

Scottish Human Rights Commission

Mental Health (Scotland) Bill

The Scottish Human Rights Commission is a statutory body created by the Scottish Commission for Human Rights Act 2006. The Commission is a national human rights institution (NHRI) and is accredited with 'A' status by the International Co-ordinating Committee of NHRIs at the United Nations. The Commission is the Chair of the European Network of NHRIs. The Commission has general functions, including promoting human rights in Scotland, in particular to encourage best practice; monitoring of law, policies and practice; conducting inquiries into the policies and practices of Scottish public authorities; intervening in civil proceedings and providing guidance, information and education.

The Scottish Human Rights Commission (the Commission) welcomes the opportunity to comment on the Mental Health (Scotland) Bill¹. The Commission is pleased that some of the areas of concern highlighted in our response to the consultation on draft proposals for the Bill² have been addressed.

The Commission notes that some of the recommendations of the McManus review are considered by the Bill, but there is no clear justification as to why some others have been excluded. The McManus review identified a broader package of changes which were required to achieve a more efficient system which delivered on the principles of the Act. The Commission's own research³ has highlighted gaps between Scotland's often strong human rights based legislation and policy and the delivery of rights in practice. These findings were particularly identified in the area of mental health care and treatment. The current Bill presents an opportunity to assure and not assume the realisation of human rights in practice. In light of that, the Commission believes that the Bill could go further to implement a number of the recommendations of the McManus review. We have made specific suggestions in this regard in this paper.

The Bill also presents an opportunity to begin to address the challenges presented by the UNCRPD, particularly the recent General Comment (authoritative interpretation) developed by the UNCRPD Committee regarding legal capacity,⁴ by taking steps towards strengthening opportunities for supported decision-making. In order to do so, further action should be taken

¹ The Commission acknowledges the contributions from Dr Jill Stavert in informing this submission.

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<http://www.scottishhumanrights.com/publications/consultationresponses/article/submissiondraftmentalhealthbill>

³ 'Getting it Right? Human Rights in Scotland' SHRC 2012

<http://www.scottishhumanrights.com/application/resources/documents/SNAP/GettingitRightAnOverviewofHumanRightsinScotland2012.pdf>

⁴ Committee on the Rights of Persons with Disabilities, *General comment No. 1 (2014) Article 12: Equal recognition before the law*

in the areas of Advance Statements, Named Persons and advocacy in particular.

With regard to the proposed amendments, the Bill makes a number of apparently administrative changes, however, it is important that changes made with the aim of increasing efficiency are assessed to ensure they continue to uphold human rights.

Human Rights Framework - Relevant law

- Human Rights Act 1998 which brings into domestic law the majority of rights in the European Convention on Human Rights and Fundamental Freedoms (ECHR) and includes a series of measures which seek to make those rights effective.
- ECHR rights applicable to mental health care and treatment include:
 - Article 2 - right to life
 - Article 3 - freedom from torture and inhuman or degrading treatment or punishment
 - Article 5 - right to liberty
 - Article 6 - right to a fair trial
 - Article 8 - right to respect for private and family life
 - Article 14 - non-discrimination in the realisation of rights
- Scotland Act 1998 which requires that all legislation of the Scottish Parliament must be compatible with ECHR rights.⁵ It also requires that Scottish Ministers must observe and implement the UK's other international obligations, which includes obligations under international human rights treaties the UK has ratified.⁶ There are several international human rights treaties that have application to mental health and mental disorder.⁷ This submission focusses on the UN Convention on the Rights of Persons with Disabilities (CRPD). Several Articles in the CRPD correspond with those ECHR rights that are particularly relevant to the Bill. Among the Articles of the CRPD which are of most relevance are:

⁵ ss29(2)(d) and s.57 Scotland Act 1988 and s.6 Human Rights Act 1998.

⁶ ss.29(2), s.35(1) and s.58 Scotland Act 1998.

⁷ For example, in this context, the UN Convention on the Rights of Persons with Disabilities, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Convention on the Elimination of All Forms of Discrimination Against Women, Convention on the Rights of the Child, European Convention for the Protection of Human Rights and Fundamental Freedoms and European Social Charter and European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, all of which impose binding obligations on the UK under international law. The Council of Europe Recommendation Rec (2004)10 *concerning the protection of the human rights and dignity of persons with mental disorder* and UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care ("MI Principles") are also influential though not binding under international law.

- Article 5 - equality and non-discrimination
- Article 12 - equal treatment before the law
- Article 14 - the right to liberty
- Article 15 - freedom from torture or cruel, inhuman or degrading treatment or punishment
- Article 17 - protecting personal integrity
- Article 19 - independent and community living
- Article 22 - respect for privacy
- Article 23 - respect for home and family

PART 1: THE 2003 ACT

Section 1: Measures until application determined

Human Rights Standards

Article 5 ECHR (right to liberty and security)

For any deprivation of liberty to be lawful:

1. It must have a legal basis and be “in accordance with a procedure prescribed by law” (Article 5(1)).
2. Where compulsory psychiatric treatment is concerned the individual must suffer from “unsound mind” (Article 5(1)(e)) which has been “reliably shown” by “objective medical experts”.⁸
3. Any measures adopted must be a proportionate. The mental disorder must thus (a) be of a nature to justify detention (in other words, treatment is necessary to alleviate the condition and/or the person needs control and supervision to prevent them causing harm to themselves or to others⁹); and (b) persist throughout the period of detention.¹⁰
4. Detention must be in an appropriate place so that the individual can receive the treatment they require.¹¹ Indeed, detention in a place that is inappropriate to the needs of an individual with mental disorder may even engage and violate Article 3 ECHR.¹²
5. Certain procedural safeguards must be present such as (a) the ability to challenge the deprivation of liberty through the courts;¹³ (b) [to allow

⁸ *Winterwerp v the Netherlands* (6301/73) (1979) 2 EHRR 387, para 39.

⁹ *Winterwerp*, para 39; *Stanev*, para 146.

¹⁰ *Winterwerp*, para 39; *Shtukaturov*, para 114; *Stanev*, para 45.

¹¹ *Ashingdane v. the United Kingdom* (8225/78) (1985) 7 EHRR 528, at para 44; *Aerts v. Belgium* (25357/94) (2000) 29 EHRR 50, para 46; *Hadzic and Suljic v Bosnia Herzegovina* (39446/06 and 33849/08)[2011] MHLR 367, para 40; *LB v Belgium* (22831/08) judgment of 2 October 2012, paras 89-105.

¹² *MS v UK* (24527/08) judgment of 3 May 2012; *Claes v Belgium* (43418/09) judgment of 10 January 2013.

¹³ *Winterwerp*, para 55; *Stanev*, paras 168-171; *DD*, paras 163-167.

the patient to take] regular reviews of the detention where the detention is lengthy or indefinite;¹⁴ and (c) timely release of a person where their detention is found to be unlawful.¹⁵

Article 5(4) ECHR provides that:

“Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful”.

The essential purpose of the requirement is to protect the individual from arbitrariness. In light of this, there is a requirement for both “speedy review” of the lawfulness of detention and continuing review “at regular intervals”, particularly in circumstances where the grounds for detention are susceptible to change over time, such as mental health¹⁶. Imposing a time limit on the period of detention before automatic review is one way of achieving these requirements.

In addition, human rights standards require that treatment and detention for mental disorder accord with the least restrictive treatment principle¹⁷, also reflected in the principles of the Mental Health (Care and Treatment)(Scotland) Act 2003.

Comments on Bill

The Bill proposes adding a further week to the duration of a Short Term Detention Certificate where an application for a Compulsory Treatment Order has been made. The total period of detention before any automatic review by a judicial body takes place would therefore extend to between 45 and 48 days. The Commission is concerned that extending the existing period of detention increases the risk that people may be subject to arbitrary detention and does not meet the requirement for speedy review. The Commission is also concerned that the restriction is not adequately justified.

The Commission is aware of the difficulties arising from multiple hearings, which this amendment seeks to address, for both patients and the burden on the system as a whole. However, any steps taken to address this issue must not result in a disproportionate restriction on patients’ rights.

As identified in the McManus review, delays in the system arise at a number of levels (the service of papers and issuing of invites by the tribunal service,

¹⁴ *Stanev*, paras 168-171; *DD*, paras 163-167.

¹⁵ *Johnson v UK* (22520/93) (1999) 27 EHRR 440, *Kolanis v UK* (517/02) (2006) 42 EHRR 12); *HL v UK*(45508/99) (2005) 40 EHRR 32.

¹⁶ *Herczegfalvy v Austria* (1992) A 244, 15 EHRR 437

¹⁷ See, for example, *Reid v United Kingdom* (50272/99)(2003) 37 EHRR 9, paras 48-52. See also Articles 8, 18-20 and 27-28 Council of Europe Recommendation Rec(2004) 10 concerning the protection of the human rights and dignity of persons with mental disorder (adopted by the Committee of Ministers on 22 September 2004). The principle is also reflected, in general terms, in Article 14 CRPD (right to liberty).

the appointment of curators ad litem, the availability of suitable solicitors, the availability of independent psychiatrists to prepare reports within short timescales etc). A number of these problems are administrative and logistical, however, the proposed amendment opts for a solution which places restrictions on patient liberty. Such a restriction can only be justified if it does, in fact, result in shorter overall detention periods by achieving the objective of reducing multiple hearings. The Commission queries whether the proposed extension will achieve this objective. Preparation for a hearing will remain dependent on swift administration and action at all of the levels identified. For example, if papers are not provided to the patient and their solicitor until towards the end of the extension period, as is often the case at present, the additional time will not result in parties being prepared at a first hearing.

The Commission recommends that less restrictive alternatives be explored before extending the deprivation of patients' liberty. The Commission believes that the least restrictive alternative is to address administrative problems in the first instance. However, at the very least, these problems must be addressed in addition to the extension of the period of detention. The Commission would support the implementation of the McManus recommendation for the Mental Health Officer to provide a copy of the application for a Compulsory Treatment Order to the patient and/or patient's solicitor at the same time as it being sent to the tribunal office. If the proposal is to be implemented, the Commission recommends that the impact on multiple hearings is closely monitored.

Section 11 & 12: Orders relating to non-state hospitals & Qualifying hospitals

For an individual to be detained in conditions of excessive security engages Article 8 of the ECHR and, potentially, even Article 3 (with corresponding Articles 17, 22 and 15 CRPD). The scope of Article 8 is broad, including the right to personal autonomy¹⁸ and "the right to live privately, away from unwanted attention" securing to the individual "a sphere within which he or she can freely pursue the development and fulfilment of his or her personality"¹⁹. Restrictions imposed by conditions of excessive security would therefore fall within the scope of Article 8 and must consequently be justified. Restrictions must have a legal basis, pursue a legitimate aim, and be a proportionate means of achieving that aim.

It must therefore be considered whether the choice of individuals who will be entitled to make such appeals is accompanied by sufficient justification. For example, evidence shows that patients are more likely to be successful in an appeal if they are on a civil order²⁰, however, the policy memorandum explains that the intention is to extend the right only to those on criminal orders (COROs, TTDs, Hospital Directions). The Bill does not, however, actually appear to define which patients will be eligible but rather makes

¹⁸ *Pretty v United Kingdom* (2002), 35 EHRR 1

¹⁹ *Smirnova v Russia* (2003), 39 EHRR 2 at para 95

²⁰ Excessive Security, Report to Scottish Government, April 2013

http://www.mwscot.org.uk/media/124446/s268_consultation_event_report.pdf

provision for Ministers to make regulations to determine “qualifying hospitals”. If this is the case, the provisions will not resolve the issue identified by *RM v Scottish Ministers*²¹, until such regulations are made. If, however, the right to make an application is to be restricted to certain categories of patients, the provisions do not appear to provide adequate justification for restricting the rights of those on civil orders. In addition, *RM* concerned a patient in a low security ward seeking transfer to an open ward. Such a patient would remain excluded from the provisions and it is difficult to see why that should be the case.

The Commission recommends that the definition of “qualifying hospitals” and patients entitled to bring proceedings should be construed more widely. At a minimum, patients on both civil and criminal orders in medium secure facilities should be brought within the provisions. However, in order to accord more closely with the principles of the Act (reciprocity, maximum benefit, least restrictive alternative) and the Article 5 requirements they derive from (outlined above) the Commission suggests that the impact of the conditions of security should be the essential factor. The provisions should be extended to anyone detained in conditions of excessive security for a significant period of time. The qualifying factor would therefore be the length of detention, rather than the category of patient, which may be a somewhat arbitrary way of determining the impact on patients.

Section 14: Detention pending medical examination

The intention to extend the maximum period for the nurses’ holding power from two to three hours is not accompanied by any justification. Given the implications this has for a patient in terms of ECHR rights i.e. their liberty and autonomy, and the inability of a patient to challenge this, any proposal of this nature should be specifically explained and justified before it can be deemed acceptable. A more proportionate response would be to retain the present provision of Section 299(4), whereby if there is no medical practitioner available within the first hour, it is then extended for an hour from the attendance of a medical practitioner. While not as immediately straightforward, the provision allows for a three hour period where circumstances require it, rather than a blanket extension in all circumstances.

Discussions with partners also suggest that the use of the existing powers is not well understood by nursing staff. The Commission recommends that efforts are made to support nursing staff within the existing powers before introducing a standard three-hour holding period which impinges on patients’ rights.

Section 15: Appeal on hospital transfer

The reduction of the period of appeal from 12 weeks to 28 days is a significant curtailment and requires to be justified. It is noted that the change is intended to bring the timeframe in line with other appeals, however, a move to the

²¹ [2012] UKSC 58

conditions of security within the State Hospital is a significant restriction on a patient's Article 8 rights and should accordingly be given particularly careful consideration. It is also noted that the reduced time period is intended to address difficulties with transferring patients pending appeal, allowing access to appropriate treatment. Section 220(4) of the Act, however, already makes provision for such a situation. The Commission queries why such a significant reduction in the right of appeal is necessary in the circumstances.

Section 18: Opt-out from having named person

A patient's nominating of a named person is an expression of individual autonomy and fits well within a supported decision-making model (discussed later with regard to Advance Statements). The McManus Review recommended that *"A service user should have a named person only if he or she has appointed one... The form appointing the named person should require the written consent of the named person."*²² The Bill makes provision for a person to opt out of having a named person, meaning that individuals will continue to have a default named person. The Commission believes that changing this opt-out, into an opt-in would more appropriately reflect the principle of autonomy and the recommendations in the McManus Review.

This is particularly important in light of the changes proposed to the information which will be provided to named persons on detention. In terms of Section 4 of the Bill, a copy of a Short Term Detention Certificate, rather than simply notification of its granting, will be sent to the named person (among others). The provision of such information without the patient's explicit consent raises concerns in terms of the Article 8 right to privacy. This will happen at a time when people are likely to be most unwell and may not be able to engage with the process of making a decision about who they wish their named person to be or even have the capacity to make a valid nomination. The McManus Review identified issues with the amount of confidential information a named person receives as a matter of course. This will now also be the case at the stage of the granting of an STDC. It is important that a person's wishes regarding their named person be ascertained before they are entitled to receive such information.

The McManus Review suggested a range of additional provisions to ensure that the interests of those who were unable to appoint a named person were safeguarded, for example, the primary carer or nearest relative having a right to appeal against orders and the appointment of a safeguarder as well as a curator ad litem. These should be considered together with the opt-in alternative to ensure that the interests of both those who can and those who cannot nominate a named person are protected. This option should be accompanied by a programme of awareness-raising and support regarding the role of the named person.

²² Recommendation 4.1 and 4.10.

Section 21: Registering of Advance Statements

Human Rights Standards

European Court of Human Rights (the Court) jurisprudence has recognized that autonomy and decision making are an integral part of the right to respect for private and family life as protected by Article 8 of the ECHR.²³ There has been found to exist a positive obligation on the State to protect individuals from interference with their legal capacity from others;²⁴ and to take reasonable steps to uncover previously stated wishes.²⁵ The Court has also considered that Council of Europe Recommendation No R (99) 4 “Principles concerning the legal protection of incapable adults”, “may define a common European standard in this area”.²⁶ Principle 9 of which includes:

1. In establishing or implementing a measure of protection for an incapable adult the past and present wishes and feelings of the adult should be ascertained so far as possible, and should be taken into account and given due respect.

Incapacity – or significantly impaired decision-making ability resulting from mental disorder as required by the 2003 Act²⁷ - should not lead to a complete disregard for autonomy²⁸ even in involuntary treatment situations where patients must be involved in all aspects of their care and treatment insofar as it is possible.²⁹

The Court has held that a restriction of a person’s legal capacity amounts to an interference with that right which must have a legal basis, pursue a legitimate aim, and be a proportionate means of achieving that aim.³⁰ This accordingly permits non-consensual treatment but only where national law provides for such intervention, the intervention is in pursuit of a legitimate aim, appropriate safeguards exist and, where there is a degree of discretion in its implementation, the scope of such discretion is defined.³¹ That being said, although the Court also accepts that medical intervention affecting a person’s moral or physical integrity will not necessarily violate Article 8³² it does not have to amount to inhuman or degrading treatment before Article 8 is violated.³³

²³ See for example *Evans v UK*, Grand Chamber (application 6339/05) judgment of 10 April 2007; *Pretty v UK*, supra at note 18

²⁴ *Storck v Germany*, (Application no. [61603/00](#)), judgment of 16 June 2005.

²⁵ See for example *Glass v UK*, Application No 61827/00. Decision of 9 March 2004.

²⁶ *Shtukaturov v Russia*, (Application no. [44009/05](#)), judgment of 27 March 2008.

²⁷ See s36(4)(b) (emergency detention), s44(4)(b) (short term detention) and s64(5)(d)(compulsory treatment orders).

²⁸ *Glass v UK* (61827/00) (2004) 39 EHRR 15, para 84; *Storck*, paras 143-44.

²⁹ For instance, Council of Europe Recommendation Rec(2004)10: Recommendation of the Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 Sep 2004) Articles 7(1), 12, 18-20 and 27-28; MI Principles A/RES/46/119, principles 1(2), 11(9) and 11(10).

³⁰ *Shtukaturov v Russia*, (Application no. [44009/05](#)), judgment of 27 March 2008.

³¹ *Silver v United Kingdom* (5947/72) (1983) 5 EHRR 347, paras 88 and 90.

³² *Bensaid v UK* (44599/98) (2001) 33 EHRR 10, para 46.

³³ *Ibid.* See also *Costello-Roberts*, para 36.

In addition, it appears that the unqualified right to respect for physical and mental integrity in Article 17 CRPD was intended to apply in situations of involuntary detention and treatment.³⁴ This may arguably strengthen the Article 8(1) ECHR right and thereby provide an additional constraint on unwarranted and excessive treatment³⁵ that may otherwise be justified under Article 8(2).³⁶

The recent radical interpretation of Article 12(4) CRPD by several human rights experts³⁷ advocates that legal capacity cannot be denied on the basis of disability (as this would constitute discrimination), that decision-making be supported not substituted (and the removal, therefore, of guardianship) and the abolition of laws providing for the compulsory treatment of mental disorder. The UN Committee on the Rights of Persons with Disabilities has recently published a General Comment to this effect.³⁸ The Commission, together with other members of the UK's Independent Mechanism under the UN CRPD, has raised concerns at the apparent dissonance between the General Comment and ECHR jurisprudence.³⁹ However, it is clear that the requirement for genuine and demonstrable respect for the autonomy of all individuals with mental disorder, whether or not they are subject to compulsion, is paramount. This view is also supported by the UN Committee on Economic, Social and Cultural Rights that has advocated that coercive treatment is used for the treatment of mental illness “*only on an exceptional basis*”.⁴⁰ The UN Principles for the Protection of Persons with Mental Illness

³⁴ See, for example, United Nations, *Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its Seventh Session* (UN Doc A/AC265/2006/2, 13 Feb 2006).

³⁵ B McSherry, “Protecting the integrity of the person: developing limitations on involuntary treatment” in B McSherry (ed), *International Trends in Mental Health Laws* (2008) 111 at 112-119; J Stavert “United Nations Convention on the Rights of Persons with Disabilities: possible implications for Scotland for persons with mental disorder” (2009) 47 *Scottish Human Rights Journal* 2.

³⁶ However, the Court has admittedly not arrived at this conclusion yet and missed such an opportunity in *DD v Lithuania*.

³⁷ For example, see European Union Agency for Fundamental Rights, *Legal Capacity of Persons with Intellectual Disabilities and Persons with Mental Health Problems*, Report, 2013, pp15-18; UN General Assembly, *Report of the Special Rapporteur on Torture, op cit*, paras 57-70

³⁸ Committee on the Rights of Persons with Disabilities, *General comment No. 1 (2014) Article 12: Equal recognition before the law*

³⁹ Joint submission from the Equality and Human Rights Commission, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Scottish Human Rights Commission, *UN Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12*, 28 February 2014, <http://www.scottishhumanrights.com/application/resources/documents/UKIMjointresponsetodrftGeneralCommentonArt%2012FINAL.doc>

⁴⁰ UN Committee on Economic, Social and Cultural Rights, “The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)” (Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No 14, 2000) para 34.

similarly warn against inappropriate, disproportionate and degrading treatments.⁴¹

The Court has recognised the heightened vulnerability of patients in psychiatric institutions⁴² pointing out that whilst treatment without consent, if therapeutically necessary, may not *per se* be illegitimate in the case of incapacitated persons, it must not exceed the “minimum level of severity” as prohibited by Article 3 of the ECHR.⁴³ Whether or not a treatment reaches the minimum level of severity threshold necessary to engage Article 3 depends on the circumstances of each case. It will not include the suffering and humiliation which inevitably forms part of legitimate non-consensual treatment.⁴⁴ However, treatment that is premeditated, applied for a long period of time, humiliates or debases, shows a lack of respect for human dignity, arouses feelings of fear, anguish or inferiority may do so.⁴⁵ Unlawful deprivation of liberty and/or restriction or denial of patient autonomy may also contribute to a finding of inhuman or degrading treatment.⁴⁶

Comments on Bill

Psychiatric advance statements are an important expression of individual autonomy and their importance, even in compulsory treatment situations, is undeniable, viewed in light of the above human rights comments. Even in compulsory treatment situations a patient’s autonomy must be respected insofar as it is possible. Advance statements also provide an indication of whether a patient would consent to a particular measure which is integral in assessing whether a deprivation of liberty engaging Article 5 of the ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR).⁴⁷ Moreover, they are an important element of supported decision-making which is reinforced by the UN Committee on the Rights of Persons with Disabilities. This is an area where there is an opportunity to address the challenges of the UNCRPD Committee’s General Comment on Article 12 and make further strides towards a supported decision-making model.

Notwithstanding their importance, relatively few advance statements are actually made. This is often owing to a lack of awareness or patient belief that they are ineffective.⁴⁸ The proposed amendments are to be welcomed as a step towards increasing the effectiveness of advance statements, however,

⁴¹ Principles 1(3), 10 and 11(11)-(15).

⁴² *Herczegfalvy v Austria* (10533/83) (1993) 15 EHRR 437, para 82; *Dybeku v Albania* (41153/06) judgment of 18 Dec 2007, para 47; *Rivière v France* (33834/03) judgment of 11 Jul 2006, paras 72 and 63.

⁴³ *Herczegfalvy*, para 82.

⁴⁴ *Kudla v Poland* (30210/96) (2002) 35 EHRR 11, para 92.

⁴⁵ *Pretty v UK* (2346/02) (2002) 35 EHRR 1, para 52; *Kudla*, para 92; *Stanev*, paras 202-204.

⁴⁶ *Pretty*, para 52; *Kudla*, para 92. See also *Tyrer v United Kingdom* (5856/72) (1979-1980) 2 EHRR 1, para 30; *Soering v United Kingdom* (14038/88) (1989) 11 EHRR 439.

⁴⁷ See J. Stavert “Added value: using human rights to support psychiatric advance statements” (2013) 17(2) *Edinburgh Law Review* 210.

⁴⁸ Mental Welfare Commission for Scotland, *Advance Statements Guidance*, 2013, p5.

further efforts need to be made to encourage people to make use of advance statements.

The Commission recommends that consideration be given, in addition to general information and awareness-raising, to a statutory duty on appropriate medical staff to discuss the making of an advance statement and explain their effectiveness as part of their after-care plan.

The Commission also recommends that accountability for overriding advance statements be strengthened and supports the recommendation of the McManus Review to require Responsible Medical Officers to review regularly any treatment in conflict with an advance statement and provide a written record of efforts made to address the person's stated wishes.

Discussions with partners have indicated that some patients may be discouraged from making Advance Statements by the fact that the information within them will be shared with the Mental Welfare Commission. In order to avoid this unintended consequence, the Commission recommends that individuals are able to choose that the information held by the Mental Welfare Commission be restricted to the fact that an Advance Statement exists and a record of where it can be accessed.

The Commission would also recommend that the definition of who may access Advance Statements be clarified. At present, allowing access to "any individual acting on the person's behalf" appears widely drawn and could raise issues in terms of the right to privacy.

PART 2: CRIMINAL CASES

Section 29: Periods for assessment orders

The Commission welcomes that the proposed extension period is 14 days, rather the 21 days proposed in the draft Bill. However, the Commission considers that any extension of times or variations of the present conditions needs to be justified, taking into account the requirements for a speedy determination and trial within a reasonable time in Articles 5(4) and 6(1) of the ECHR. That justification is still lacking. The Commission recommends that, if such an extension is introduced, the use of the provision be monitored to ensure that a 28 day order does not become a 42 day order as a matter of course.

PART 3: VICTIMS' RIGHTS

Whilst the extension of the victim notification and representation arrangements are welcomed as an important step towards implementing the EU Directive⁴⁹, the right to receive information and make representations relating to mentally disordered offenders subject to certain orders must be given careful consideration.

⁴⁹ 2012/29/EU

Human rights principles allow for “*the views and concerns of victims to be presented and considered at appropriate stages of the proceedings where their personal interests are affected, without prejudice to the accused and consistent with the relevant national criminal justice system.*”⁵⁰ However, any move to amend the current practice to allow representations to be made by victims should also allow for proper opportunity for those representations to be challenged by the offender in order to avoid the potential for non-compliance with the ECHR (Articles 5 and 6). Similarly, consideration needs to be given to data protection, confidentiality and privacy rights as a consequence of disclosure of sensitive information.

In response to the draft Bill, we commented that offenders subject to Compulsion Order have often committed only minor offences. To allow the proposed notification in such cases may be an unnecessary and disproportionate limitation of their right to private and family life (Article 8 of the ECHR). We therefore welcome the restriction of the provisions to offenders subject only to Compulsion Order and Restriction Orders (COROs). We note, however, that in terms of Section 48, the Scottish Ministers will have the power to amend the provisions so that it may apply to persons who are not subject to Restriction Orders. This re-opens the possibility of persons who are subject to Compulsion Orders for minor offences being included within the scheme and the Commission queries why such a power is required.

Additional Matters

The introduction of the Bill into the Scottish Parliament also provides the opportunity to attend to the following additional matters:

1. *Independent advocacy*

The McManus Review Report reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland.⁵¹ It made several recommendations to reinforce the right to independent advocacy in s.259 of the 2003 Act, particularly in terms of adequacy of provision of such advocacy by local authorities and health boards.⁵²

Independent advocacy is integral to the enjoyment of human rights, particularly in terms of promoting autonomy and supported decision-making (see earlier comments). It is therefore disappointing that no provision is made in the Bill to strengthen the duty to provide for such advocacy so that the right to independent advocacy can be fully realised by those who are entitled to it under the 2003 Act. It is therefore recommended that the Bill include provisions to implement the McManus recommendations regarding advocacy.

⁵⁰ *UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power* (1985),

para. 6(b).
⁵¹ pp10-11.

⁵² Paras 3.1-3,6, p.12

2. The use of force, restraint and covert medication

At present, there is little reference to the use of force, restraint or covert medication in the 2003 Act's Code of Practice. The manner in which any non-consensual treatment is administered must be considered with the Act's underlying principles and human rights standards firmly in mind. The Mental Welfare Commission highlighted specific issues in relation to the wording of s.242 regarding the use of force in the community⁵³. They also highlighted that there remain situations where the use of force may be necessary to administer care, rather than medication. The authority required for the use of force in various settings is an area where widespread confusion exists in practice. It would be beneficial for both patients and staff to have a clearer understanding of the boundaries and legal requirements to protect patient's rights. Given the potential for Articles 2, 3, 5 and 8 of the ECHR to be engaged in such situations, and taking in account the aforementioned comments on Article 12 CRPD, clearer direction and guidance is required in the legislation itself and its supporting Code of Practice.

3. Incompatibility between s.242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000

A full consideration of any areas of incompatibility between the two Acts may be more productive following the anticipated amendment of the 2000 Act in light of the forthcoming Scottish Law Commission report on adults with incapacity and deprivation of liberty. However, at this stage, the opportunity should be taken to amend s.242 of the 2003 Act in order to provide clarity. This raises issues under Article 8 ECHR and Article 12 CRPD⁵⁴ and the role of substituted decision makers in compulsory treatment situations.

Essentially, s.50 of the 2000 Act permits substituted decision-makers to consent to medical treatment on behalf of an adult with incapacity. However, where such an adult falls to be treated for mental disorder under the 2003 Acts, s.242, which relates to treatment for mental disorder other than that requiring special safeguards, it is unclear as to whether such consent is permitted.

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⁵³ http://www.mwscot.org.uk/media/189940/mha_consultation_further_doc_t.pdf

⁵⁴ For a more detailed discussion of the legislative and human rights issues involved see J.Stavert, "Substituted decision makers and the interaction between the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003" (2014) 42(February) *Mental Capacity Law Newsletter* 29 <http://www.lexology.com/library/detail.aspx?g=6ac72509-f375-4838-af78-03cd531e103c> (accessed 7 March 2014).