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The Functional Model of Legal Capacity: An Analysis of the Regulation of Legal Capacity in three Common Law Jurisdictions

El modelo funcional de capacidad jurídica: análisis de la regulación de la capacidad jurídica en tres jurisdicciones del Common Law

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Abstract

This paper introduces the developments of the functional model of legal capacity in the Common Law tradition to Spanish-speaking academic audiences. To achieve this, a brief comparison is drawn between different models to assess whether an adult lacks the necessary capacity to enter legal transactions. It is observed that, out of all these models, the functional model is the only one currently enjoying relative acceptance. For this reason, we comment on its virtues and defects. After the introductory part, this piece moves on to a study of how forensic practice in three jurisdictions that are considered examples of this legal tradition, namely England and Wales in the United Kingdom, British Columbia in Canada, and Queensland in Australia, all regulate the legal capacity of people with disabilities.

Keywords: *Legal Capacity; Functional model; mental capacity; CRPD.*

Resumen

Este trabajo introduce para la literatura hispanoparlante el desarrollo que ha tenido el modelo funcional de capacidad jurídica en la tradición del Common Law. Para ello se comparan brevemente los distintos modelos a los que se ha recurrido para evaluar si una persona adulta carece o no de la capacidad necesaria para poder celebrar negocios jurídicos. Se constata que, de todos ellos, el modelo funcional es el único que en la actualidad goza de relativa aceptación. Por esta razón se comentan en seguida sus virtudes y defectos. Realizada dicha introducción, el trabajo se aboca a estudiar la manera en que la práctica forense en tres jurisdicciones, consideradas como ejemplos de dicha tradición legal, (Inglaterra y Gales en el Reino Unido;

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Columbia Británica en Canadá; y Queensland en Australia) regulan la capacidad jurídica de las personas con discapacidad.

Palabras clave: *Capacidad jurídica; modelo funcional; capacidad mental; CDPD.*

I. INTRODUCTION

The doctrinal developments of continental law use the concept of *legal capacity* ("LC" hereafter) to signify, on the one hand, the legal aptitude of a person to hold rights, to acquire such rights, or more generally, to be subject of law (*capacity to hold rights*); while on the other hand, this concept is also identified as the aptitude to exercise rights without the consent, authorization or intervention of another person (*capacity to act*).[1] While the capacity to hold rights has been regarded as an inseparable attribute of personality, even considered to be inherent to every human being, concerning the capacity to act on them, which is studied in connection to the general theory of legal acts, traditionally it has been understood that such capacity can be absent in some persons.[2]

Nowadays, under the influence of international law of human rights, both the notion and the regimes of LC are undergoing a profound transformation in civilian legal systems worldwide. The right to legal capacity on an equal basis is enshrined in Article 12 of the *Convention on the Rights of Persons with Disabilities* ("CDPD"),[3] and has had a significant effect on the debate on this matter, as it imposes on the states the obligation to recognize the LC of persons with mental disabilities[4] on an equal basis with others, supporting them to make decisions and the safeguards to prevent abuses.[5]

Seen this way and following an interpretation of Article 12 that is backed by the Committee on the Rights of Persons with Disabilities (the "Committee"), disability does not constitute a sufficient basis for the restriction of a person's LC. This would mean that every form of denial of LC and every system that substitutes the will of a disabled person by the will of a third party would be in open contravention to the abovementioned norm.[6] Thus, the Committee and an important part of the literature[7] have understood the aforementioned obligation as requiring from states parties to the Convention, the implementation in their national legal systems of a universal LC model, where both LC and the capacity hold rights are seen as being a universal attribute of the person, thus seeking to separate this legal construct, both in theory and practice, from the degrees of *mental capacity* which a specific

[1] DUCCI (2015), pp. 122-123; BARCIA LEHMANN (2007), pp. 67-69.

[2] This piece addresses the latter dimension of capacity as it presupposes the existence of incapable subjects. Therefore, all subsequent references to LC refer to the capacity to act on those rights.

[3] *Convention on the Rights of Persons with Disabilities*, (2006). Art. 12 (2).

[4] In Chilean law, the concept of mental disability usually encompasses intellectual and psycho-social disabilities, as well as other impairments affecting a person's decision-making capacity, see Art. 2, Act N°18.600 [Ley N°18.600] (1987) and Art. 5°, Act Nº20.422 [Ley Nº20.422] (2010).

[5] SERIES & NILSSON (2018).

[6] Comité CDPD (2014). Observación General N°1.

[7] ARSTEIN-KERSLAKE & FLYNN (2016), pp. 474-75; BACH (2012), pp. 60 y ss.; QUINN (2010), pp. 10 y ss.

individual can concretely display in making her decisions.[8] Although the individual capacity to decide could sometimes fail, the full recognition of personal autonomy must be seen as the preponderant value in the legal sphere.[9] The former, added to the progressive acceptance of a *social model of disability*,[10] has popularized the assumption that we are indeed witnessing a *paradigm shift* concerning how society in general, as well as care professions, and legal practitioners in particular, have all historically understood and approached the concepts of capacity, disability, dependence, and individual autonomy.[11] Despite this not being the place to discuss the merits of the specific arguments invoked by the Committee in its backing of such an interpretation, it has to be noted that a part of doctrinal writers has questioned such a view,[12] and also met with resistance in several member states,[13] with both approaches insisting on the fact that full recognition of LC would be, in some cases, incompatible with the duty to protect people with disabilities.[14] The restriction of the LC continues to be a widely entrenched practice,[15] and the aforementioned justification continues to inform most LC regimes in the world.[16] This being the current outlook, the number of countries endeavoring to implement Art. 12 of the CDPC in their respective internal laws has grown, with several Latin American jurisdictions leading the way. Whereas many states have resisted a shift away from their traditional systems of assessing capacity and their old practices of substituted decision-making in the form of tutorship and guardianship, the notion of LG as a universal human right has been progressively included in Argentina (2015)[17], Costa Rica (2016)[18], Peru (2018)[19] and Colombia (2019)[20]. These jurisdictions have enacted statutes that have transformed their general guardianship into frameworks that support the exercise of LC, thus showing a serious attempt to apply the recommendations issued by the CDPD

[8] As noted below, the practice of measuring the degree of mental capacity in a person is not epistemologically uncontroverted either. Since, in short, and with Beirce's irony: "*It is noteworthy that persons are pronounced mad by officials destitute of evidence that themselves are sane*." BEIRCE (2000) p. 159.

[9] CAMPS (2021) p. 128.

[10] See MARSHALL (2020) pp. 56-57.

[11] QUINN (2010) pp. 3; 12 and ff.

[12] For a general review of the questions and difficulties arising from this interpretation, See: GOODING (2015).

[13] Article 12 was subject to numerous reservations and statements on the compatibility of the text of the CDPD with the continued existence of substitute decision-making instances, among them those from: Australia, Canada, Egypt, France and the Netherlands, see: *Convention on the Rights of Persons with Disabilities*, (2006). United Nations, Treaty Series. Available in: **¡Error! Referencia de hipervínculo no válida.** (visited on June 30th, 2021). Moreover, during the elaboration of General Observation N°1, the Committee CDPD received critical remarks to the first draft regarding the prohibition of instances of substitute decision-making from Denmark, France, Germany, Norway and New Zealand. See: https://www.ohchr.org/en/hrbodies/crpd/pages/dgcarticles12and9.aspx (visited on June 30th, 2021).

[14] MARSHALL (2020) p. 47.

[15] BREGALIO & CONSTANTINO (2022).

[16] ARSTEIN-KERSLAKE (2017), pp. 64–65.

[17] MARTINEZ-PUJALTE (2019).

[18] AMEY & FERNÁNDEZ (2019).

[19] CONSTANTINO (2020).

[20] HERNÁNDEZ RAMOS (2020); ISAZA (2021). For a comparative analysis of these reforms, see MARSHALL *et al* (2023).

Committee.[21] Taking into consideration, on the one hand, this strict approach to capacity is still in force in many civil law jurisdictions[22] and on the other hand, the recent developments that place it at the forefront of a universal dimension of human rights, it is possible to see that many legal systems have not yet reformed their general regimes of LC and are still analyzing the advantages offered by the alternatives available.[23] As already expressed elsewhere, such an exercise is necessary because an overly accelerated legal change in this area would be at risk of failing.[24] Against this background, the objective of the present piece is to introduce Spanish-speaking specialist audiences to the developments of *Common Law* jurisdictions, whose evolution has taken a different path when compared to the one found in the Latin American legal systems, in which the recent reforms have led to a transition from a regime of total and permanent substitution of will, to a system of universal recognition of LC and supporting ideas, without, in most cases, previously having gone through an intermediate regime between these two extremes.

Conversely, in the Anglo-Saxon *Common Law*, the functional model of capacity prevails as a result of a wave of reforms that predate the CDPD, and aimed at establishing a regulation that could be regarded as more respectful of the dignity of the person, without abolishing all cases of substituted decision-making. As a result, these intermediate systems are articulated around procedures destined to evaluate the mental capacity of disabled persons for decision-making, which have been designated as a *functionality test* whose justification, as discussed below, has been called into question in later years.

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[21] MARSHALL *et al.* (2023); MARTINEZ-PUJALTE (2019). Recently also, Spain (2021) has been added to the list of reforms, which is why it may be better to start referring to the Hispanic-American leadership on this matter. See: HERNÁNDEZ SÁNCHEZ (2022).

[22] It is a *demanding* understanding of capacity because although this is presumed as a general rule, it simultaneously allows the application of a procedure aimed at denying capacity to anyone who does not meet certain minimum standards of rationality rendering the person's will relevant and its manifestations, legally effective. It is a private law understanding precisely because, in this legal sphere, capacity is discussed as an element that must concur in order to conclude valid legal transactions, which is ultimately related to the establishment of legal measures that restrict personal autonomy and are aimed at preserving and protecting their patrimony.

[23] Such is the case of Chile, which ratified the CDPD as part of its internal law through the Decree 202 of the Ministry of Foreign Affairs (Decreto 201 del Ministerio de RR.EE), published in the Official Gazette (Diario Oficial) on November 17th, 2008. It has to be mentioned that under Chilean law the model of denying capacity for the reason of status (through a judicial declaration of absolute incapacity as a result of a mental illness), established by the Civil Code (1857) and reinforced by Act 18.600 (Ley 18.600), which establishes norms for the mentally disabled (1987). Aimed at harmonizing legislation in accordance with the CDPD standard, two different reform bills were introduced in the National Congress in 2019. These are: Bulletin (Boletín) N° 12441-17, which "Modifies various legal texts with the purpose of eliminating discrimination against persons with intellectual, cognitive and psycho-social disability and recognizes their right to autonomy" ("Modifica diversos textos legales con el objeto de eliminar la discriminación en contra de personas con discapacidad intelectual, cognitiva y psicosocial, y consagrar su derecho a la autonomía"); Bulletin (Boletín) N°12612-07, which "gradually restricts the capacity to act of older adults with cognitive impairment" ("Restringe gradualmente la capacidad de ejercicio de los adultos mayores con deterioro cognitivo"); to these, on January 2022, a further Bulletin (Boletín N°14.783-079) was added, which "Creates a Statute of Facilitators and Assistants, establishes a new interdiction procedure for mentally ill persons, and modifies the Civil Code and other legal bodies" ("Crea un Estatuto de Facilitadores y Asistentes, establece un nuevo procedimiento de interdicción de las personas dementes, y modifica el Código Civil y otros cuerpos legales que indica"). See: MARSHALL (2020) pp. 46-47; JARUFE (2022); LATHROP (2022) pp. 248-250.

[24] MARSHALL (2020) p. 47.

The structure of this piece is the following: In section II, some general ideas on the evolution of the *functional model* are reviewed. Afterward, the following sections deliver an overview of this way of regulating LC by reference to three of the jurisdictions belonging to the *Common Law tradition*. This analysis starts with a detailed presentation of the English *Mental Capacity Act*, *qua* paradigmatic example of the functional model. After that, the examples of the Canadian and Australian jurisdictions are studied as variations of the English model, which, at least in the case of British Columbia in Canada, perhaps overcomes it, since it has elements that bring it closer to the abovementioned Latin American reforms.

Table 1. Analyzed Jurisdictions

State	Regulation	Acronym
England and Wales (United Kingdom)	Mental Capacity Act (2005)	MCA
British Columbia (Canada)	Representation Agreement Act (1996)	RAA
Queensland (Australia)	Guardianship and Administration Act (2000, reform from 2019)	GAA

II. THE RISE OF A FUNCTIONAL MODEL OF CAPACITY

In those legal systems where restrictions to the LC of adults remain in force, doctrine usually differentiates among three approaches:

(a) a status-based model, which makes incapacitation dependent on the existence of a (relevant) disability;

(b) an outcome-based model, in which the decision taken by a person is regarded as invalid if it is perceived as being harmful to their wellbeing; and

(c) a functionality-based model, in which a mental capacity test is applied to the person to determine their competence in adopting a particular decision.[25]

However, this range of options is available only in theory since not all of these options enjoy the same degree of popularity. This entails that, in reality, among these options, it is only the functional model that can be defended with relative success.

As previously stated, the functional model of LC can be regarded as the outcome of a reform process in this region dating back to the end of the past century, which saw a time of growing consensus around the idea that neither a medical diagnosis nor the adoption of an irrational decision constituted objective factors against which the incapacity of a person could be determined.[26] Thus, once the application of the status-based approach came to be seen as increasingly discriminatory, as it meant that following a medical diagnosis, the system would impose permanent labels regarding the capacity of a person, one can see that the outcome-based approach would also be deemed as increasingly inadequate because it demanded from

[25] In this vein, see: BRITISH COLUMBIA LAW INSTITUTE (2013), pp. 16 and ff; ARSTEIN-KERSLAKE (2017), p. 69.

[26] KONG (2017), pp. 18–19.

a person to act according to the values of the assessor of the conduct and thus, "penalizes individuality and demands conformity at the expense of personal autonomy".[27] The generalized perception of these shortcomings was precisely the factor that triggered a wave of reforms in Common Law jurisdictions towards the end of the century, aimed at reviewing guardianship systems (equivalent to the regime of guardians in continental legal systems) while preserving this institution as an *ultima ratio* solution, together with a new set of planning instruments created for the maximization of capacity and autonomy of disabled persons.

Accordingly, the functional model was perceived as being much more progressive and sophisticated than the regimes preceding it, for it offered a view that was more respectful of a person's autonomy, giving them a set of minimum guarantees during the assessment of their capacity for adopting decisions, as well as a series of stricter safeguards to protect them from potential abuses. In this line, it is a general principle of the functional model to seek the imposition of measures that are seen as least restrictive of a person's rights, thus aiming at protecting their autonomy through procedural safeguards.[28] Furthermore, according to its supporters, the declaration of incapacity solely affects a particular decision which means that it would guarantee that the agency of the person is preserved regarding all other matters.[29] In summary, as will be discussed in connection to the three jurisdictions object of the present comparison, to be materialized, the functional model requires the application of the so-called *functionality test* or *test of mental capacity*, whose particular features, although vary depending on the specific system, tend to contemplate two assessments. Firstly, a diagnostic test that identifies the mental impairment[30] that produces such an alteration in an individual's cognitive processes that effectively prevents them from making decisions in a rational manner. And secondly, it considers the execution of a *functionality test in a strict sense*. This is an exam aimed at determining whether the extension of the impairment affects the person's ability to understand the nature and the consequences of their acts.

III. ENGLAND AND WALES (UNITED KINGDOM)

3.1 The Principles of Application of the MCA and the Mechanism of Informal Decisions

A good example of how the functional model operates in practice is presented in the *Mental Capacity Act* (2005) of England and Wales ("MCA" hereafter).[31] This act, together with its *Code of Practice*[32] form the legal framework regulating the assessment procedure for people

[27] THE LAW COMMISSION (1995), para. 3.4.

[28] STEVENS & HEBBLEWHITE (2014), p. 16.

[29] STEVENS & HEBBLEWHITE (2014), p. 16; WILLNER *et al* (2011), p. 159; QUINN & ARSTEIN-KERSLAKE (2012), pp. 44–46.

[30] In addition to mental (intellectual and/or psychical) impairment, other sources of cognitive decline commonly cited by Anglo-Saxon doctrinal writers include the state of delusion, depression and drug abuse. See: BRITISH COLUMBIA LAW INSTITUTE (2013), pp. 13-15.

[31] *Mental Capacity Act* (2005). Scotland has its own regulation on this matter which is contained in the *Adults with Incapacity Act* (2000).

[32] *Mental Capacity Act 2005: Code of Practice* (2007).

above the age of 16 for the adoption of a particular decision in the event that their mental capacity for deciding in a particular instance has been put into question.[33]

There are five principles governing the application of the MCA. These can be summarized as follows:

1. A person must be assumed to have capacity unless it is established that they lack such capacity.
2. A person is not to be treated as unable to make a decision unless all the measures available to help them make such a decision have been adopted without success.
3. The adoption of an unwise decision does not make a person incapable. An unwise decision is still a decision.
4. The decisions made on behalf of a person who lacks mental capacity must be taken in their best interest.
5. When making a decision, the substitute decision-maker must always prefer the course of action that is least restrictive of the person's rights and freedom of action.[34]

What can be seen is that such a test places the burden of proof on the person challenging the presumption of capacity, which is why the first principle is to be regarded as an 'empowering principle'.[35] The second principle has also been described in these terms as it stipulates that substitution of will constitutes a subsidiary solution. Efforts must be aimed at increasing a person's autonomy, which requires enabling decision-making support of variable intensity depending on the individual case. This, as the third principle indicates, implies incorporating the 'dignity of the risk',[36] by allowing decisions that may be considered unwise. In this way, the first responsibility of a potential substitute decision maker will be to *maximize* the person's capacity, providing them with the necessary support and information for the required decision. They must also be capable of demonstrating that they made all reasonable efforts for this purpose.

According to the MCA, the person assessing a person's mental capacity shall be whoever is in the position of directly interacting with them (*directly concerned*) when a particular decision must be made, where their capacity has been called into question.[37] Ordinarily, this would concern the person in charge of their daily care (family members, nurses, assistants, etc.). However, in more complex contexts, as a result of consent being required in order to agree to a medical intervention, this assessment may be carried out by the treating physician.[38] If it is then deemed that there are reasonable grounds to believe that the person lacks capacity to make the decision, then the person calling on the assessment shall make the decision on their behalf, which is why this mechanism is also known as pertaining "informal decisions".[39] In performing this task, it is not compulsory to consult those who are close to

[33] The legal safeguards established in the MCA came to replace the old *Common Law* procedures that were in place up until then. See: BRITISH COLUMBIA LAW INSTITUTE, (2013), p. 12.

[34] *Mental Capacity Act* (2005), Sec. 1.

[35] STEVENS & HEBBLEWHITE (2014), p. 18.

[36] BOGG & CHAMBERLAIN (2015), p. 15.

[37] *Code of Practice* (2007), para. 4.38.

[38] *Mental Capacity Act 2005: Code of Practice* (2007), para. 4.51.

[39] BACH (2012), p. 89.

the person or disability specialists, but it is good practice to do so.[40] Here it is important to highlight that the declared incapacity concerns each decision considered in itself. This by no means implies a declaration with general or permanent effects.

3.2 The Capacity test in practice

The capacity test has two parts that are regulated in the MCA. Firstly, there is a "diagnostic test"[41] that is aimed at determining whether the person has "an impairment of, or a disturbance in the functioning of the mind or brain", which can be caused by a temporal or definitive condition. The *Code of Practice* builds on this provision in a broad sense, indicating that the impairment can be due to a mental illness, "dementia", or learning disabilities, as well as due to medical or physical conditions causing confusion, including symptoms produced by the use of alcohol or drugs, among others. Afterward, in the second part, the "*functionality test in a strict sense*" is used to determine whether the presence of this impairment or disturbance hinders the person's decision-making on a concrete matter at a specific time. The time of the decision is also designated as the "relevant moment" for the functional assessment of the capacity for making decisions. The cognitive threshold established by the MCA is contained in s. 3(1). An adult person is unable to make a certain decision for themselves if they are:

i. Unable to understand the information relevant to the decision.
ii. Unable to retain that information.
iii. Unable to use or weigh that information as part of the process of making the decision

or,

iv. Unable to communicate their decision.[42]

In practice, this assessment is carried out through a series of questions formulated for the disabled person with the purpose of determining whether the referred threshold has been met: for example — Do you know what would happen if you fail to pay the rent this month?, is a question recommended by the *Mental Capacity Policy and Implementation Team.*[43] *Important factors to be assessed in such an inquiry would be a general intellectual skills, memory, attention and concentration, reasoning, information processing, verbal comprehension by different means of communication, cultural influences, the social context, and the ability to communicate. Nevertheless, the* MCA clarifies that this diagnosis regarding mental capacity rests on a balance of probabilities,[44] one which the eventual substitute decision-maker must know how to weigh, thus implicitly acknowledging that infallible results are not to be expected from this test.

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[40] *Mental Capacity Act 2005: Code of Practice* (2007), para. 5.49; National Institute for Health and Care Excellence (2018), para. 15.7.

[41] JAMES (2012), p. 35.

[42] This list of requirements echoes the criterion already being used in case law more than 150 years ago: see *Banks v. Goodfellow* (1870). A detailed commentary on this and other similar cases can be found in: ZUSCAK *et al.* (2019), p. 30.

[43] JAMES (2012).

[44] *Mental Capacity Act* (2005), Sec. 2 (4).

3.3 The Substitution in Decision-Making and the Role of Best Interests

If, after the functional test is applied, the assessor reasonably believes that the person lacks the sufficient mental capacity to make the decision, the former will be authorized to act as a *substitute decision-maker*, having to decide according to the person's *best interests*. The MCA does not indicate what this *best interest* entails. That is to be determined each time concretely. In any case, its supporters insist that this parameter would result in an objective criterium of compliance, by contrast to what the person making the decision could subjectively want or prefer. However, Section 4 MCA and Chapter 5 of the *Code of Practice* include a series of recommendations directed to the person making the determination, which must be complied with "so far as it is reasonable" when determining in each case what the person's best interests are. In this endeavor, they must consider as far as possible the person's wishes, beliefs and values, and whether these are current or past.[45] Neither age nor physical appearance nor behavior constitute enough reasons for establishing what would be better for the person, who must also assume and active role in this procedure. The person making the determination shall invite them to get involved to the maximum viable degree and needs to take into account the opinions of those who are part of their care network as well. In endeavoring to consider all relevant circumstances, the decision maker shall pose the question of whether the person is likely to recover their mental capacity in the future. If the answer is affirmative, then the *Code of Practice* recommends postponing the decision for a reasonable time, pending the recovery of the person's capacity. On this, case law from the *Court of Protection* ("COP" hereafter) has repeatedly advised to balance the medical, socioeconomic and emotional aspects of the matter to which the decision relates.[46]

3.4 Competent Court and Hierarchy of Substitute Decision Makers

The COP is a special court created by the MCA[47] which hears and resolves disputes concerning the decisions involving persons lacking mental capacity according to the aforementioned rules. An infraction of these rules on the part of the substitute decision-maker discharging their duties (whether they are formal or informal decision-makers) may be reported to the COP by anyone interested person.[48] Moreover, the COP has the power to determine whether a person is mentally capable of making particular decisions or not; deciding on their behalf, favoring their best interests; and appointing (and removing) one or more third parties (who will typically be family members) called *deputies whose purpose is to continually decide* on behalf of the person on matters concerning their property, finances, health and/or personal welfare.

3.5 Private Planning Instruments

Aside from family members, friends, or certain professionals that act as informal decision-makers, and the *deputies* formally appointed by the COP, the MCA also establishes

[45] It has been noticed that, under the influence of the CDPD over the MCA, the requirement of considering the desires, the will and the preferences of disabled persons has started to acquire an ever-greater weight in the best interest equation. See, KEENE & AUCKLAND (2015), p. 299.

[46] For an inventory of the cases in which the COP has applied the MCA, see: 39 ESSEX CHAMBERS (2022).

[47] *Mental Capacity Act* (2005), Sec. 45.

[48] *Mental Capacity Act 2005: Code of Practice* (2007), para. 8.

the possibility that persons above the age of 18 still have their mental capacity, but fearing to lose it in the future, may themselves appoint in advance an attorney using a document known as a *Lasting Power of Attorney* ("LPA"), which is a private instrument of personal and/or patrimonial planning that replaced the preexisting *Enduring Power of Attorney*. According to the nature of the matter to be decided, there are two classes of LPA: (a) one authorizing the attorney to decide on the personal welfare of the person appointing them (which includes deciding on medical interventions) and; (b) another empowering them to make decisions concerning their property and finances. A document known as *Advance Decision to Refuse Treatment* ("ADRT") belongs to this category. It allows a person with the capacity to act to refuse medical treatment in advance, thus anticipating a situation in which their capacity to refuse such treatment could eventually be contested at the relevant time.[49]

3.6 The Office of the Public Guardian and the Independent Mental Capacity Advocate

To be valid, all LPAs must be registered with the *Office of the Public Guardian* ("OPG"), also established by the MCA. Its primary function is to act as a safeguard for disabled persons, which effectively entails, together with the obligation to maintain this registry in which the planning instruments and the *deputies* appointed by the COP must be registered, the task of overseeing the performance of the duties of both, providing the COP with periodic reports, so the latter, if necessary, could appoint visitors in order to investigate possible abuses.

Moreover, and as a solution specific to particularly vulnerable persons who lack support networks, that is, who have no family members, friends or attorneys to whom it would be appropriate to consult when deciding on necessary medical treatments, the MCA created the *Independent Mental Capacity Advocate* (IMCA") which is a support service that, without deciding on their behalf, must advocate in favor of their best interests, collaborate and, on occasion, confront the staff in charge of a person's health.[50]

3.7 Special Safeguards of Personal Liberty: The Case of the Deprivation of Liberty Safeguards

Lastly, the *Deprivation of Liberty Safeguards* ("DOLS") is a safeguard that was added in 2009 in an amendment of the MCA and is destined to provide legal protection to especially vulnerable persons (those without support networks) above the age of 18 and lacking sufficient capacity to consent on matters regarding their welfare, whose best interest and the prevention of self-inflicted harm requires them to be deprived of their liberty in either hospitals or asylums registered according to the *Care Standards Act*.[51] The DOLS protect disabled persons through the provision of a complex legal procedure comprised of six parts,[52] which must be

[49] *Mental Capacity Act* (2005), Sec. 24.

[50] The functions of the IMCA, from the year 2006, are presented in: *The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations* (2016).

[51] *Care Standards Act* (2000).

[52] For a complete guide on this procedure, see: JAMES (2012); SOCIAL CARE INSTITUTE FOR EXCELLENCE (SCIE) (2020a).

requested by the party interested in obtaining authorization of their medical admission from the administrative body created for such purpose, which is the *Supervisory Body*.[53]

IV. BRITISH COLUMBIA (CANADA)

4.1 The Innovation Introduced by the Representation Agreement Act: Towards a Post-Functional Concept of Capacity?

Because it is a federal country, Canada admits as many LC systems as provinces and territories in which it is politically divided. The Province of British Columbia ("BC" hereafter) is remarkable insofar as it is a pioneering jurisdiction in what concerns the implementation of decision-making support systems, being ahead even of the CDPD itself regarding the recognition of the right of disabled persons to be assisted in the exercise of their LC.[54] This has been the case since the establishment of the *Representation Agreement Act*[55] ("RAA") in 1996, which accords them the possibility of concluding "Representation Agreements" ("AR") which is a private legal instrument that is available as an alternative to decision-making substitution by curatorship.[56]

BC's world-leading position in this matter was consolidated after a three-year process by a Joint Working Committee, where disabled people were actively involved in drafting the act.[57] This Committee concluded that there was no such thing as an entirely reliable test to determine a lack of mental capacity. The best alternative we could count on were procedures that, with enough time and adequate consultation, might suggest capacity in a person.[58] The influence of this thesis can be observed both in the presumption of capacity, as well as in the protection of the principle of self-determination, and the recognition of the role played by interdependence in decision-making, all principles that inform the application of the RAA as a whole. This new design appears from the purposes of the RAA (Section 2). This indicates that its object is to provide adults (over the age of 19) with a mechanism that: (a) allows them to arrange in advance what will happen in the future concerning their decisions in the event that they become incapable of making decisions independently; and, (b) to avoid the need for the court to appoint substitute decision-makers when an adult becomes incapable.

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[53] In March 2014, this regulation was complemented by the Supreme Court ruling in *Cheshire West* in which the exam known as the "*Acid Test*" was created, which through two simple questions, serves the purpose of determining when a disabled person is deprived of their liberty, which was not clear enough in the DOLS. These questions are: 'Is the person subject to continuous supervision and control?'; and 'Is the person free to abandon the premises?'.

[54] Gheorghe (2010), pp. 13 and ff.

[55] *Representation Agreement Act, RSBC 1996, c 405* (1996).

[56] According to the provisions of other statutes that regulate this phenomenon in parallel. See, *Adult Guardianship Act, RSBC 1996, c 6* (1996); *Patients Property Act RSBC 1996, c. 349* (1996); *Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181* (1996); *Public Guardian and Trustee Act RSBC 1996, c. 383* (1996).

[57] Kerzner (2011), p. 36.

[58] Nidus (2012), p. 16.

4.2 Overview of Private Planning Instruments in BC

The AR is not the only planning instrument available in BC. There are two additional planning instruments. First, the power is known as *Enduring Power of Attorney* ("EPOA"),[59] by which it is possible to appoint an attorney for her to make decisions concerning the person's legal and financial matters[60] with greater freedom than under an AR in any of its two formats.[61] The second available planning instrument from 2011 onwards is the legal authorization of the so-called *Advance Directives* ("AD").[62] Even though no representative or attorney is appointed through them, these are documents containing specific instructions concerning determined medical interventions or treatments.[63] Nevertheless, since these tools are future-oriented, thus preempting what would happen in case of a future lack of capacity, none of these documents can originate in the will of a person who has been judicially declared incapable at the time they were given. Such is, in effect, the general rule of the LC regime in BC. The AR constitutes the exception.

The AR can be defined as a private personal planning legal tool by which an adult gives powers to one or more persons they recognize as part of their support network. These can assist them in making decisions or deciding on their behalf on some issues. In this sense, the AR reminds us of the British LPA. Both are instruments aimed at the adult population in general so that people can make plans for potential future incapacity. The innovative element of the regulation found in BC, which nonetheless places it apart from every other planning mechanism in the world, is that it does not require present capacity in order to make an AR, at least, as we shall see, not in the functional sense of the term. This means that depending on the capacity of the agent, there are two kinds of AR. The first of them, regulated in Section 9 of the RAA ("AR9"), also known as "AR with broader powers"[64], is a personal planning mechanism valid for the adult population that is able to "understand the nature and the consequences of their actions" at the time of concluding the agreement. Even though this document has been specially designed to empower others to decide on matters concerning the health and personal care of the person making the agreement (it cannot be used to formalize support), it also includes the authority to decide on prolonging or interrupting a person's medical life support, and it can also relate to financial and commercial matters of ordinary management.[65]

The second and more interesting kind of AR is regulated in Section 7 of the RAA ("AR7"), and it is also known as an "AR with standard powers". This document can be made, modified, or revoked by persons with "*diminished capacity*", which refers to the state of their

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[59] *Power of Attorney Act RSBC 1996, c. 370* (1996).

[60] An EPOA cannot refer to either health or personal matters.

[61] This is reflected on a fundamental level in the different roles assigned by the law to the disabled person's wishes, values and beliefs. In the EPOA this acquires a secondary role in front of what might involve their best interest. By contrast, in AR this is a priority. MCCONCHIE (2020), p. 26.

[62] This is done through an amendment of Section 2.1. of the MCA.

[63] LAW (2017), pp. 39 and ff.

[64] MCCONCHIE (2020), p. 26. Even though the RAA appears as a "*non-standard representation agreement*".

[65] Although this configuration of the AR9 is still possible, after the general amendment of 2011, everything in this legal document concerning financial matters is subjected to the regulation of the EPOA. Therefore, from 2011 onwards, an AR9 that includes health and patrimonial matters is virtually a tool of mixed legal nature. *Representation Agreement Act Regulation BC Reg 199/2001 (2001),* Sec. Transitional regulation 44.2.

mental capacity at the time of the act. This means that, as regulated by the RAA in its Section 8, an adult may make an AR7 "even though the adult is incapable of concluding a contract or managing his or her health, personal care, legal matters or the ordinary management of his or her financial affairs." Rather, an individual's capacity for making an AR7 depends on four factors based on their capacity to communicate by any means their will, feelings, and the trust relationship that they maintain with their eventual representative, as well as the understanding of what this relationship entails. As for its object, through an AR7, it is possible to appoint support or a substitute decision-maker for the adoption of decisions relative to personal care, as well as on major and minor healthcare matters and matters of ordinary financial management.[66]

Regardless of the specific AR, the obligations acquired by the *representative are the same*. Representatives must act honestly, in good faith and according to the law. Their main responsibility is to assist the disabled person in making their own decisions. This way, the role the representative acquires in the lives of disabled persons widely differs from the role that would correspond to a tutor or guardian, since the representative, at least in principle, is not called to act in the person's best interest. Conversely, their task is to make sure that the voice of the person they represent is heard. To fulfill this duty, the representative must consult them about their wishes, preferences, and beliefs and faithfully abide by them. However, if we are in the presence of an AR7, the representative will not be obliged to follow the desires of the disabled person if abiding by them would not be reasonable, nor if, after consulting with them within the boundaries of reason, it is impossible for the representative to ascertain them.

4.3 Planning Instruments' Safeguarding

The RAA contemplates several safeguards aimed to be applied at the time of making the AR and during the entire time of its validity. Firstly, concerning the *formalities at the formalization phase,* in order to make an AR9 or an AR7, the presence of two witnesses is required, although regarding the latter, just one witness will be necessary if the AR7 is to be made by a person that is fully capable at the time of the act. At the stage of its formalization, one or more *alternate representatives* may be appointed, whose function is to substitute the main representative in case they are prevented from carrying out their functions.

Secondly, a *monitor* is a person acting as a safeguard with overseeing powers concerning the representative's actions during the discharge of the duties arising from the AR. In the AR9, it is optional to designate a monitor, even though their appointment is imperative when it comes to an AR7, which includes the power to decide on financial matters unless, in the latter case, the representative is the spouse of the adult making the act.[67] If the monitor considers that the representative is not discharging their duties correctly, the former shall communicate this concern to the latter, being authorized to order them to produce a report on their management while also being empowered to present them before the Office of The *Public Guardian and Trustee*, if irregularities of any sort arising from this inspection. Confronted with this scenario, the latter body has to investigate the issue.

Thirdly, concerning the *registration of planning instruments*, the RAA does not establish a public registry, and the rest of the legislation of BC does not assign this function to any public

[66] *Representation Agreement Act Regulation BC Reg 199/2001 (2001)*, Sec. 2 (1).

[67] *Representation Agreement Act, RSBC 1996, c 405*, Sec. 12 (1).

body, which has been identified as a failure in implementing the law.[68] The task of managing a centralized registry of the AR and of the EPOA that has been made has been undertaken by an entity originated within civil society, the *Nidus Personal Planning Resource Centre and Registry* ("Nidus"), a community non-profit organization established in 1995 as a result of the joint effort of associations of persons with disabilities in the region. Nowadays, Nidus is the expert center in BC on the matter of AR and fulfills the functions of outreach and educating the general population.[69]

4.4 The Persisting System of Substituted decision-making in BC

Since AR7 has the virtue of serving as an alternative for those disabled persons who cannot exercise their LC according to traditional standards of mental capacity, it can be asserted that we are in the presence of implicit recognition that the capacity to decide is a right that does not depend upon a person's "functionality".[70] In this sense, the RAA establishes legal instruments for future planning and creates a document that can be used to create support mechanisms for decision-making aimed at those who currently lack the capacity to make them. However, this option exists within a general regime of LC that authorizes forms of incapacitation similar to interdiction in some cases.[71] In other words, the LC still admits proof to the contrary, which implies that in the event that a person whose capacity has been put into question does not have any of the aforementioned planning documents, a mechanism of informal decisions shall operate, which entails a framework essentially analogous to the one studied concerning the MCA, although in this Canadian province, it is restricted to health services. In this sense, a person other than the judge can also declare the incapacity to make a particular decision. This person (who is chosen by the healthcare provider among family members and friends of the person), is known as a *Temporary Substitute Decision Maker* ("TSDM"),[72] will eventually have to interact with the medical staff in charge to protect the best interest of the person in their care.

Outside this healthcare context, or when disputes concerning the decisions made in that context arise, a judicial procedure is contemplated, which is conducted upon the request of a party and heard before the *Supreme Court of British Columbia*,[73] in which a *committee* shall be appointed that will have under their custody either the personal welfare (*Committee of the Person*) or the property-related matters (*Committee of Estate*) of the person, or both. These functions typically fall on different individuals, who will generally be the person's family members, friends or close ones.

That said, if a person lacks a support network, according to the *Adult Guardianship Act*, their custody shall ultimately be assumed by the *Public Guardian and Trustee* after applying a

[68] NIDUS (2011), p. 2.

[69] NIDUS (2013) p. 2.

[70] KERZNER (2011), p. 39.

[71] For example, *Adult Guardianship Act*, RSBC 1996, c 6.

[72] *Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181* (1996), part. 2.

[73] *Patients Property Act*, RSBC 1996, c 6. See, LAW (2017), pp. 44 and ff.

special administrative procedure that enables it.[74] Moreover, this body oversees the actions of judicially appointed guardians.

V. Queensland (Australia)

5.1 The LC Regime in Queensland before the reform

The rules on LC in Queensland exist within a national legal system that delivers powers to each of its seven states to legislate on private law matters.[75] That said, despite this apparent normative dispersion, in general, the whole Australian inter-jurisdictional regulation system concerning LC is primarily comprised of a series of guiding principles[76] and common planning instruments[77] which are, in turn, very similar to the British MCA, thus confirming the archetypical role of the latter.[78] This means that all Australian states effectively presume the LC of disabled persons, the presumption that, after being rebutted through applying a functional test, enables the substitute decision-maker to make decisions on a particular matter and ensure the person's best interests are considered. That possibility is understood as an *ultima ratio* solution.

In this scenario, the state of Queensland did not represent an exception and the laws that formed the normative framework of LC[79] confirmed as a whole the full validity of the principles established in the MCA,[80] including, even though this time is restricted to the field of health, informal mechanisms of decision-making. This meant that, as noted regarding the MCA cases and in the system of BC, in Queensland we will also find a hierarchy of individuals in charge of substituting the will of disabled persons in making individual decisions. The *Statutory Health Attorney* (who could be the spouse, the person managing their care or some other close person) will be authorized to subsidiarily decide on behalf of the person in the least restrictive way possible,[81] Only if the latter has not previously decided on formalized representatives, through an EPOA o alternatively through an *Advance Health Directive* ("AHD").[82] This shall proceed if there are no judicially appointed guardians by the *Queensland Civil and Administrative Tribunal* ("QCAT").[83] In that order, the last entity, other than the

[74] Public Guardian and Trustee of British Columbia & Ministry of Health of British Columbia (2016).

[75] Harvey (2009), pp. 51-58.

[76] The efforts for formalizing this Australian normative harmony at the national level have not been scarce. To this date, the *National Decision-Making Principles* remain the most important proposal on the matter. See, The Australian Law Reform Commission (2014), p. 53 & ff.

[77] It is indicative in this regard that the current *National Disability Strategy* (which is being revised in order to draft a new one) had been the first piece on which all Australian states were genuinely in agreement: Queensland Advocacy for Inclusion (2020a).

[78] Queensland for Inclusion (2014), p. 23.

[79] *Powers of Attorney Act, Qld* (1998); *Guardianship and Administration Act, Qld* (2000); *Public Guardian Act, Qld* (2014); *Mental Health Act, Qld* (2016).

[80] Queensland Advocacy for Inclusion & Queensland Law Society's Ethics Centre (2014), pp. 19 and ff.

[81] Office of the Chief Psychiatrist (2020), p. 9.

[82] It must be highlighted that, unlike the case of its parallel document in BC, namely the AD, in Queensland, it is possible to appoint a representative through an AHD.

[83] *Queensland Civil and Administrative Tribunal Act, Qld* (2009).

judge[84] who will be in charge of deciding on behalf of the person and appointed by the QCAT, will be the Office of the *Public Guardian*, which is responsible for ensuring that the rights of disabled persons are respected and has the power to supervise the conduct of the substitute decision-makers and submit requests and reports to the QCAT, always considering the best interest of the respective persons as its intervention criterion.[85]

5.2 The 2019 Reform: A Functional Model 2.0?

The described substituted decision-making system has experienced important transformations in the last time due to the influence of a new capacity regime favored by the CDPD and its Committee.[86] On the other hand, the participation of local disabled people's organizations has been essential, where the efforts of the *Queensland Advocacy for Inclusion* constitute one of the main sources[87] of development seen in the 2017 reform bill[88] which was ultimately enacted in 2019 as the *Guardianship and Administration and Other Legislation Amendment Act* ("GAA2").[89] Alongside this innovation, there is the also the one of a kind Queensland *Human Rights Act* of 2019,[90] which came into force on January 1st, 2020.

Although the new CJ regulation in Queensland keeps the described regime of substituted decision-making, it introduced corrections that brought them closer to the legislation in BC. In fact, the most significant part of the reform relates to the central role that decisions, opinions, wishes and preferences of disabled persons have in the decision-making process.[91]

5.3 Impacts on Private Planning Documents

This greater relevance of wishes and personal preferences appears in the design of the new EPOA and AHD,[92] which means that adults subscribing to this type of document may include relevant information that their attorneys will necessarily have to consider at the time of the decision. The adult may also nominate third persons with the sole purpose of notifying them when this occurs. Moreover, since the GAA2 is in force, planning instruments originating in other Australian territories and also in New Zealand became fully valid in the state of Queensland.

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[84] The QCAT is also included on the list of substitute decision-makers. However, the cases in which the Queensland judge is called to intervene directly on behalf of the person are quite exceptional. See: *Guardianship and Administration Act, Qld* (2000) S. 81.

[85] THE QUEENSLAND LAW HANDBOOK (2016).

[86] MBA LAWYERS (2020)

[87] QUEENSLAND ADVOCACY FOR INCLUSION (2014).

[88] BURGESS (2017).

[89] *Guardianship and Administration and Other Legislation Amendment Act, Qld (2019).*

[90] *Human Rights Act, Qld* (2019).

[91] QUEENSLAND ADVOCACY FOR INCLUSION (2020b).

[92] QUEENSLAND GOVERNMENT (2022).

5.4 Impact on the Substituted decision-making Procedure and the New System of Informal Decisions

As for the judicial procedure for the appointment of guardians, it is an obligation for the QCAT to respect to the greatest possible extent the beliefs, wishes and preferences expressed or shown in any way by the disabled person during the procedure.[93]

At the time of deciding on their capacity, either intra or extra-judicially, the new guidelines insist that incapacity may only be declared after all practical efforts for providing the person with all the necessary support and information to adopt the decision by herself have been exhausted. In this way, the duty to *maximize* the mental capacity of the person in question is reinforced. For this purpose, and thus fulfilling its legal mandate, the government of Queensland has issued new guidelines for the assessment of capacity in harmony with the new principles.[94]

The new system of informal decisions, on the other hand, departs considerably from the MCA since healthcare and care providers of disabled persons without attorneys will not be able to remain as their *Statutory Health Attorneys*, which means that a physician will no longer be able to consent or refuse treatment on behalf of her patient. In contrast, the system established by the GAA2 is based on a classification between formal and informal decisions, depending on their importance for the disabled person. So, the general rule is that the substitution of will regarding health and financial matters requires a formalized substitute decision maker.

Lastly, this reform strengthens the protecting role of the *Public Guardian*. The GAA2 expressly grants the QCAT the power to remove this body as a subsidiary guardian of the disabled person if someone appears who belongs to their support network and is, therefore, more appropriate to act as guardian. As for its powers to investigate possible abuses of the substitute decision-makers, these may now be exercised even after the person's death, ensuring greater confidentiality to those reporting such infractions.

VI. Conclusions

Starting with England and Wales, our analysis of the treatment given to LC in *Common Law* jurisdictions has aimed to show the image of a system that is much more complex and developed than it would appear to us in principle if we were to approach it solely based on the opinions of its detractors or to focus on its more general features. In this sense, the critique of the MCA, according to which the application of the functionality test would produce consequences virtually identical to those resulting from the status-based approach, seems somewhat hasty.[95] The latter model classifies people in a permanent and general manner as either capable or incapable of making their own decisions on the sole basis of a medical diagnosis. Although the MCA is by no means immune to objections, it anchors its interpretation in five practical principles aimed at preserving and even increasing the capacity of the person in question, as well as insisting that a declaration of incapacity concerns a particular decision at a specific time, which avoids unfavorable comparisons with the status-

[93] Queensland Advocacy for Inclusion (2020b), p. 2.

[94] *Queensland Capacity Assessment Guidelines* (2020).

[95] Cft. Arstein-Kerslake (2017), p. 87.

based model and, in its turn, also with the outcome-based model (this is because according to the MCA bad decisions are still decisions). Nevertheless, the fourth of these principles provides that when it is necessary to make a decision substituting the decisions of someone who has not been able to successfully pass the functionality test, this decision will have to be made considering the person's best interests, a paradigm opposed to the primacy of the will and preferences of disabled people, which the CDPD recommends to observe. The former is especially worrying if we take into account that, in England and Wales, this best interest may even come to justify the restriction of the freedom of movement of a person against her will. Moreover, including the diagnostic test can indicate the preservation in the MCA of elements belonging to the status-based model, an observation that has led to certain jurisdictions, such as Northern Ireland, to forego this element.

Conversely, the wishes and preferences of disabled people gain greater recognition in the regime found in British Columbia, which is mainly reflected in the special design of one of the formats (AR7) named "Representation Agreement", for which a concept of LC is established, different from the one that is demanded to conclude all other legal transactions in this province. This is not based on the functional test of capacity but privileges the person's confidence in relationships and care networks. In this way, whereas on the one hand, through this document, a person can autonomously formalize a relationship in which they will be able to be supported for making their own decisions, this does not exclude the possibility that their will may be nonetheless overridden. This makes the LC regime in BC one of the most progressive in the world, even though it paradoxically preserves the current model of incapacitation.

Lastly, in Queensland, it is possible that the legal system has positioned itself between the MCA and the Canadian model after the last implemented reform. This is so because the new system contemplates decision instances in which the best interest criterion must give precedence to the wishes and preferences of the disabled person, guidelines that substitute decision-makers shall observe in the exercise of their duties, as well as by the judge in its judgments, and by the and the *Public Guardian* in its safeguard functions. Furthermore, greater recognition is granted to the idea that mental capacity can be "increased" if adequate support is provided, and the reform consequently establishes a support duty.

After analyzing these three systems, it becomes apparent that they share a common legal tradition which can be seen in the normative structures aimed at regulating incapacity. In these, the assessment of an individual's capacity to make decisions considers the person's ability to understand the nature and consequences of their actions, albeit restricting the effects of the assessment to individual acts and preserving the capacity to make other decisions.

In all reviewed jurisdictions, it is possible to establish an order of precedence for those called to substitute the person's will. The first one will be the attorney appointed by the disabled person herself when she was capable (also if the person was not capable at the time of the appointment, in the case of BC). Generally, these planning tools admit several settings. This allows people to rely on different options for building their support network, an arrangement that has the virtue of fostering their self-determination and empowering them, preventing courts from appointing a third person to act on their behalf. This is why judicially appointed guardians are subsidiary entities in this hierarchy of substitute decision-makers.

Of course, as previously discussed, the referred advances do not exempt the functional model from all criticism. The application of the functional test presupposes a minimum

understanding threshold, which shall lead to incapacitation in case the person fails the test. This implies that below this threshold, the person's will and preferences are the only reason to appoint a substitute decision-maker. Seen this way, cognition remains tied to the full recognition of personal autonomy.

To this, one can add some level of skepticism of the supposed aptitude that medical sciences have to determine a person's cognitive level with certainty.[96] Even if we could determine it with certainty, it would still be necessary to answer, as the Committee, that a person's cognitive level is not an acceptable criterion for denying someone the possibility of deciding about their rights on an equal basis with others. In this sense, contrary to its purposes, the functional approach would not satisfactorily overcome the criticism that accuses it of being discriminatory, especially concerning the diagnostic test, as its application would disproportionally affect disabled persons very.[97] In other words, through the functional model, disabled persons are burdened with the need to submit to a test of their decision-making skills, whereas this test is not generally required from others. This shows unequal treatment before the law prohibited by Article 12 of the CDPD.[98]

The functional model would still be based on a medicalized concept of incapacity, even though it includes more guarantees for disabled persons. The substituted decision-making is subsidiary in nature and episodic. The most specific problem with applying the functionality test is not that it exists. However, the purpose is ascribed to it since there could very well exist an evaluation aimed at finding out the intensity of the supports that a person will concretely need for exercising her capacity instead of being directed at restricting her autonomy. This way, in designing a procedure for assessing the needed support, some of the parameters examined here regarding the functionality test could perhaps be useful.

[96] ARSTEIN-KERSLAKE (2017), p. 70 and ff.

[97] BACH (2012), p. 67.

[98] ARSTEIN-KERSLAKE (2017), p. 90.

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