Mental Health (Scotland) Bill

Introduction
The opportunity to provide written evidence on the Mental Health (Scotland) Bill is welcomed and the following are comments on the Bill. It is, however, recommended that the opinions of those directly affected by the legislation which the Bill seeks to amend and practitioners should be taken into account in terms of the potential practical implementation and procedural aspects of the Bill.

Question 1: Do you agree with the general policy direction set by the Bill?

The Bill takes forward some of recommendations of the limited review by the McManus Committee of the Mental Health (Care and Treatment)(Scotland) Act (the 2003 Act) and provides clarification of some aspects of this legislation. It also takes into account other matters raised by service users and practitioners in response to the Scottish Government’s own consultation on such McManus Report recommendations and following consultation on the introduction of a notification scheme for victims of mentally disordered offenders. It is also noted that the Bill incorporates some of the recommendations made in response to the recent Scottish Government consultation on the draft Bill. These include the retention of the requirement for two medical reports on applications for compulsory treatment orders (CTOs) and removal of the power of the Mental Health Tribunal for Scotland to appoint a named person for an adult where one has not been appointed both of which are welcome given the consequences in terms of an individual’s liberty and autonomy.

However, several of the McManus Review recommendations and other matters which could be usefully incorporated in primary legislation have been omitted and the Bill provides an opportunity to take forward them all forward. These will be discussed in the following sections.

In terms of policy direction the importance of the role of the 2003 Act in promoting and respecting the right to the highest attainable standard of health and supporting individuals with mental disorder towards effective living and recovery cannot be over-

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4 As identified in, for example, Article 12 UN Covenant on Economic, Social and Cultural Rights and Article 25 UN Convention on the Rights of Persons with Disabilities.
emphasised. The Millan Report recommendations, which shaped the form and content of the 2003 Act, reflect that this is most effectively achieved in an unrestricted environment as is possible, with respect for patient autonomy and without discrimination. This is reinforced by human rights standards identified in the European Convention on Human Rights (ECHR) and in other international treaties that the UK has ratified such as, amongst others, the Convention on the Rights of Persons with Disabilities (CRPD). Not only must the Act’s implementation be undertaken in accordance with its underlying principles and the criteria required before compulsory measures are used, but also the content and implementation of the Act must be compatible with such human rights standards. Compliance with ECHR rights is required regarding legislative content and implementation and legislation can be prevented or set aside if it fails to comply with the UK international human rights treaties obligations. This also applies to any amendments to the 2003 Act and their subsequent implementation.

Relevant human rights

European Convention on Human Rights (ECHR)

It is vital to appreciate that compulsory care and treatment of individuals with mental disorder is without their consent. This accordingly has significant implications in terms of an individual’s legal capacity and thus autonomy, their liberty and dignity, and their right to due process and not to be subjected to discrimination. For this reason, Articles 5 (the right to liberty), 8 (the right to private and family life (in other words, autonomy)), 3 (freedom from torture and inhuman or degrading treatment or punishment), and 14 (non-discrimination) ECHR are particularly relevant. Additionally, Article 6 (the right to a fair trial) ECHR clearly has important application to proceedings before the Mental Health Tribunal for Scotland and the right to life in Article 2 may be engaged whilst a person is in the care and control of the state.

International human rights standards: UN Covenant on the Rights of Persons with Disabilities (CRPD)

Several CRPD rights correspond with, and reinforce, those ECHR rights that are particularly relevant to the proposed amendments in the Bill. Moreover increasing references to the CRPD are being made in European Court of Human Rights cases which, given its superior status under international law, means that it is likely to influence the interpretation of ECHR rights.

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6 ss1(3), 1(4) and 2(4).
7 See, for example, ss44(3) regarding compulsory treatment orders and ss44(3)-(4) regarding short-term detention certificates.
8 ss29(2)(d) and s.57 Scotland Act 1988 and s.6 M Human Rights Act 1998.
9 ss.29(2), s.35(1) and s.58 Scotland Act 1998. Even where the rights are not specifically incorporated into UK law, the UK nevertheless has an international law obligation to ensure their recognition and protection nationally.
10 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) and Article 23 (respect for home and family).
Application of human rights standards in the context of compulsory treatment

Legal capacity and autonomy

In order to make fully autonomous decisions about any aspect of one’s life an individual requires recognition of their legal capacity. Where legal capacity is denied the consequences may be far-reaching and can often lead to, amongst other things, the restriction of a person’s autonomy, and deprivation of liberty and involuntary medical treatment. To be compatible with Article 8 ECHR any legislation, or its amendment, providing for the compulsory care and treatment of persons with mental disorder must therefore reflect that:

1. There is a presumption of legal capacity for persons with mental disorder.
2. Capacity must be assessed on a functional basis.\(^{11}\)
3. Non-consensual treatment is permissible 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.\(^{12}\)
4. Medical intervention does not have to amount to inhuman or degrading treatment before the right to private and family life in Article 8 is violated.\(^{13}\)

Additionally, Article 17 CRPD identifies an unqualified right to respect for physical and mental integrity and it seems that it is intended to apply in situations of involuntary detention and treatment.\(^{14}\) This therefore arguably strengthens the Article 8(1) ECHR right and thereby provide an additional constraint on unwarranted and excessive treatment\(^{15}\) that may otherwise be justified under Article 8(2).

What is clear is that incapacity or significantly impaired decision-making ability resulting from mental disorder (as required by the 2003 Act\(^ {16}\)) should not equate with a total disregard for autonomy\(^ {17}\) even in involuntary treatment situations. Patients must be involved in decisions about their care and treatment whenever possible.\(^ {18}\)

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\(^{11}\) Shtukaturov v Russia (44009/05) (2008) 54 EHRR 27, paras 90, and 93-95. Although note that the UN Committee on the Rights of Persons with Disabilities in its General Comment of Article 12 CRPD (see below) states that such assessment must not be discriminatory.

\(^{12}\) Silver v United Kingdom (5947/72) (1983) 5 EHRR 347, paras 88 and 90.

\(^{13}\) Bensaid v United Kingdom (44599/98) (2001) 33 EHRR 10, para 46. See also Costello-Roberts v United Kingdom (13134/87) (1993) 19 EHRR 112, para 36.


\(^{16}\) See s36(4)(b) (emergency detention), s44(4)(b) (short term detention) and s64(5)(d) (compulsory treatment orders).

\(^{17}\) Glass v UK (61827/00) (2004) 39 EHRR 15, para 84; Storck v Germany (61603//00) (2006) 43 EHRR 6, paras 143-44.

Finally, the implications of the UN Committee on the Rights of Persons with Disabilities’ General Comment on Article 12 CRPD (the right to equal recognition before the law)\(^\text{19}\) adopted on 11 April 2014 are yet to be fully realised. However, it is highly likely that it will reinforce the requirement for genuine and demonstrable respect for legal capacity, and therefore the autonomy, of all individuals with mental disorder and even greater emphasis on supported decision-making\(^\text{20}\). Indeed, the Bill provides the opportunity to address the strengthening of all forms of supported decision-making particularly independent advocacy, named persons and advance statements.

**Detention for care and treatment purposes**

Legislation, or its amendment, and its implementation requires that certain criteria are satisfied to ensure that detention for the purposes of treatment of mental disorder does not also violate an individual’s right to liberty under Article 5 ECHR. It must provide that:

1. The individual is genuinely suffering from mental disorder (Article 5(1)(e)) which has been “reliably shown” by “objective medical experts”\(^\text{21}\).
2. It must be a proportionate measure. This means that detention must be demonstrated to be necessary for, and only be for long as it is necessary for, treatment of the condition and/or to prevent harm being caused to the individual or to others\(^\text{22}\).
3. Detention must be in a place where the individual can be receive the treatment they require\(^\text{23}\). Indeed, detention in a place that is inappropriate for

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\(^{21}\) Winterwerp v the Netherlands (6301/73) (1979) 2 EHRR 387, para 39.

\(^{22}\) Winterwerp, para 39; Shtukaturov, para 114; Stanev, para 45. This accords with the least restrictive treatment principle 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 (right to liberty) CRPD.

the needs of an individual with mental disorder may even engage and violate Article 3 ECHR\(^\text{24}\).

4. Procedural safeguards are available such as (a) the ability to challenge the lawfulness of the detention through the courts\(^\text{25}\); (b) regular reviews of the detention where it is lengthy or indefinite\(^\text{26}\); and (c) timely release of a person where their detention is found to be unlawful\(^\text{27}\).

It should also be remembered that whilst deprivation of liberty engaging Article 5 clearly includes detention in a prison or psychiatric institution, restrictive measures amounting to a deprivation of liberty may be employed in other settings (for example, residential care homes, in community and domestic settings]\(^\text{28}\).

The above-mentioned human rights requirements have been taken into account in this response.

**Question 2: Do you have any comments on specific proposals regarding amendments to the Mental Health (Care and Treatment)(Scotland) Act 2003 as set out in Part 1 of the Bill?**

**Section 1 - Measures until application determined**

Although included as a recommendation in the McManus Report the Bill’s proposal to increase from the existing 5 to 10 working days the period within which the Mental Health Tribunal must make a determination regarding a compulsory treatment order where a person is subject to short term detention is unacceptable. Whilst it is noted that the reasoning behind the McManus Report recommendation was to avoid multiple hearings which can be distressing for the person concerned such an the Bill’s proposal does extend the period of time a person is subjected to detention without proper review. This has Article 5(4) (the right to liberty) and 6 (1) (the right to a fair trial) ECHR implications in terms of timely review of the necessity for compulsory measures.

It is noted that it is proposed to deduct from the ultimate period of compulsion (under ss64 and 65) the time during which the person has been detained in hospital on short term or extended short term detention pending the Mental Health Tribunal’s determination. It would be useful to know exactly how this will be calculated.

**Section 2 - Information where order extended**

In addition to the proposed amendment in section 2 of the Bill it is considered that section 85(3) of the 2003 Act should be repealed. This is so that the Mental Health

\(^{24}\) MS v UK (24527/08) judgment of 3 May 2012; Claes v Belgium (43418/09) judgment of 10 January 2013.

\(^{25}\) Winterwerp, para 55; Stanev, paras 168-171; DD, paras 163-167.

\(^{26}\) Stanev, paras 168-171; DD, paras 163-167.


\(^{28}\) See Scottish Law Commission (2012) Discussion Paper on Adults with Incapacity, Discussion Paper No 156, Edinburgh: The Stationery Office, Chapters 2 and 6 on the relevant ECHR principles and also P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent) [2014] UKSC 19.
Officer obligation under section 85(2) to interview the patient and inform them of their rights in relation to determination and the availability of independent advocacy services is provided at all times not only when it is “practicable” to do so. Knowledge of rights and the means of support to ensure they are observed are essential for the effective realisation of rights.

Sections 11-12 - Conditions relating to non-state hospitals and qualifying non-state hospitals and units
The 2012 Supreme Court ruling in *RM v The Scottish Ministers* \(^{29}\) made it clear that the necessary regulations must be made to ensure that the right not to be detained in conditions of excessive security in non-state hospitals can be effectively exercised. This has important Article 8 ECHR and, potentially even Article 3 ECHR (with corresponding Articles 17, 22 and 15 CRPD), implications.

The Bill does address the matter to some extent but not entirely. It amends the 2003 Act by clarifying \(^{30}\) who may appeal against detention in conditions of excessive security in a hospital other than in the State Hospital, namely patients detained by virtue of a restriction order, a compulsion order a hospital direction or a transfer treatment direction and provides some clarity regarding the definition of non-state hospitals. However, the regulations that the Supreme Court stressed are vital remain absent. Moreover, the proposed amendments only refer to patients held in medium secure settings and not those in low secure settings \(^{31}\). This latter category of patients also have the protection of the rights mentioned in the above paragraph and it is likely to amount to discrimination \(^{32}\) to exclude them from exercising this right under the 2003 Act.

Section 14 - Nurse’s holding power
The Bill retains the provision extending the maximum period for a nurse’s holding power \(^{33}\) from two to three hours. There is no ability for a patient to challenge this. It is respectfully submitted that the comment in the Policy Memorandum \(^{34}\) “This additional time seeks to balance the need for flexibility to arrange for a medical examination with maintaining the need for minimum restriction on patients.” does not demonstrate why this is a reasonable and proportionate measure justifying the potential risk to a patient in terms of their liberty and autonomy.

Section 15 Appeal on hospital order
The Bill proposes the reduction of the existing 12 week period, in section 220, within which a patient may appeal against an order for transfer to the State Hospital to 28 days.

The Policy Memorandum \(^{35}\) states that this is to avoid delays in a patient’s treatment.

\(^{29}\) *RM v The Scottish Ministers* [2012] UKSC 58.
\(^{30}\) S.11.
\(^{31}\) Indeed, *RM v The Scottish Ministers* concerned a patient in such a setting.
\(^{32}\) Article 14 ECHR in conjunction with Article 8 ECHR and Article 5 CRPD.
\(^{33}\) S.299.
\(^{34}\) Para. 75.
\(^{35}\) Para 80.
However, it should be noted that, notwithstanding this, Section 220(4(b)) still permits the Mental Health Tribunal to order the transfer where an appeal is pending "if satisfied that, pending determination of the appeal, the patient should be transferred as proposed…". Whilst the Tribunal will be aware of its obligations in regard to the patient’s Article 5,6 and 8 ECHR rights an additional safeguard of such rights would be to repeal Section 220(4)(b).

Sections 18-20 Named Persons

The McManus Review noted that there is a lack of understanding by many service users, named persons and even by professionals about the precise role of named persons. It would therefore be very useful if the Bill were to provide clarity on this.

The Policy Memorandum states\(^\text{36}\) that the Scottish Government considered that an individual should only have a named person if they chose to have one. However, the opt out provision proposed in section 18 of the Bill does not achieve this. The opt out provisions requires specific action on the part of the patient to choose not to have a named person but they may not be in a position to exercise this right owing to being unwell or unaware of their right to opt out. This raises the potential that a named person may be involved in decisions about care and treatment and be provided with confidential information concerning a patient without that patient’s explicit consent to this. This has important implications in terms of the individual's legal capacity, autonomy and privacy supported and the requirements of Article 8 ECHR and Articles 12 and 17 CRPD, as mentioned above, must be taken into account.

Section 21 - Advance statements

Psychiatric advance statements are an important expression of individual autonomy identified in Article 8 ECHR and, even in compulsory treatment situations, are of considerable importance. The fact that advance statements also provide an indication of whether a patient would consent to a particular measure is also arguably integral in assessing whether a deprivation of liberty engaging Article 5 ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR)\(^\text{37}\). They also reflect supported decision making which is reinforced by the Committee on the Rights of Persons with Disabilities (see above). The problem is, however, that relatively few advance statements are actually made. There are various reasons for this but significant factors include a lack of awareness about them and patient misunderstanding about their effectiveness\(^\text{38}\).

The proposed amendments are to be welcomed. That being said, whilst legislation alone cannot increase the number of advance statements made it can provide greater opportunities and encouragement for patients to make such statements. It is therefore recommended that the Bills provides for a statutory duty be placed on specified medical staff to discuss the making of an advance statement, and to explain their effectiveness, as part of their after-care plan.

\(^{36}\) Para 90.


Question 3: Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?
Section 29 - Periods for assessment orders
Section 29(4)(c) of the Bill increases the period the court may extend an assessment order for from 7 to 14 days. Whilst it is noted that the draft Bill provided for an increase to 21 days and the Bill has reduced this period there nevertheless remain important Article 5(4) and 6(1) ECHR requirements for timely hearings. It is questionable whether the proposed amendment is a necessary and proportionate extension of the period in question.

Question 4: Do you have any comments to make on Part 3 of the Bill and the introduction of a victim notification scheme for mentally disordered offenders
Section 44 - Right to information: compulsion order
Offenders subject to compulsion orders have often committed only minor offences and the Bill therefore contains an additional provision that the right to receive information concerning an offender subject to a compulsion order applies only where “an offence has been perpetrated against a natural person”\(^\text{39}\). However, care will nevertheless still have to be taken to ensure that the Victim Notification Scheme is not operated discriminatorily with mentally disordered offenders being treated differently to other offenders as this would be contrary to the requirements of Article 14 ECHR in conjunction with Article 8 ECHR and taking into account of Articles 3(b), 4(1)(b) and 5 CRPD.

Question 5: Is there anything from the McManus Report that’s not been addressed in the Bill and that you consider merits inclusion in primary legislation?
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\(^\text{40}\). Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. It is disappointing that no provision has been 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 this be addressed in the final draft Bill. This is particularly important in light of the previously mentioned interpretation of legal capacity in the General Comment on Article 12 CRPD that strongly advocates supported decision-making

Matters beyond the McManus Report
In addition, outside the scope of the McManus Report, there remain other issues which the Scottish Parliament should consider incorporating in the Bill. These include:

1. The use of covert medication and restraint
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

\(^{39}\) Section 44.
\(^{40}\) pp10-12.
treatment is administered must be considered with the Act’s underlying principles and human rights standards firmly in mind. However, notwithstanding this, given the potential for Articles 2, 3, 5 and 8 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.

2. Deaths of psychiatric patients
The state has an operational duty, under Article 2 ECHR, to protect the right to life for detained psychiatric patients and this may also extend to non-detained psychiatric patients. Moreover, Article 2 requires an effective national legal framework that will provide for an independent and impartial investigation into the deaths of individuals in custody and following hospital care and treatment. The European Court of Human Rights appears to permit a degree of domestic discretion as to the manner and form of such investigations provided they fulfil certain criteria identified in its developing jurisprudence relating to this issue. Notwithstanding this, it is questionable whether the investigative framework in Scotland is fully compliant with Article 2. This was partially explored in the 2009 Report of Findings of Review of Fatal Accident Inquiry Legislation but remains to be addressed in terms of putting in place necessary legislative changes and any outstanding procedural measures. This should be undertaken now in order to give full effect to the requirements of Article 2.

3. Areas of incompatibility between s242 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 section 242 of the 2003 Act in order to provide clarity. This raises issues under Article 8 ECHR and Article 12 CRPD and the role of substituted decision-makers in compulsory treatment situations.

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43 Shumkova v Russia (App no 9296/06) judgment of 14th February 2012, para 109.
Section 50 of the 2000 Act permits substituted decision-makers (welfare attorneys and guardians) 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, section 242, which relates to treatment for mental disorder other than that requiring special safeguards, it is unclear as to whether such consent is permitted.

4. **Section 244 2003 Act Scottish Ministers’ power to make provision in relation to treatment for certain informal patients**

It is submitted that the regulations referred to in this section should be made and that they state that where artificial nutrition is given informally to a child under the age of 16 years this is supported by a second specialist opinion which is recorded.

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