The Law Society of Scotland

Mental Health (Scotland) Bill

Introduction
The Law Society of Scotland aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interest of solicitor members but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making process.

To help us do this, we use our various Society committees which are made up of solicitors and non-solicitors to ensure we benefit from knowledge and expertise from both within and outwith the solicitor profession.

The Mental Health and Disability Sub-Committee (the Committee) welcomes the opportunity to consider and respond to the Mental Health (Scotland) Bill (the “Bill”). The Committee has the following comments to put forward in response to the questions posed in the Call for Evidence.

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

The Committee welcomes steps taken by the Scottish Government to improve upon, and bring additional clarity to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the “2003 Act”). Whilst a number of the Bill’s provisions achieve this, we do have some concerns. In particular, many of the Bill’s provisions are based on recommendations made following the limited review of the 2003 Act by the McManus Committee, which was conducted in the main during 2008 and reported on in March 2009. With the delay in producing the Bill, the Society is of the view that some of the McManus recommendations no longer reflect current needs or practice. Our specific concerns follow below.

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
The proposal to extend the short term detention pending determination of the application under section 68(2) of the 2003 Act from 5 to 10 working days did not appear in the Scottish Government’s consultation earlier this year on the draft proposals for a Mental Health Bill. Nevertheless, the Committee did note in its consultation response to the draft Bill that they were pleased that this McManus Report recommendation was not contained in the draft Bill. It is the Society’s view that such an extension of time is no longer necessary and an unmerited further encroachment on the patient’s rights. In particular, it affords less legal and procedural safeguards for the patient in terms of Articles 5
(right to liberty and security) and 6 (right to a fair trial) of the European Convention on Human Rights ("ECHR").

We question how the proposal to deduct the period in which a patient has been detained in hospital, under a short term detention certificate or an extension certificate, from the 6 month period, in the case of section 64, or 56 day period, in the case of section 65 of the 2003 Act, will work in practice. It may be difficult for the Responsible Medical Officer (RMO) (or in practice, the medical records office) and the Tribunal to accurately calculate the maximum period of compulsion remaining. This is partly because there will be no uniform practice on when the patient will attend a hearing during the 10 working day period. We therefore believe that this amendment may result in unnecessary complications regarding the calculation of time and uncertainty.

Section 2
We welcome the move to place this information on a statutory footing.

Section 4
We have no particular concerns about this section and we particularly welcome section 4(4) which requires managers of the hospital, when giving notice under subsections (2) or (3), to send a copy of the certificate to each recipient of the notice.

Section 9
We recognise that calculating a “9 month” period of suspension has led to uncertainty¹ and we therefore welcome the proposal to substitute this with a period of “200 days”. This amendment will lead to greater clarity.

However, we do not support the proposal at section 9(2) to insert a new section 127(2A) to the 2003 Act that will exclude any period of suspension authorised by the RMO that is less than 12 hours outwith the times of 9 pm and 8 am. It is regrettable that, to our knowledge, the Scottish Government did not consult on this proposal. We believe that this proposal is unnecessary and will likely add confusion when calculating the permitted suspension period.

We also do not support the proposal in section 9(10) to grant the Tribunal the authority to extend the period of suspension by a further 100 days in a given 12 month period. Again, it is regrettable that, to our knowledge, the Scottish Government did not consult on this proposal. We do not believe that there is a need to change the current law. The proposal will result in further tribunals for the patient and an increase in the overall volume of hearings for the Tribunal, which is already one of the busiest of the devolved jurisdictions. We suggest that where a patient is approaching the maximum period of suspension the more appropriate route towards extending this is for the RMO to make an application to have the order varied.

¹ See for example DC, Petitioner, 2011 GWD 39-805
Section 10
Repealing section 266 of the 2003 Act will remove the power of the Tribunal to grant the Health Board a further 28 day period (in addition to the 6 month period) to find an alternative place where a patient could be appropriately detained, where the patient has been detained in conditions of excessive security. We recognise that the effect of this repeal will be to reduce the number of Tribunal hearings.

Section 11
We acknowledge that the definitions of “qualifying patient” and “qualifying hospital” for the purposes of section 268 of the 2003 Act were to be provided in regulations but that no regulations have yet been enacted. The effect of this is that there is presently no provision for an appeal against levels of excessive security for patients other than those detained within the state hospital. The Supreme Court decision of RM v Scottish Ministers\(^2\) held that the Scottish Ministers had acted unlawfully in failing to bring forward regulations under section 268 of the 2003 Act. The Committee does not believe that the Bill’s proposals fully address the RM decision. In particular, we are concerned that the Bill does not provide a right to appeal to the Tribunal for an order declaring that the patient is being detained in conditions of excessive security in respect of patients held in low secure settings. The RM decision concerned a patient’s detention in a low secure hospital. Confining the right of appeal to patients in medium secure facilities is, in the Committee’s view, restrictive and discriminatory. Low security may extend beyond those patients who are detained within low secure (locked) hospital wards. For example, a patient who is detained within an intensive psychiatric care unit/ward (“IPCU”) may consider the conditions of security to be excessive, in comparison to being detained within an open psychiatric ward. We acknowledge that the IPCU is not ordinarily described as a “low secure ward” but it is nevertheless an environment where the patient’s liberty is subject to additional restriction. Whilst we accept that the Scottish Government may have concerns about unmeritorious claims, detained patients should nevertheless be able to make a free and unrestricted appeal.

It follows that we believe that the definition of “relevant patient” in section 11(5) is too narrow and unduly excludes the right to appeal from classes of patient. We suggest that a general definition of “relevant patient” is enacted to ensure that it includes patients subject to an order requiring them to be detained in conditions of medium and low security.

The Bill must be compatible with rights under the ECHR. There are significant implications in terms of an individual’s autonomy, liberty, dignity, due process and non-discrimination where a patient is detained in conditions of excessive security, whether high, medium or low security. For this reason, Articles 5 (right to liberty), 8 (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) are relevant. Additionally, Article 6 (right to a fair trial) has application in relation to any appeal to the Tribunal. Nor must the Bill

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\(^2\) [2012] UKSC 58
contravene the UK’s obligations under international human rights treaties that it has ratified. These may not be expressly incorporated into UK law but several such treaties have application to persons with mental disorders which impose obligations on the UK under international law. In the context of persons with mental disorders, the most relevant treaty is the UN Convention on the Rights of Persons with Disabilities (CRPD). Several CRPD rights correspond with those ECHR rights that are particularly relevant to the Bill. Moreover, in light of increasing references to the CRPD being made in European Court of Human Rights cases, and its superior status under international law, it is likely to ultimately influence the interpretation of ECHR rights.

As currently drafted, section 11(5) provides that ““relevant patient” means a patient whose detention is authorised in hospital by – (a) if the patient is also subject to a restriction order, a compulsion order...””. This is not grammatically correct and may lead to uncertainty.

Section 12
This section provides that a “qualifying hospital” is a hospital other than a state hospital, with the other requirements for qualification to be defined by regulations. Scotland has three medium secure units – Rowanbank Clinic, Glasgow; Orchard Clinic, Edinburgh and Rohallion clinic, in Perth. However, each of these units has different characteristics and security levels between them. Therefore simply using the same form of words as the section 264 test may be problematic. We suggest that direction is required to harmonise certain aspects of the three units, for example physical security, to ensure consistency with the Scottish Government’s guidelines for medium security. We believe that the Bill requires to provide further clarity on what is meant by “level of security”. The Society notes that not all regions within Scotland have all levels of secure facilities. For example, in Edinburgh there is no low secure hospital provision – only a general IPCU facility and a medium secure unit. In contrast, Glasgow has different levels of security units/wards within the same hospital (as there is for example within Leverndale Hospital in Glasgow, which provides, IPCU, separate locked and unlocked low secure wards). These inconsistencies and variations in the provision of different levels of secure environments within different regions could result in patients, who would be best suited to lesser levels of security, being admitted to the higher level of security within the region. Any patient detained in a more secure setting than they clinically require should be able to make a free and unrestricted appeal to the Tribunal.

Section 14
We generally support the amendments this section makes to section 299 of the 2003 Act as we believe that these will reduce the emphasis on the purpose of section 299 being only to obtain a medical opinion. The amendments will place an onus on nurses to detain the patient where they believe that the necessary criteria in section 299(3) have been fulfilled.

However, we are concerned that the Bill has not amended section 299(3) of the 2003 Act. The wording of this section - “the patient be immediately
restrained from leaving the hospital” – suggests that the patient requires to take active steps to leave the hospital before a nurse is able to exercise the holding power. Even where patients have no capacity, the wording suggests that the patient would be held unlawfully unless he or she was trying to leave the hospital. We understand that this causes particular problems in out-of-hours situations where nurses may not immediately call the doctor because the patient is not actively trying to leave. We understand that in such situations nurses traditionally rely on their skills to keep patients content, even though they may have recognised several hours earlier that the patient has no capacity and should not continue to be held as an informal patient. Accordingly, we suggest that section 299(3) is amended to remove any suggestion that patients must actively attempt to leave the hospital before nurses can exercise the holding power.

Section 15
We have no objection to the proposal to reduce the time limit for making an appeal from 12 weeks to 28 days.

Section 16
We recognise that this section seeks to tidy up the statutory language in the 2003 Act with respect to non-civil orders and we acknowledge that this may help provide additional clarity with respect to the application of sections 189 and 213 of the 2003 Act. However, there are no analogous provisions in the Bill with respect to civil orders. This will unnecessarily lead to two different procedures. We are unsure if this was the Scottish Government’s intention. We recommend that the position for civil and non-civil orders is the same for consistency and to reduce the likelihood of confusion.

Section 17
This section depends on the Scottish Government introducing statutory timescales, which do not appear in the Bill. Accordingly, this section does not make sense as things currently stand. The Society notes that the proposal to introduce statutory timescales appears in the first [draft] Bill.

Sections 18 - 20
The policy memorandum accompanying the Bill provides that “The Scottish Government considers that an individual should only have a named person if they chose to have one.” However, this does not coincide with the position in the Bill. The Bill retains the default provisions outlined in section 251 of the 2003 Act. This outlines the position where no named person is nominated or the nominated person declines to act. If the Scottish Government wishes to fulfil their policy intent then we suggest that section 251 should be repealed.

We do not support the requirement in section 18(3) that a declaration, in relation to a named person, requires to be made in writing. It is unusual for law to require a person to make a formal declaration that they do not want something. We have some doubt on whether the requirement for writing would be compatible with section 1 of the 2003 Act. We suggest that a patient should be able to make their views known by any means, in writing or
otherwise. For example, by telling their independent advocate, their representative or by making an oral statement at a Tribunal hearing.

These issues aside, we support this section of the Bill as it provides additional clarity by outlining, on a statutory footing, what is to happen where a person indicates that they do not want a named person.

**Section 21**
We suggest that the reference to “the thing” in section 276C(2)(a) should be substituted for more appropriate statutory language which will provide clarity.

**Sections 24 and 25**
We emphasise that the principles in section 1 of the 2003 Act (and corresponding ECHR and CRPD rights, including that of non-discrimination) must be adhered to and respected at all times in the implementation of these provisions.
When Scottish Ministers grant a warrant for transfer of a patient subject to detention out of Scotland, the patient has the right of appeal to the Tribunal. However, the named person has no right of appeal. The Committee suggests that the 2003 Act requires to be amended to grant the right of appeal to the named person. This will require to be achieved by primary legislation and not by regulations.

**Section 26**
We do not believe that the requirement for a Mental Health Officer (MHO) to agree in writing to the transfer before the transfer takes place will be workable. This is particularly so with respect to emergency transfers of patients from a hospital in mainland Scotland who have an ordinary place of residence in a Scottish island community. In this example, the MHO will be located in the area of the patient’s ordinary place of residence.

**Question 3:**
Do you have any comments on the provisions in Part 2 of the Bill on criminal cases?

**Sections 28 and 29**
The Committee notes that no provision is made for cross-border transfers in the new section 52D of the Criminal Procedure (Scotland) Act 1995. We anticipate that problems may be encountered with respect to female and child patients on remand who should be detained in a high secure facility, given that Scotland’s state hospital does not have provision for female or child patients.

Section 29(4)(c) allows the court to extend the Assessment Order for a period of 14 days. We note that the consultation to the first [draft] Bill proposed extending the period to 21 days. Whilst we acknowledge that it is in the patient’s interests that as full an assessment as possible is made, we do not support the increase from 7 days to 14 days. Articles 5(4) and 6(1) ECHR require a timely hearing and we are not convinced that such an extension is necessary or proportionate.
Sections 41 and 42
We welcome these provisions and believe that they will help achieve a consistent approach with respect to both civil and criminal matters.

Section 44
We suggest that the statutory language adopted for the new section 16A(1)-(3) of the Criminal Justice (Scotland) Act 2003 is cumbersome. The following wording is proposed to provide greater clarity:-

“(1) Where—
(a) an offence has been perpetrated against a natural person,
(b) another person (“O”) has been made subject to a compulsion order and a restriction order in proceedings in respect of that offence,
(c) a person has asked to be given information about O under this section and that person is, or was at the time of asking, a person entitled to ask to be given the information (see section 16B),
(d) O has attained the age of 16 years, and
(e) there are no exceptional circumstances which, in the opinion of Scottish Ministers, make it inappropriate to do so,
the Scottish Ministers must give the information about O described in section 16C to the person mentioned in subsection (1)(c).”

We further suggest that the proposed section 16C(2)(c) of the Criminal Justice (Scotland) Act 2003 should be amended to read “that O has died, and the date of O’s death”.

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
Generally, we would be concerned if the effect of the Bill was that mental health patients were subjected to more disclosure requirements than perpetrators of crime.

Section 44(3) provides that “Scottish Ministers need not give a person information under this section if they consider there to be exceptional circumstances”. We are unclear on what is meant by “exceptional circumstances”. Guidance on this will be necessary.

As drafted, the victim’s rights provisions in Part 3 of the Bill are restricted to patients that are subject to compulsion and restriction orders. Currently, the victim’s rights will not extend to situations where that patient’s restriction order is removed. We are unsure if this was the Scottish Government’s intention.
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? If so, please set out why.

As stated at Question 1 above, we note that the Scottish Government did not consult in the first [draft] Bill on the McManus recommendation, now contained in section 1 of the Bill, to extend the period of short term detention possible under section 68(2)(a) from 5 working days to 10 working days. Despite the absence of draft provision, we noted in our consultation response to the first [draft] Bill that we were not in favour of this. We maintain that the proposed extension is unnecessary and an unmerited further encroachment on the individual’s rights. In particular, it affords less legal and procedural safeguards for the patient in terms of Articles 5 (right to liberty and security) and 6 (right to a fair trial) of the ECHR.

This aside, the McManus Report reaffirmed the importance of independent advocacy for persons with mental health issues and noted the inadequacy of its provision across Scotland\(^3\). It should also be noted that mentally disordered offenders in prisons have inadequate access to independent advocacy. Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. It is disappointing that no provision is made in the Bill to strengthen and extend the duty to provide for such advocacy (for both civil patients and mentally disordered offenders) so that the right to independent advocacy can be fully realised by those who are entitled to it. It is recommended that this is addressed.

Separately, there are a number of matters, not arising directly from the McManus Report that the Committee believes merit inclusion in primary legislation. 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. Any non-consensual treatment must be considered and administered with the 2003 Act’s underlying principles and human rights standards firmly in mind. However, given the potential for Articles 2, 3, 5 and 8 of the ECHR to be engaged in such situations, 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\(^4\) and this may also extend to non-detained psychiatric patients\(^5\). Moreover, Article 2 requires an effective national legal framework that will provide for an independent and impartial

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\(^3\) pp10-12.


\(^5\) Rabonne v Pennine Care NHS Foundation Trust [2012] UKSC 2.
investigation into the deaths of individuals in custody and following hospital care and treatment. 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. We recommend that this should be undertaken now in order to give full effect to the requirements of Article 2. The Mental Welfare Commission’s monitoring report Death in detention monitoring reinforces this need.

3. Incompatibility between section 242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000
The opportunity should be taken to amend section 242 of the 2003 Act in order to address any areas of incompatibility between this and the Adults with Incapacity (Scotland) Act 2000 (the “2000 Act”). Section 50 of the 2000 Act permits welfare attorneys and guardians to consent to medical treatment on behalf of an adult with incapacity. However, where treatment of such an adult for mental disorder under the 2003 Act is being considered, it is unclear as to whether such consent is permitted. The particular problem concerns the inter-relationship of the 2000 Act and the 2003 Act as regards the status under the 2003 Act of decisions and consents on behalf of a patient by an appointee (guardian, attorney or appointee under an intervention or duty) under the 2000 Act. This requires to be addressed and we recommend that Scottish Government take this opportunity to do so.

4. Curators ad litem
At present, the 2003 Act contains no provision allowing curators ad litem the right of appeal from the Tribunal to the Sheriff Principal or to the Court of Session. This should be included in the Bill.

5. Recorded matters
At present, the 2003 Act contains no provision allowing recorded matters to be made by the Tribunal in a compulsion order. This should be included in the Bill.

6. Section 244 2003 Act – Scottish Ministers’ power to make provision in relation to treatment to certain informal patients
We also propose that regulations be introduced under section 244(a) of the 2003 Act to provide that when artificial nutrition is being provided, informally, to a child under the age of 16 years, this is supported by a second, specialist, opinion. This will introduce an additional safeguard. We understand that this proposal is supported by the Mental Welfare Commission.

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6 Shumkova v Russia (App no 9296/06) judgment of 14th February 2012, para 109.
Question 6:
Do you have any other comment to make about the Bill not already covered in your answers to the questions above?

Additional comments on the proposals were outlined in our consultation response to the draft Bill. A copy of this response is appended in the appendix for consideration.

The Law Society of Scotland
August 2014
APPENDIX

Consultation on draft proposals for a Mental Health (Scotland) Bill

The Law Society of Scotland's response
April 2014

Introduction
The Law Society of Scotland aims to lead and support a successful and respected Scottish legal profession. Not only do we act in the interest of solicitor members but we also have a clear responsibility to work in the public interest. That is why we actively engage and seek to assist in the legislative and public policy decision making processes. To help us do this, we use our various Society committees which are made up of solicitors and non-solicitors and ensure we benefit from knowledge and expertise from both within and outwith the solicitor profession.

The Mental Health and Disability Sub-Committee (the Committee) welcomes the opportunity to consider and respond to the Scottish Governments consultation on the proposed Mental Health (Scotland) Bill. The committee has the following comments to put forward:

Comments:

Mental Health (Care and Treatment) (Scotland) Act 2003.
The Committee notes that the 2003 Act is internationally regarded as an example of good practice in terms of patient-centred and human rights compatible legislation. However, it must, of course, be kept under review to take into account developments in international human rights standards and practice.

The Act’s provisions govern the compulsory care and treatment of persons with mental disorder. That being said, it is important to appreciate that the Act’s principles endeavour to ensure that it will operate as part of an environment in which the primary objectives are that the right to the highest attainable standard of health is recognised and individuals with mental disorder are supported towards effective living and, hopefully, recovery. For example, the Act’s underlying principles require anyone ‘exercising functions’ to consider a number of factors. These include having regard to the range of available options, patient participation, the least restrictive option, whether the intervention will be of maximum benefit to the individual and non-discrimination10. The patient’s wishes, background and circumstances and the views of named persons, carers, guardians and attorneys must also be taken into account as well as the encouragement of patient participation11. Additionally any functions involving children or young persons under 18 years of age must also be discharged in a “manner that best secures the welfare of the patient”12.

10 ss1(3)(c)-(g) and 1(4).
11 ss1(3)(a),(b) and (h).
12 s.2(4).
Importantly, the presence of mental disorder alone is insufficient justification for compulsory treatment to be ordered or for short-term detention to occur. Issues of treatability, risk, the existence of significantly impaired decision making ability owing to mental disorder, and the necessity for such compulsory treatment, must also be considered\(^\text{13}\).

**European Convention Human Rights (ECHR) – compliance / compatibility**

Consideration and implementation of the 2003 Act, and any amendments to it, must be compatible with ECHR rights\(^\text{14}\). Compulsory care and treatment of individuals with mental disorder is without their consent. This accordingly has significant implications in terms of an individual’s autonomy, liberty, dignity, due process and non-discrimination. For this reason, Articles 5 (right to liberty), 8 (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) are relevant. Additionally, Article 6 (right to a fair trial) clearly has 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 state institutions.

**International human rights standards**

Nor must the 2003 Act and any amendments to it contravene the UK’s obligations under international human rights treaties that it has ratified\(^\text{15}\). These may not be expressly incorporated into UK law but several such treaties have application to persons with mental disorder which impose obligations on the UK under international law. In the context of persons with mental disorder the most relevant treaty is the UN Convention on the Rights of Persons with Disabilities (CRPD). Several CRPD rights correspond with those ECHR rights that are particularly relevant to the draft Proposals\(^\text{16}\). Moreover, in light of increasingly references to the CRPD being made in European Court of Human Rights cases\(^\text{17}\), and its superior status under international law, it is likely to ultimately influence interpretation of ECHR rights.

At the time of submitting this response, the outcome of the recent consultation held by the UN Committee on the Rights of Persons with Disabilities on its

\(^{13}\) ss.64(5) and 44(3)-(4).

\(^{14}\) ss29(2)(d) and s.57 Scotland Act 1988 and s.6 Human Rights Act 1998.

\(^{15}\) ss.29(2), s.35(1) and s.58 Scotland Act 1998.

\(^{16}\) 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).

\(^{17}\) For example, see Glor v Switzerland (13444/04) judgment 30 Apr 2009; Kiss v Hungary (38832/06) judgment of 20 May 2010; Stanev v Bulgaria (36760/06 ) judgment of 17 Jan 2012; DD v Lithuania (13469/06 ) judgment of 14 Feb 2012; ZH v Hungary (28973/11) judgment of 8 November 2012; Sykora v Czech Republic (23419/07) judgment of 22 November 2012; Mihailovs v Latvia (35919/10) judgment of 22 January 2013; Lashin v Russia (33117/10) judgment of 22 April 2013; MS v Croatia (36337/10) judgment of 25 April 2013; MH v UK (11577/06) judgment of 22 October 2013; Koroviny v Russia (31974/11) judgment of 27 February 2014.
Draft General Comment on Article 12 CRPD is unknown. As drafted, the comment proposes 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. However, whatever form the General Comment finally takes, what is clear is that genuine and demonstrable respect for the autonomy of all individuals with mental disorder, whether or not they are subject to compulsion, will be paramount.

**Advance Statements**

**Question 1:** Do you have any comments on the proposed amendments to the Advance Statement provisions?

Advance statements are an important expression of individual autonomy and are of considerable importance even in compulsory treatment situations. The fact that advance statements also provide an indication of whether a patient would consent to a particular measure is 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)\(^\text{18}\). They are also reflect supported decision making which is reinforced by the Committee on the Rights of Persons with Disabilities (see above).

The proposed amendments are therefore to be welcomed. However, relatively few advance statements are actually made. For this reason, in addition to general information and awareness-raising, the Committee suggests the following:

1. That a statutory duty should be placed on the Responsible Medical Officer (RMO) to:
   a. Discuss the making of an advance statement, and to explain its effectiveness, as part of the patient’s after-care plan; and
   b. To periodically review the advance statement with the patient at no less than three yearly intervals starting with making of the original advance statement.

2. That the Act permits the RMO to delegate their aforesaid duty to another person such person to be specified in regulations.

3. That the Act’s Code of Practice provides guidance on the operation of the register to be maintained by the Mental Welfare Commission and that the Scottish Government has regard to the Commission’s recent guidance on advance statements\(^\text{19}\).

**Named Person**

**Question 2:** Do you have any comments on the proposed amendments to the Named Person provisions?


As with psychiatric advance statements, a patient’s nominating of a named person is an expression of individual autonomy and reflects supported decision-making model.

However, the Draft Bill contains some areas of concern:

1. **Definition of “named person”**
   The 2003 Act currently contains no definition of “named person”. There is a lack of understanding by many service users, named persons and even by professionals about the precise role of named persons. It is therefore recommended that a definition of “named person” be included in the draft Bill.

2. **The retention of the default provisions**
   A named person may assist in establishing an holistic picture of the patient’s preferences and circumstances which is valuable in the preparation of their care and treatment plan. Where a named person is nominated without the patient’s consent this is a restriction of their right to autonomy (Article 8(1) ECHR) which may be difficult to justify under Article 8(2) as always being in pursuit of a legitimate aim although the Committee acknowledges that there may be limited circumstances where the rights of an individual who is unable to nominate a named person are most effectively protected by the default provisions.

3. **The proposed removal of the current automatic right of a named person to be involved in Tribunal proceedings as a party and requirement to apply for leave to appeal.**
   Refusal to permit a named person to automatically be included as party in proceedings to represent the patient’s interests is contrary to the exercise of the patient’s right to autonomy and to s1 of the Act. It removes an important additional patient safeguard which, again, is difficult to justify under Article 8(2). The draft Bill should be amended to ensure that such safeguards remain.

In relation to appeals, the Bill does not specify how the “Tribunal's prior leave” is to be addressed. It is therefore difficult to ascertain how this would work in practice and it could present a considerable challenge in time critical appeals, for example, a section 50 application under the 2003 Act, (to revoke a Short Term Detention Certificate) which is ordinarily fixed within 5 working days from receipt to hearing. If a “leave to appeal” process is to be introduced this will undoubtedly lead to delays and possibly multiple hearings. The Committee has previously expressed considerable concern to the Scottish Government over delays in the scheduling of section 50 applications during the period 2005 to 2008.

Finally, the Committee recommends that section 290 (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) be amended to introduce a right of appeal to the named person, which is in

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21 s257(1)
keeping with section 289 (Cross-border transfer: patients subject to requirement other than detention).

**Medical matters**

**Question 3: Do you have any comments on the proposed amendments to the medical examination and compulsory treatment order provisions?**

**Medical Examinations and Compulsory Treatment Orders (CTOs)**

The Scottish Government justifies a single medical report in CTO applications on the basis of concern about the involvement of GPs, a perceived lack of independence between the two reports and of conflicts of interest. It should be emphasised, however, that the McManus Report stated that there was widespread support for the involvement of primary care in long term compulsory treatment and little support for CTOs being accompanied by a single medical report. If the current proposed amendment is founded on resourcing issues – although, admittedly, the consultation paper does not state this - then it should also be recalled that the McManus Report did state that a lack of availability of GPs should not be justification for preventing them from providing such report.

We also emphasise how important it is that patients should regard the Tribunal as independent and impartial. This may not be the perception where the Tribunal requests the second medical report.

In light of the implications for a person who is subject to a CTO application, and requirements of Article 5 ECHR, it is strongly recommended that the additional safeguard of a second medical report is retained.

**Suspension of detention**

**Question 4: Do you have any comments on the proposed amendments to the suspension of detention provisions?**

We acknowledge that the current provisions are lacking in clarity and that case law has not helped to significantly resolve the issue. We recommend that the time limit is not removed but clarified instead. The proposed amendment is compatible with respect for autonomy and the least restrictive treatment alternative but it leaves the possibility of the original order being left in place as a precautionary measure in circumstances when it is no longer required or appropriate. This could place the patient in the situation where he or she is subject to greater measures than is necessary, which is also contrary to the least restrictive alternative. Whilst a patient can seek revocation this is placing the onus on them to do so which is contrary to the procedural requirements of Article 5(4) ECHR.

**Information about extending a CTO**

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22 Para 14.
24 Even though it also identified that GPs were requested to provide the second report in less than 50% of cases (op cit, p.28).
26 That an individual is not deprived of their liberty except where they suffer from a genuine which has been “reliably shown” by “objective medical experts” and only where such deprivation of liberty is required for their effective treatment (Winterwerp v The Netherlands ((6301/73) (1979) 2 EHRR 387, para 39; Shukatarov v Russia (44009/05) (2008) 54 EHRR 27, para 114; Stanev v Bulgaria (36760/06 ) judgment of 17 Jan 2012, para 45).
27 For example, DC, Petitioner [2011] CSOH 193
Question 5: Do you have any comments on the proposed amendment requiring a MHO to submit a written report to the Mental Health Tribunal? This requirement is protective of the patient and appears to be a reasonable amendment.

Emergency, short-term and temporary steps
Question 6: Do you have any comments on the proposed changes to the emergency, short-term and temporary steps provisions?
The sharing of personal medical and other data falls within the ambit of the right to privacy in Article 8(1) ECHR. Any interference with this right must be justified under Article 8(2). At the same time, however, an individual’s Article 8(1) right allows them to choose who they share information with unless this can, again, be justified under Article 8(2).
Any wishes of the individual that one of the specified persons or the Mental Welfare Commission is informed of their detention must therefore be respected unless it can be justified in terms of Article 8(2) ECHR. This should be reflected in the legislation.

Suspension of certain orders etc
Question 7: Do you have any comments on the proposed changes to the suspension of certain powers etc. provisions?
We have no comments regarding the proposed amendments to apply the same suspension provisions to Interim Compulsion Orders and Compulsion Orders that currently apply to CTOs in the case of an emergency or a short-term detention certificate being granted. However, we repeat the cautionary note made above regarding the use of emergency detention.

Removal and detention of patients
Question 8: Do you have any comments on the proposed amendments to the removal and detention of patients provisions?
The proposed amendment about MHO notification, is acceptable as it provides an additional safeguard for the individual affected at a time when his or her rights to autonomy and liberty are likely to be restricted.
However, the proposal to extend the maximum period for a nurse’s holding power from two to three hours is not justified in the consultation paper. Given the implications this has for a patient in terms of their liberty and autonomy, and the inability of a patient to challenge this, this proposal is therefore of concern to us.

Timescales and referrals and disposals
Question 9: Do you have any comments on the proposed amendments to the timescales for referrals and disposals provisions?
The Mental Health Tribunal will be well aware of its obligations under Articles 5(4) and 6 ECHR. However, in light of the significance of the matters to be considered, it is submitted that the requirement on the Tribunal should be imperative.

Support and services

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Question 10: Do you have any comments on the proposed amendments to the support and services provisions? If you disagree please explain the reason(s) why.
We welcome the proposed amendments to section 261 (extending the provision of assistance to patients with communications difficulties) and section 24 (extending provision of services for certain mothers with post-natal depression to mothers with mental disorder). They reflect the requirements of Articles 5, 6, 8 and 14 ECHR and also with Articles 5, 6 (women with disabilities), 12, 13 (access to justice), 14, 17 and 23 CRPD.

Arrangements for treatment of prisoners and cross-border patients and absconding patients (paras 42-49)

Question 11: Do you agree with the proposed amendments to the arrangements for treatment of prisoners and cross border-and absconding patients provisions? If you disagree please explain the reason(s) why.

a. Arrangements for treatment of prisoners
The proposed amendment seeks to rectify the fact that there is currently no legislative requirement that Scottish Ministers consult MHOs when considering a Transfer for Treatment Direction (TTD) for a prisoner. This is out of step with other applications under the 2003 Act. This is a reasonable amendment but the additional burden on MHOs must be considered and adequate resources allocated. Moreover, delays in receipt of the MHO report should not delay the transfer of prisoners for treatment and the legislation should reflect this.

b. Cross-border patients and absconding patients
We emphasise that the principles in section 1 of the 2003 Act (and corresponding ECHR and CRPD rights, including that of non-discrimination) must be adhered to and respected at all times in the implementation of these provisions.

We are concerned about the proposed amendments to sections 301-310 regarding treatment of absconding prisoners which seem to provide for the provision of care in an emergency or short term capacity during the period where the prisoner is waiting to be returned from to the place from where they absconded. Section 243 already provides for emergency treatment. We concerned that any extension of sections 301-310 may render patients from outside Scotland vulnerable to treatment (e.g. non-consensual invasive treatment) without safeguards that they would not be able to receive in the jurisdiction from which they came. This is at odds with the principles set out in section 1 of the Act.

There will also be inevitable resourcing issues to consider in regard reception of prisoners from out of the jurisdiction.

Criminal Cases
Making and effect of orders
Question 12: Do you have any comments on any of the proposed amendments relating to the “making and effect of orders” provisions?
It is in the patient’s interests that as full an assessment as possible is made. However, the extension of 7 to 21 days is considerable. Given the Articles 5(4) and 6(1) ECHR requirement for timely hearing, further clarification than
the need to take into account the “vagaries of situations that may be met within the criminal justice system” is required as to the necessity of such a time extension and why this is deemed a proportionate response in such situations.

**Variation of certain orders etc**

**Question 13:** Do you have any comments on the proposed amendments to the “variation of certain orders” provisions?

No comment..

**Question 14:** Do you agree with the proposed approach for the notification element of this VNS? If not, please explain why not and please outline what your preferred approach would be.

**Question 15:** Do you agree that victims should be prevented from making representations under the existing mental health legislative provisions once they have the right to do so under the proposed Victim Notification Scheme? Please provide reasons for your answer.

**Question 16:** Do you agree with the proposed approach for the representation element of a Victim Notification Scheme relating to Mentally Disordered Offenders? If not, please explain why not and please outline what your preferred approach would be.

In general, the extension of the victim notification and representation arrangements are reasonable. However, it would be discriminatory for mentally disordered offenders to be treated differently to other offenders in this respect under Article 14 ECHR in conjunction with Article 8 ECHR and taking into account of Articles 3(b), 4(1)(b) and 5 CRPD. The provisions must not, therefore, go beyond that which would apply to other offenders.

Related to this, reconsideration of the right to receive information relating to offenders subject to compulsion orders (proposed section 16A of the Criminal Justice (Scotland) Act 2003 is also necessary. Offenders subject to compulsion order have often committed only minor offences. To allow the proposed notification in such cases may therefore be an unnecessary and disproportionate limitation of their right to private and family life (see previous comments on Article 8 ECHR and privacy).

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30 Para 57, Consultation Document.
Chapter 5 Assessing Impact

Equality

Question 17: Please tell us about any potential impacts, either positive or negative, you feel any of the proposals for the Bill may have on particular groups of people, with reference to the "protected characteristics" listed above.

See response above.

Business and Regulation

Question 18: Please tell us about any potential costs or savings that may occur as a result of the proposals for the Bill, and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible.

The relevant authorities must be consulted on the actual costs involved. However, the following are likely to involve resourcing considerations:

(a) For local authorities as a result of the additional duties required of MHOs in connection with extending CTOs (Question 5) and being consulted in connection with proposed TTDs (Question 11).
(b) For local authorities and health boards as a result of the reception and treatment of patients from other jurisdictions.
(c) For the Mental Health Tribunal the additional costs that may arise from more interim hearings if more independent reports are ordered as a result of the proposals regarding medical examinations and CTOs (Question 3).
(d) The possible multiple hearings identified in relation to Question 2 may also incur costs for the Tribunal, patients and other parties involved.
(e) The proposed amendment to section 24 (extending provision of services for certain mothers with post-natal depression to mothers with mental disorder) will also incur costs for health boards.

It is important, however, that legislative changes must not be resource driven where individuals’ rights are at stake. The Scottish Government’s obligations in relation to recognition and protection of the rights in the ECHR and other international treaties identifying civil and political rights are therefore emphasised. This was also fully recognised in the Millan Report\(^{31}\) which shaped the form and content of the 2003 Act.

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**Additional Matters**

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

1. **Section 268, 2003 Act – detention in conditions of excessive security in non-state hospitals**

For an individual to be detained in conditions of excessive security engages Article 8 ECHR and, potentially, even Article 3 (with corresponding Articles 17, 22 and 15 CRPD). Following its recent consultation\(^{32}\), the Scottish Government should make the necessary Regulations or legislative changes to ensure that this right to challenge detention in conditions of allegedly excessive security can be effectively exercised.

2. **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. Any non-consensual treatment must be considered and administered with the Act’s underlying principles and human rights standards firmly in mind. However, 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.

3. **Deaths of psychiatric patients**

The state has an operational duty, under Article 2 ECHR, to protect the right to life for detained psychiatric patients\(^{33}\) and this may also extend to non-detained psychiatric patients\(^ {34}\). 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\(^ {35}\) and following hospital care and treatment\(^ {36}\). This was partially explored in the 2009 *Report of Findings of Review of Fatal Accident Inquiry Legislation*\(^ {37}\) 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. The recent Mental Welfare Commission monitoring report *Death in detention monitoring* reinforces this need\(^ {38}\).

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\(^{34}\)Rabonne v Pennine Care NHS Foundation Trust [2012] UKSC 2.

\(^{35}\)Shumkova v Russia (App no 9296/06) judgment of 14\(^{th}\) February 2012, para 109.


4. **Incompatibility between section 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\(^\text{39}\). That being said, the opportunity should be taken now to amend section 242 of the 2003 Act in order to provide clarity.

Section 50 of the 2000 Act permits welfare attorneys and guardians to consent to medical treatment on behalf of an adult with incapacity. However, where treatment of such an adult for mental disorder under the 2003 Act is being considered, section 242 it is unclear as to whether such consent is permitted.

5. **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\(^\text{40}\). It should also be noted that mentally disordered offenders in prisons have inadequate access to independent advocacy.

Independent advocacy is an integral element of patient support, particularly in terms of promoting autonomy and decision-making. It is disappointing that no provision is made in the draft Bill to strengthen and extend the duty to provide for such advocacy (for both civil patients and mentally disordered offenders) 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.

6. **Curators ad litem**

At present, the 2003 Act contains no provision allowing curators ad litem the right of appeal from the Mental Health Tribunal to the Sheriff Principal or to the Court of Session. This should be included in the draft Bill.

7. **Multiple hearings**

The McManus Report recommended that the time limit of five working days for a extension of a short-term detention certificate when an application for a CTO has been made (section 68(2)(a)) be increased to ten working days as a means of reducing multiple hearings\(^\text{41}\). In its response to the McManus Review consultation, this was opposed by the Committee on the basis that it afforded less legal and procedural safeguards for the patient (Articles 5(4) and 6 ECHR). We are pleased to note that the McManus recommendation is not contained in the Draft Bill.

8. **Recorded matters**

At present, the 2003 Act contains no provision allowing Recorded Matters to be specified in Compulsion Order cases. This should be included in the draft Bill.


\(^{40}\) Recommendation 6.1, p50.
9. Section 244 2003 Act – Scottish Ministers’ power to make provision in relation to treatment to certain informal patients

We also propose that regulations be introduced under section 244(a) of the 2003 Act to provide that when artificial nutrition is being provided, informally, to a child under the age of 16 years, this is supported by a second, specialist, opinion. This will introduce an additional safeguard when this form of medical treatment is being provided without compulsion. We understand that this proposal is supported by the Mental Welfare Commission.

The Law Society of Scotland
August 2014