiatry 844.

103 Szmukler (n 67 above).

104 See 'General Comment No 1' (n 58 above) 2.

above. In that regard the guiding principles do not contain the 'best interests' principle, which differs from the approach in the MCA (NI) as discussed above. The Committee on the Rights of Persons with Disabilities has further clarified that in instances where efforts fail to ascertain a person's will and preferences a 'best interpretation of will and preferences' is needed to replace 'best interests' determinations.[105] This is in the Committee's view essential in respecting the 'rights, will, and preferences' as required in article 12(4) of the CRPD.[106] The Committee is explicit that the 'best interests' principle is not a safeguard which complies with article 12 in relation to adults. As Nilsson has explained, the Committee's view is that the 'personal views take precedence over generic accounts of best interests'.[107] This perspective ultimately won out in the law reform debate with the legislature accepting the need to move away from paternalism.

Therefore, the approach in the ADMCA is seen as a positive development that may facilitate interpretation of the legislation in a manner that recognises the person's legal capacity and defend against attempts to interfere with a person's decision-making. The provisions in the ADMCA on supported decision-making have the potential to support the exercise of legal capacity where a person's mental capacity has been called into question. The guiding principles underpinning the ADMCA represent a vast improvement on those originally envisaged in the Mental Capacity Bill 2008.

The framework contained in the ADMCA is more flexible and provides a more functional definition of capacity than the ward of court system.[108] The legislation provides that capacity is assessed only in relation to the matter in question and only at the time in question. If a person is found to lack decision-making capacity in relation to one matter, this will not necessarily mean that they lack capacity in another decision-making area. The legislation recognises that a person's mental capacity can fluctuate. Essentially, the ADMCA now offers three new categories of decision-making options. The three decision-making support options are that decisions can be made on personal welfare, property and finance or a combination of both. Assisted decision-making permits a person to appoint a decision-making assistant.[109] It is envisaged that a family member or support person will generally undertake this role. This support is managed through a

105 See Ibid 5.

106 Ibid.

107 Anna Nilsson, *Compulsory Mental Health Interventions and the CRPD: Legal Capacity, Mental Integrity and Human Rights* (Bloomsbury 2021) 28.

108 See s 3, ADMCA.

109 See Decision Support Service, *Code of Practice for Decision-making Assistants* (April 2023).

formal decision-making assistance agreement to support the person in accessing information to understand, make and express decisions. Importantly, decision-making responsibility remains with the person and the decision-making assistant will be supervised by the director of a new regulator called the Decision Support Service.

The second category of decision-making is co-decision-making.[110] Co-decision-making involves a person appointing a trusted family member or friend as a co-decision-maker to make decisions jointly with them under a co-decision-making agreement. Decision-making responsibility is shared jointly between the person and the co-decision-maker. The legislation regulates the performance of functions of co-decision-maker, registration of co-decision-making agreements, objections to registration, review of co-decision-making agreements, reports by the co-decision-maker and variation of co-decision-making agreements and revocation of co-decision-making agreements. Again, the co-decision-maker will be supervised by the Decision Support Service.

The third category is that of decision-making representative, a form of substitute decision-making which is at odds with article 12 of the CRPD.[111] It is envisaged that the decision-making representative provisions will apply to a small minority of persons who are not able to make decisions even with the provision of support. The ADMCA provides for the Circuit Court to appoint a decision-making representative. A decision-making representative makes decisions on behalf of the person but must abide by the guiding principles set out in section 8 of the ADMCA, which includes having regard to their will and preferences where known or reasonably ascertainable. Decision-making representatives must reflect the person's will and preferences, where possible. The functions of decision-making representatives are limited in scope and duration as is reasonably practicable. The decision-making representative is also supervised by the Decision Support Service.

The ADMCA also introduces for the first time provision for advance healthcare directives into Irish law.[112] The purpose of the advance healthcare directive is to enable a person to be treated according to their will and preferences and to provide healthcare professionals with important information about the person in relation to their treatment choices. The ADMCA permits a person to develop an advance healthcare

110 Decision Support Service, *Code of Practice for Co-decision Makers* (April 2023).

111 Decision Support Service, *Code of Practice for Decision-making Representatives* (April 2023).

112 Decision Support Service, *Code of Practice on Advance Healthcare Directives for Healthcare Professionals* (April 2023) and Decision Support Service, C*ode of Practice for Healthcare Professionals* (April 2023).

directive and appoint a designated healthcare representative to take healthcare decisions on their behalf when they are no longer considered to have the capacity to make decisions, in accordance with their specific treatment instructions and/or their will and preferences.[113] The directive maker can confer powers on the designated healthcare representative to refuse/consent to treatment including life-sustaining treatment. A specific statement must be included for the designated healthcare representative to have powers in relation to life-sustaining treatment. Again, the designated healthcare representatives will be supervised by the Decision Support Service. The status of advance healthcare planning under the ADMCA and the MCA (NI) will be discussed in greater detail below.

ADMCA 2022

It was expected that it would take several years for the ADMCA to be commenced, given the complexity of the legislation, the allocation of the resources required and the establishment of the new regulator, the Decision Support Service. The legislation was finally commenced on 26 April 2023. The significant delays in commencement of the ADMCA have been widely criticised by a range of stakeholders. Part of the delay can be explained with reference to the need for an amending piece of legislation to address issues identified after the enactment of the principal legislation. The Explanatory Memorandum to the amending legislation stated that its purpose was to 'streamline existing provisions in the ADMCA and will also improve safeguards, reduce bureaucracy for those using options under the Act and enable the Decision Support Service (DSS) to undertake its role more effectively'.[114] In preparing for the commencement of the original ADMCA to come into force, the Department of Justice and later the Department of Children, Equality, Disability, Integration and Youth had responsibility for the legislation and identified additional provisions that needed to be addressed in the amending legislation.

The ADMCA 2022 is extremely complex and provides for both technical and procedural amendments deemed necessary before ADMCA can be commenced. The ADMCA 2022 retains the provisions on assisted decision-making, co-decision making and for the appointment of a decision-making representative. The significant number of amendments required in the ADMCA 2022 underscore its

113 Decision Support Service, *Code of Practice for Designated Healthcare Representatives* (April 2023).

114 See 'Explanatory Memorandum: Assisted Decision-Making (Capacity) (Amendment) Bill 2022'.

intricacy and the implications its commencement has for a range of other pieces of legislation.[115]

DISTINCTIVE ELEMENTS: A COMPARATIVE ANALYSIS OF KEY PROVISIONS IN THE MCA (NI) AND ADMCA

This section considers the contrasting approaches to key provisions within the legislation in Northern Ireland and Ireland. This analysis will cover the different approaches in assessing mental capacity, the principles underpinning the MCA (NI) and the ADMCA and recognising advance healthcare directives. This comparative analysis underscores the significance of these different approaches from a human rights perspective, emphasising how legislative frameworks play a vital role in safeguarding individual autonomy and human rights. The discussion suggests that the approach in the ADMCA more effectively aligns with the ethos and requirements of article 12 of the CRPD than the MCA (NI). This analysis is useful as the models represented by both the MCA (NI) and the ADMCA are attracting international interest among academics, law reformers and policymakers. These frameworks are being closely observed as potential alternatives to traditional guardianship laws. As such, understanding the key differences is important.

Áine Flynn, the Director of the newly established Decision Support Service under the ADMCA, has noted that the model adopted in Ireland is attracting significant attention from different jurisdictions.[116] As

115 This is a list of other statutes affected by the 2022 Bill: Adoptive Leave Acts 1995 and 2005, Assisted Decision-Making (Capacity) Act 2015 (No 64), Carer's Leave Act 2001 (No 19), Civil Law and Criminal Law (Miscellaneous Provisions) Act 2020 (No 13), Civil Service Regulation Acts 1956 to 2005, Companies Act 2014 (No 38), Data Protection Act 2018 (No 7), Data Sharing and Governance Act 2019 (No 5), Disability Act 2005 (No 14), Electoral Act 1992 (No 23), Ethics in Public Office Acts 1995 and 2001, Freedom of Information Act 2014 (No 30), Garda Síochána Act 2005 (No 20), Irish Human Rights and Equality Commission Act 2014 (No 25), Juries Act 1976 (No 4), Lunacy Regulation (Ireland) Act 1871 (34 & 35 Vict, c 22), Maternity Protection Acts 1994 and 2004, Minimum Notice and Terms of Employment Acts 1973 to 2005, National Disability Authority Act 1999 (No 14), Organisation of Working Time Act 1997 (No 20), Parent's Leave and Benefit Act 2019 (No 35), Parental Leave Acts 1998 to 2019, Paternity Leave and Benefit Act 2016 (No 11), Protection of Employees (Fixed-Term Work) Act 2003 (No 29), Protection of Employees (Part-Time Work) Act 2001 (No 45), Public Service Management (Recruitment and Appointments) Act 2004 (No 33), Redundancy Payments Acts 1967 to 2014, Succession Act 1965 (No 27), Terms of Employment (Information) Acts 1994 to 2014, Unfair Dismissals Acts 1977 to 2015.

116 Áine Flynn, 'Foreword' in Mary Donnelly and Caoimhe Gleeson (eds), *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections* (Health Service Executive 2021) x.

discussed above, the fusion model in Northern Ireland is similarly attracting significant attention. Bodies responsible for capacity legislation in other jurisdictions have remarked on both the breadth and the ambition of the ADMCA model.[117] The initial reform proposals in Ireland were anchored in the work of the Law Reform Commission and leaned heavily on the medical model of disability. However, through the advocacy of human rights campaigners, activists and civil society organisations, there was a move away from the proposed model, which closely mirrored the Mental Capacity Act 2005 (England and Wales). The deliberate exclusion of the term 'mental capacity' from the legislation's title signified this important shift. Flynn elaborated that the inclusion of 'capacity' within parentheses in the ADMCA's title underscores this fundamental change in approach.[118] Rather than solely devising new methods for evaluating capacity or obtaining consent, the Act's primary aim is to empower people to exercise their legal capacity and make decisions that are respected and legally effective. Flynn also points out that, in its initial drafts, what is now known as the Decision Support Service was initially proposed to be called the 'Office of Public Guardian'.[119] The change in name to Decision Support Service should be seen as a conscious effort to move away from any paternalistic implications, aligning more closely with the Act's core principles and objectives around recognising legal capacity and providing support when needed.[120] The approach taken under the MCA (NI) distinguishes itself in the title of the legislation and in part 7 of the Act, which establishes the role of a Public Guardian.

As discussed above, the MCA (NI) in section 3 defines 'lacks capacity' as a situation where a person, due to an impairment of or a disturbance in the functioning of the mind or brain, is unable to decide regarding a specific issue at the time when a decision needs to be made. This definition emphasises the relevance of the incapacity to the specific moment and issue, rather than assessing a person's general ability to make decisions. Section 4 further details the criteria for determining an inability to make decisions, which include difficulties in understanding, retaining, using, or weighing information relevant to a decision, and communicating the decision. The approach in the MCA (NI) contrasts with the approach in Ireland under the ADMCA, which does not include a diagnostic stage in favour of a purely functional assessment of capacity.[121] Unlike the MCA (NI), the focus in the ADMCA is on how the person decides and the steps they take in the decision-making

117 Ibid.
118 Ibid.
119 Ibid.
120 Ibid.
121 See ADMCA, s 3, 'Person's capacity to be construed functionally'.

process. The Decision Support Service is explicit in its guidance that 'capacity assessment must *only* consider the issue and circumstances in which the decision is being made at a specific point in time' (emphasis added).[122] Therefore, when assessing a person's capacity to make a specific decision, the assessor must consider whether the relevant person is able: to understand information and facts relevant to the decision; to retain that information long enough to make a voluntary choice; to use or weigh up that information as part of the process of making the decision; and to communicate the decision by any means, including by assistive technology.[123] The person will be considered to lack capacity if they fail to meet one or more of these criteria in relation to a specific decision.[124]

Therefore, under the ADMCA framework, a stronger emphasis is placed on the autonomy and rights of persons to make their own decisions, reflecting a greater commitment towards respecting individual autonomy, the human rights model of disability, and the jurisprudence of the Committee on the Rights of Persons with Disabilities than the corresponding legislation in Northern Ireland. As discussed above, the ADMCA also distinguishes itself from the Northern Ireland legislation by explicitly omitting the concept of 'best interests' as a guiding principle for decision-making on behalf of others. Instead, the ADMCA aligns more closely with article 12 of the CRPD, emphasising the importance of respecting the will and preferences of the person. This shift represents a significant departure from traditional models of substitute decision-making. The ADMCA also places emphasis upon a broader spectrum of support options designed to support people in making their own decisions.

There is now a discussion of the different approaches to advance healthcare directives (AHDs) under the ADMCA and the MCA (NI). It is noteworthy that in Ireland one of the most contentious issues that has arisen in the parliamentary process around the ADMCA 2022 related to AHDs. AHDs are essential in supporting persons to articulate their will and preferences in health treatment decision-making, including in mental health treatment decisions.[125] This is essential when a person's views may become unclear or unknown.[126] Under the ADMCA, people

122 Decision Support Service, *Code of Practice for Supporting Decision-Making and Assessing Capacity* (March 2023) 6.

123 Ibid.

124 Ibid 7.

125 Charles O'Mahony and Fiona Morrissey, 'Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 Summary of Recommendations' (Mental Health Reform October 2021).

126 Mary Donnelly, 'Developing a legal framework for advance healthcare planning: comparing England and Wales and Ireland' (2017) 24 European Journal of Health Law 67–84.

who are involuntarily detained in hospital under part 4 of the Mental Health Act 2001 are specifically excluded from making legally binding AHDs. The ADMCA 2022 has expanded legally binding AHDs to people detained under section 3(b)(i) and (ii) of the 2001 Act, but still excludes people detained under section 3(a), the significant risk to self or other grounds. As such, persons under this category have no legal right to have their advance wishes respected, even though they had mental capacity to make decisions about their mental health care and treatment at the time of making their AHD. There is no other group of persons that are specifically excluded from this legal right under the ADMCA; an inadequacy that is clearly contrary to the CRPD. Essentially, AHDs as provided for in the ADMCA cover decisions regarding future healthcare treatment in the event the person is unable to communicate or make such decisions. This includes decisions regarding future mental health treatment. AHDs are considered a critical support to enable people to exercise their legal capacity in making treatment decisions and avoid the need for coercion and non-consensual treatment, which is prohibited under the CRPD. The research suggests that the process of developing an AHD confers recovery and capacity-building benefits for the person.[127] An international systematic review reported that AHDs reduced involuntary admissions by 23 per cent.[128] AHDs are also associated with a reduced need for readmission into hospital[129] and enhanced recovery.[130] This is particularly relevant in the Irish mental health system where 60 per cent of admissions are readmissions.[131]

In Ireland there is an ongoing law reform process to make significant changes to the Mental Health Act 2001, responsibility for which is vested in the Department of Health. This culminated in the publication of a Heads of Bill in 2021. In that Heads of Bill, it is proposed to amend section 57 of the 2001 Act to provide for 'designated healthcare representatives' as per section 88(1)(b)(ii) of the ADMCA. The explanatory note that accompanies section 57 states that this

127 Marvin Swartz and Jeffrey Swanson, 'Commentary: psychiatric advance directives and recovery-oriented care' (2007) 58(9) Psychiatric Services 1164.

128 Mark de Jong et al, 'Interventions to reduce compulsory psychiatric admissions: a systematic review and meta-analysis' (2016) 73(7) JAMA Psychiatry 657–664.

129 Claire Henderson et al, 'Effect of joint crises plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial' (2004) 329(7458) British Medical Journal 136 and Chris Flood et al, 'Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial' (2006) 333(7571) British Medical Journal 729.

130 Swartz and Swanson (n 127 above).

131 There were 16,710 admissions to Irish psychiatric units and hospitals in 2019: 60 per cent of these were readmissions and 14 per cent were involuntary: Health Research Board, 'National Inpatient Reporting System Bulletin' (Health Research Board 2020).

amendment seeks to introduce 'designated healthcare representatives' as per subsection 88(1)(b)(ii)' of the ADMCA. It notes that sections 85(7) and 136 of the ADMCA will need to be amended to ensure these provisions can operate and will ensure parity of treatment for those with mental health issues. Therefore, it appears that the intention in the Heads of Bill is to provide parity in terms of the application of AHDs in respect of both voluntary and involuntary categories: an approach that would align with the requirements of article 12 of the CRPD, at least in terms of non-discrimination in decision-making in general and mental health treatment.

As discussed above, under the ADMCA 2022, AHDs are not legally enforceable for people detained under section 3(a) and are considered a significant risk to self or others but are enforceable for people detained under section 3(b)(i) and (ii) (non-risk grounds). AHDs are legally enforceable for people admitted voluntarily for mental health treatment. While the exclusion would appear to only affect a small proportion of people, in practice it impacts all persons admitted to hospital for mental health treatment due to regrading powers under the 2001 Act to change a person's status from voluntary to involuntary and powers conferred on clinicians regarding the grounds on which a person is detained under section 3(a) or 3(b)(i) and (ii) or both. The exclusion impacts the legal enforceability of AHDs for everyone admitted to the mental health system given that a person may be regraded or the grounds for detention can be changed if the person refuses a proposed treatment, leaving the person at risk of human rights violations and forcible treatment.

An AHD can be taken into consideration, but it is not legally enforceable in these circumstances. The exclusion of persons detained under the 2001 Act violates the CRPD as it discriminates on the grounds of disability.[132] Similar legislative provisions were litigated as discriminatory under the Americans with Disabilities Act in the United States.[133] The Assisted Decision-Making (Capacity) Amendment Bill 2019 proposed to remove this exclusion from the ADMCA. The Bill reached Seanad stage (upper house of the Irish Parliament) but lapsed with the dissolution of the Irish Parliament in March 2020. The responsible minister stressed that this amendment 'was not the final word on this matter' and 'that more is needed to achieve full parity of care' and indicated that the legislation to reform the 2001 Act would

132 See 'Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: the right to liberty and security of persons with disabilities' (UN Committee on the Rights of Persons with Disabilities, adopted during the Committee's 14th session, held in September 2015).

133 *Hargrave v State of Vermont, No 2*: 99-CV 128 (2001); *Hargrave v State of Vermont*, 340 F 3d 27 (2nd Cir 2003).

further address this area.[134] However, the approach adopted in the ADMCA 2022 calls into question the Irish Government's commitment to realising the rights provided for in the CRPD. In addition, the proposed amending legislation to the 2001 Act retains involuntary detention and treatment of persons subject to the mental health legislation, which is at odds with article 14 and allied provisions in the CRPD. It is also in conflict with other rights in the CRPD, specifically article 12, the right to exercise legal capacity on an equal basis with others, article 15, the right to be free from torture, cruel and inhuman treatment, article 17, the right to physical and mental integrity, and article 25, the right to health.

The approach taken to advance planning in the new legislation for Northern Ireland has been described as 'delicately side-step[ping] the issue of advance decisions to refuse treatment by giving them statutory force, but not defining them save by the reference to the common law relating to such decisions'.[135] The law as it currently stands in Northern Ireland provides no statutory basis for advance health planning to consent or refuse treatment. Advance decisions in Northern Ireland have been determined by principles set down under English common law, which pre-dates the introduction of the Mental Capacity Act 2005 in England and Wales and the MCA (NI).[136] The MCA (NI) does not regulate this area. However, section 9 of the MCA (NI) does provide statutory recognition of advance decision-making. Unlike the ADMCA and the Mental Capacity Act 2005 (England and Wales) the MCA (NI) does not codify advance decisions 'preferring instead to be guided by jurisprudential development through the common law'.[137] The Department of Health for Northern Ireland's rationale for not codifying the law on advance directives is that, given that the evolving nature of fused approach adopted in the MCA (NI), it would be 'premature to fix it in statute at this point'.[138] Section 99 of the MCA (NI) provides guidance in respect of advance planning and the provisions on lasting power of attorney. It provides that an attorney giving or refusing consent to treatment is subject to any effective advance decision that was made at the same time or after the lasting power of attorney was made. Therefore, if the lasting power of attorney conferred authority to the attorney to consent to or refuse treatment and then the donor

134 Ibid.

135 Alex Ruck Keene and Catherine Taggart, 'A brave new (fused) world: the draft Northern Irish Mental Capacity Bill, 2014' (2014) Elder Law Journal 395–401.

136 Department of Health, 'Review of the law relating to Advance Decisions to Refuse Treatment: Mental Capacity Act (NI) 2016 section 284' (Presented to the Northern Ireland Assembly by the Department of Health on 14 June 2019).

137 Ibid 1.

138 Department of Health, 'Draft Mental Capacity Bill (NI) Consultation Document' (May 2014) 11.

makes an advance decision refusing consent to such treatment, the donor's later personal choice takes precedence. If an effective advance decision regarding treatment is already in place, section 99 provides that the advance decision is withdrawn by the making of the lasting power of attorney, which gives the attorney authority to consent to or refuse the treatment.

The approach adopted in the MCA (NI) can be considered problematical for a number of reasons. Codification eliminates inconsistent approaches and addresses ambiguities in the law, creating a uniform understanding of the law, an opportunity missed in the MCA (NI). The lack of consensus in the consultation on the MCA (NI) on codification of advance planning flags the potential difficulties in recognising persons' treatment decisions (particularly refusal in mental health settings) in practice. The foregoing discussion of the debate about the applicability of the ADMCA to persons involuntarily detained under the Mental Health Act 2001 highlights the potential for fragmentation in approaches in the capacity legislation in Ireland.

One of the key recommendations from the report of the Bamford Review was the creation of 'a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern Ireland'.[139] The rationale for this recommendation was that such an approach would support a reduction in stigma and prejudicial attitudes directed towards having separate mental health legislation, while simultaneously augmenting protections for persons considered to lack capacity and support them to make legally effective decisions relating to mental or physical health, personal welfare or financial decisions.[140] As such this overarching rationale of the fused legislation in Northern Ireland is undermined by not codifying and ensuring a unified approach to decision-making in both general health and mental health. While the Department of Health for Northern Ireland in its consultation document articulated the view that 'a doctor will no longer have the authority to override an effective advance decision to refuse medical treatment for a mental disorder (which can happen at present)' the lack of codification runs the risk of reducing the legal safeguards for decision-making by persons receiving mental health treatment.[141]

The approach in Ireland under the ADMCA, which excludes persons involuntarily admitted for mental health treatment, is discriminatory and stigmatising. While the approach in Northern Ireland under the MCA (NI) in not codifying the law on advance planning might in practice fail to shore up the decision-making of persons receiving

139 Ibid.
140 Ibid.
141 Ibid 12.

mental health treatment. No other area of healthcare in Ireland involves persons being given treatment without their consent (outside of emergency situations). As such this exclusion is discriminatory and feeds into the stereotype that people experiencing mental distress are a risk when in fact they are more likely to be the victims of violence than perpetrators.[142] There is no evidence to show any increased risk for this group yet they are not allowed to exercise their legal capacity and have their treatment wishes in their AHD respected on an equal basis with others in general healthcare.[143] Equal access to AHDs should be provided for in both the ADMCA and in the legislation amending the 2001 Act and should be codified in the MCA (NI). AHDs are a critical support measure which should be made equally available to everyone, particularly those who are involuntarily detained. The research exploring this area in Ireland suggests that the group who need AHDs the most to increase trust and respect in healthcare are excluded from the legislation.[144] The retention of this exclusion could lead to further discrimination and alienation for a group of people who live in fear of being subjected to unwanted treatment with serious long-term side effects should they become unwell again in the future, leaving this group at high risk of human rights violations. Therefore, it is essential that AHDs should be provided for all persons on an equal basis and the legislation requires further amendment. Similarly, the MCA (NI) should codify this area of law to ensure that the advance healthcare planning of persons is respected in the future. The failure to do so is at odds with the obligations under article 12 of the CRPD and allied rights as discussed above.

SHARED LEARNINGS ON THE DEVELOPMENT OF CAPACITY LAWS IN NORTHERN IRELAND AND IRELAND

Both legislative models seek to move away from regimes that have placed a premium on substitute decision-making by enacting a range of provisions that support persons to a greater extent to make legally effective decisions with regards to health decisions, personal welfare and financial decisions etc. Both jurisdictions also retain substitute

142 Karen Hughes et al, 'Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies' (2012) 379(9826) The Lancet 1621–1629.

143 John Monahan et al, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* (Oxford University Press 2001).

144 Fiona Morrissey, 'The introduction of a legal framework for advance directives in the UN CRPD era: the views of Irish service users and consultant psychiatrists' (2015) 1 Ethics, Medicine, and Public Health 325–338.

decision-making provisions which they anticipate will be used only after all supports are exhausted. Despite this appetite for law reform, both jurisdictions have seen considerable delays in developing, enacting and commencing the new legislation. Part of the delay with the commencement of the legislation in both jurisdictions can be attributed to the complex nature of the legislation, particularly so in Northern Ireland with the intricacies of designing and delivering a fused model. A disjointed approach in Ireland to developing the mental health and capacity law partly explains the delay. The Department of Health has responsibility for the amending legislation to the Mental Health Act 2001, while the Department of Justice and later the Department of Children, Equality, Disability, Integration and Youth led on the enactment of the ADMCA. This approach has certainly led to delays, inefficiencies and a fragmented approach, as illustrated by the conflicting provisions on AHDs. In contrast one government department in Northern Ireland (the Department of Health) was vested with responsibility for the legislation. Nonetheless, there have also been long delays in enactment of this legislation.

The Bamford Review identified that confusion arose as a result of having legislation covering mental illness and another piece of legislation covering mental capacity.[145] Therefore, it considered it desirable for:

> one law for decisions about physical illness and another for mental illness is anomalous, confusing and unjust ... the Review considers that Northern Ireland should take steps to avoid the discrimination, confusion and gaps created by separately devising two separate statutory approaches, but should rather look to creating a comprehensive legislative framework which would be truly principles-based and non-discriminatory.[146]

Another key difference between the legislation in both jurisdictions is that the MCA (NI) provides for persons aged 16 and over, while in Ireland the ADMCA applies to persons aged 18 and over, meaning a lack of safeguards for 16- and 17-year-olds who wish to avail of decision-making supports under the ADMCA. This concern was shared by the Subcommittee on Mental Health in its Report on Pre-Legislative Scrutiny of the Draft Heads of Bill to Amend the Mental Health Act 2001.[147] The Committee recommended that the ADMCA should be

145 Legal Issues Committee, 'A Comprehensive Legislative Framework. Belfast: Bamford Review of Mental Health and Learning Disability (Northern Ireland)' (2007) 36.

146 Ibid.

147 Subcommittee on Mental Health, Report on Pre-legislative Scrutiny of the Draft Heads of Bill to Amend the Mental Health Act 2001 [2022] Oireachtas, 33/HO/04, 58.

amended to cover 16- and 17-year-olds. The CRPD places a premium on recognising the evolving capacity of the child and this certainly is a serious lack of rights protection for persons aged 16 and 17 in Ireland whose decision-making capacity is disputed.

As discussed above, part 1 of the MCA (NI) emphasises the key principles underpinning the legislation and includes the notion of 'best interests'. In contrast, the ADMCA deliberately omitted the inclusion of 'best interests' in the legislation, reflecting the requirements of the CRPD. As discussed above, rationale for the inclusion of 'best interests' in the MCA (NI) is that it insulates third parties from both civil and criminal liability when making decisions on behalf of a person. This runs the risk that the legislation will be interpreted and applied in a paternalistic manner, denying persons subject to the legislation their legal capacity through the imposition of substitute decision-making. As both legislative regimes are implemented and applied in practice, future research would usefully explore to what extent the concept of best interests impacts the rights of persons subject to the legislation in Northern Ireland. Similarly, in Ireland exploration of how the courts understand, interpret and apply the notion of 'will and preferences' will be useful in determining whether the Irish courts depart from the paternalistic impulses that have permeated their adjudication of cases decided under the Mental Health Act 2001 on the basis of the 'best interests' principle.[148] Similarly, the assessment method for capacity provided for in the MCA (NI), incorporating both a diagnostic and functional test, embeds the medical model in the legislation, an approach at odds with article 12 of the CRPD. It can be argued that this aspect of the MCA (NI) is disablist, a repackaging of the medical model, which measures a person against a standard of 'normalcy' rather than embracing the human rights model. In contrast, the ADMCA relies solely on a functional assessment of capacity, which arguably moves closer to compliance with the CRPD as it does not embed the medical model to the same extent.

Another key difference in the approaches in Northern Ireland and Ireland relate to the provisions regulating deprivation of liberty. As mentioned above, the MCA (NI) is being implemented in stages. The MCA (NI) provides for deprivation of liberty safeguards (DoLS), which were implemented in stage one. DoLS essentially provide for a new process regulating deprivation of liberty.[149] In Ireland it was recognised that the ADMCA required provisions regulating deprivation

148 For a discussion on the paternalistic interpretation of the Mental Health Act 2001, see Department of Health, 'Report of the Expert Group on the Review of the Mental Health Act 2001 (2015) 12.

149 The research provisions came into operation on 1 October 2019 and the DoLS and money and valuables provisions came into operation on 2 December 2019.

of liberty of persons considered to lack mental capacity. This was seen as essential to meet Ireland's obligations under the CRPD and the European Convention on Human Rights. It was anticipated that the amending legislation to the ADMCA would address this omission in the principal legislation. However, this was not the case. The explanation from Government for this omission was given that this was such a complex area '[i]t is not possible for the General Scheme to address all of the issues which arise in such a fundamental reform of the law on capacity'.[150] It was suggested that the applicable safeguards for persons deprived of their liberty will be dealt with in separate legislation, legislation prepared by the Department of Health.

A final point on the different approaches in both jurisdictions is that the United Kingdom of Great Britain and Northern Ireland has ratified both the CRPD and its OP. This allows the Committee on the Rights of Persons with Disabilities to hear complaints from individuals or groups affected by the MCA (NI) who allege violations of their rights under the CRPD. In contrast, Ireland's failure to ratify the OP has left a significant gap in oversight and accountability. Ratification of the OP would address this disparity.

CONCLUSIONS

The right of autonomy and self-determination are central principles in allowing everyone to participate as members of society. In that regard, the law in both Northern Ireland and Ireland has been wholly insufficient in facilitating persons requiring support to make legally effective decisions and has operated for generations to deny the legal capacity of persons whose mental capacity has been called into question. The slow development of law reform proposals and their subsequent implementation in Ireland and Northern Ireland requires closer comparative examination, particularly due to the unique social, legal and political arrangements for the island of Ireland. Cross-border movement for Irish and British citizens adds complexity to legal protections for persons subject to these legislative provisions.

The approach in Northern Ireland differs from the approaches in other jurisdictions of the UK. The MCA (NI) places the impairment of mental capacity and the requirement to act in the person's best interests at the centre of the new system, while also recognising advance healthcare planning to respect decision-making. The approach in the ADMCA underscores a broader shift in legal and societal attitudes towards persons with disabilities and their rights and autonomy. By

150 Joint Committee on Children, Equality, Disability, Integration and Youth, Debate, Wednesday 16 February 2022.

prioritising respect for a person's will and preferences and providing an array of supports to facilitate decision-making, Ireland's legislation endeavours to empower and respect human rights and autonomy in a manner that aligns with the principles set forth in the CRPD. This contrasts with the more paternalistic approach in Northern Ireland, where the 'best interests' principle underpins the legislation.

While it can be argued that the MCA (NI) better aligns with the requirements of article 12 of the CRPD, it is clear that it falls short of what is required. The MCA (NI) employs a combination of diagnostic and functional assessment to determine if a person lacks capacity. However, this dual assessment approach conflicts with article 12 of the CRPD. Article 12 emphasises the equal recognition of all persons before the law, advocating for supported decision-making rather than substituted decision-making based on assessments of capacity. The concern is that the MCA (NI)'s reliance on diagnostic and functional tests is paternalistic, based on the medical model and, at least in some cases, could lead to decisions being made for persons rather than supporting them to make their own decisions. While there has been broad support for the experimental fusion model within Northern Ireland, the delayed implementation is regrettable. Given the complexity of the legislation, delayed implementation and its conflict with the requirements of the CRPD, it is hard to accept that the approach in Northern Ireland is a CRPD-compliant one. As this legislation is commenced, it will be crucial to apply rigorous scrutiny to determine whether it indeed fulfils its goal of better respecting human rights, ensuring that it does not merely promise reform but actively promotes and protects the autonomy and dignity of persons subject to its provisions.

Ireland was one of the first state parties to sign the CRPD when it opened for signature in 2007 and the last EU member state to ratify it in 2018. Despite firm commitments from successive governments, the delayed enactment of the legislation has jeopardised the rights of persons governed by the outdated framework of wardship. Recognising the legal capacity of persons with disabilities is paramount, as it serves as a gatekeeper right that unlocks access to a spectrum of other human rights. The commencement of the ADMCA marks an important moment, offering substantial enhancements over both the old system and earlier reform proposals. This legislation marks a significant advancement, reinforcing the rights of persons with disabilities (and others) to make legally effective decisions and ensuring their decision-making is respected, notably through support mechanisms like advance planning for healthcare decisions. However, similarly to the legislation in Northern Ireland, it falls short of its goal of complying with article 12 of the CRPD, although the model arguably moves closer than the MCA

(NI). It is contended that the supported decision-making provisions in the ADMCA have the potential to provide safeguards against substitute decision-making and the denial of legal capacity. Conversely, it is argued that the provisions on substitute decision-making may undermine other positive provisions on supported decision-making. It is hoped that the guiding principles, with their inclusion of the will and preferences of the person, will ensure that the paradigm shift required in article 12 will guide the effective implementation and interpretation of the legislation.

It is surprising that the development of new legislation in both jurisdictions has not yielded more comparative analysis of the models adopted. Given the substantial interest in Ireland's legislation and the fusion model adopted in Northern Ireland it is clear that these approaches are coming to the forefront of international discussions on reforming capacity legislation. The attraction of these models to policymakers and law reformers in other jurisdictions underscores the urgency and relevance of these discussions in the context of article 12 of the CRPD. The models implemented in Ireland and Northern Ireland represent innovative attempts to align domestic law with international human rights standards. The ADMCA's model, with its focus on decision support mechanisms, and the fusion model's integrated approach both aim to enhance autonomy and move beyond guardianship laws, which are often more restrictive systems. The growing attention to these frameworks indicates they could potentially be used as models or points of reference for other jurisdictions looking to develop or reform their capacity laws.[151] However, their actual effectiveness in practical application is still to be fully assessed. There is a need for comprehensive research to scrutinise these models, examining their impact upon the lives of persons they aim to support, their operational challenges and their overall effectiveness in realising the requirements of the CRPD. This research could significantly enrich our understanding of how to implement article 12 of the CRPD, offering insights beyond the island of Ireland.

151 See Domański Maciej and Lackoroński Bogusław (eds), *Models of Implementation of Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD)* (Routledge 2023); Nilsson (n 107 above) 48–49; and NSW Law Reform Commission, 'Background Paper: Review of the Guardianship Act 1987' (NSW Law Reform Commission, 2018) 21.