Mental Capacity Law Newsletter April 2014: Issue 45

Scotland

Introduction

Welcome to the April issue of the Mental Capacity Law Newsletter. The Newsletter has a new look this month, and, in a step upon which we would welcome feedback, we have decided to split the newsletter into five members of a family: (1) CoP: Health, Welfare and Deprivation of Liberty; (2) CoP Property and Affairs; (3) Practice and Procedure; (4) Capacity outside the CoP; and (5) Scotland. Each will be available separately, but it is always possible to read the entirety as one newsletter. The introduction will also always be the same across each of the members of the family.

The division comes at a vital time for the MCA 2005 – in one week in March we had first the report of the House of Lords Select Committee on the MCA 2005 (covered in more detail in the Capacity outside the CoP newsletter), and then the landmark decision of the Supreme Court in *Cheshire West* and *P and Q* (to which we devote almost the entirety of the Health, Welfare and Deprivation of Liberty newsletter). The Supreme Court also handed down an important decision in relation to litigation capacity and the settlement of civil proceedings, covered in detail in the Capacity outside the CoP newsletter, as are two important decisions on testamentary capacity. In the Property and Affairs newsletter, we cover important cases on gifts and the notification requirements in relation to statutory wills. In our Practice and Procedure newsletter we cover, amongst other things, the evidence given by the President and Vice-President of the Court of Protection to the Justice Select Committee. Last, by very much no means least, we cover in the Scottish newsletter the implications of the decision in *Cheshire West* for Scotland and also the consultation on draft proposals for a Mental Health (Scotland) Bill.

As if this were not enough, we also this month offer guidance notes: (1) on the implications of *Cheshire West*; and (2) on capacity assessments; the second part of Adrian's note on Scottish adult incapacity law; and an article by Simon Edwards on testamentary capacity and the MCA 2005.

Editors

Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Anna Bicarregui

Scottish contributors
Adrian Ward
Jill Stavert

Table of Contents

Hyperlinks are included to judgments; if inactive, the judgment is likely to appear soon at www.mentalhealthlaw.co.uk.

Scottish Adult Incapacity Law Part 2

We would invite even those readers who consider themselves familiar with the provisions of Scottish adult incapacity law to read Adrian's note because of the points at which he considers that the 2000 Act requires amendment in order to ensure compliance with the UNCRPD as well as his view that the intervention orders could be used to authorise defined interventions expected to recur intermittently into the future.

Deprivation of liberty and adults with incapacity: A Scottish perspective – Addendum after *Cheshire West*

Introduction

In the January 2014 issue of this newsletter a brief overview was provided of the post-*Bournewood* implications for Scottish legislation, notably the Adults with Incapacity (Scotland) Act 2000 and s13ZA Social Work (Scotland) Act 1968[1]. Since then, there has been the Supreme Court *Cheshire West* judgment.[2] So, what does this mean for Scotland?

As indicated in the January issue, questions that have been exercising minds, including that of the Scottish Law Commission whose report[3] on the matter is expected later this year, are:

1. What exactly is a "deprivation of liberty" engaging Article ECHR? And

2. Where such a deprivation of liberty exists:

   a. Does Scottish legislation provide the requisite Article 5 lawful authority for it? And

   b. Do the necessary Article 5 compatible legal and procedural safeguards exist for the person who has been deprived of their liberty?

Cheshire West: Brief facts

A reading of the full case is strongly recommended but the following are the brief essential facts.

This case involved two conjoined appeals – that of P and Q, also known as MIG and MEG, and of P - which raised the issue of what criteria should be used to assess whether the living arrangements made for a mentally incapacitated person who cannot give valid consent to restrictions on their activities amounts to a deprivation of liberty.

P and Q, also known as MIG and MEG, are sisters with learning disabilities who were placed in care at the ages of, respectively, 16 and 17. MIG was placed with a foster mother to whom she was devoted and referred to as "Mummy". She did not require medication and attended, on a daily basis, a further education unit daily and was taken on trips and holidays by her foster mother. Although she did not attempt to leave the foster home on her own she would have been restrained from doing so had she tried. MEG was originally in foster care but it was not possible to manage her aggressive behaviour there so she was moved to an NHS residential home for learning disabled adolescents with complex needs. She sometimes

[1] J. Stavert, *Deprivation of liberty and adults with incapacity: a Scottish perspective*.

[2] *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.

[3] Following its consultation *Discussion Paper on Adults with Incapacity*, No 156, 2012.

required physical restraint and received sedative medication.

P is an adult born with cerebral palsy and Down's syndrome. He requires 24 hour care. He lived with his mother until he was 37 years old until her health deteriorated. The local social services authority then obtained Court of Protection orders providing that it was in P's best interests if he now live in accommodation arranged by the local authority. He has lived, since late 2009, in a staffed bungalow with other residents near his home. He has one to one support that enables him to regularly leave the bungalow for activities and visits. Sometimes intervention is required when he exhibits challenging behaviour although he is not on sedative medication. He also requires prompting and assistance with all aspects of daily living. He needs to wear continence pads and because he has a tendency to pull at these and put piece in his mouth he wears all-in-one underwear to prevent this.

Definition of "Deprivation of Liberty"

The seven Justice panel of the Supreme Court unanimously ruled that P had been deprived of his liberty and by a majority of 4 to 3 that MIG and MEG had been deprived of their liberty.

Lady Hale's delivered the leading judgment stating that what is pivotal, and in all three cases she believed that these criteria has been met regarding MIG, MEG and P, is whether the person is "under continuous supervision and control and not free to go,"[4] and she noted that she did not agree that supervision and control is relevant only where the person is not free to leave.[5] She stressed that everyone has the equal protection of human rights and to be deprived of liberty is the same for all whether or not one has a physical or mental disability,[6] firmly rejecting the 'normality' approach previously suggested by Lord Justice Munby in the Court of Appeal.[7]

Indeed, the normality approach was rejected by all seven Justices. Lady Hale and Lords Sumption, Neuberger and Kerr all agreed that restrictions employed for an individual with incapacity's benefit do not form part of the assessment of whether or not there has been a deprivation of liberty engaging Article 5 ECHR.

Admittedly there was a very narrow majority on the finding regarding MIG and MEG. Moreover, although Lord Neuberger[8] rejects the minority opinion that a person confined to an "ordinary" domestic home setting, or something closely resembling this, is not deprived of their liberty he does indicate that it is unlikely restrictive measures employed by natural or adoptive parents would amount to a deprivation of liberty[9]. Additionally, as was acknowledged by several of the Justices, Strasbourg has not yet been invited to rule on a set of facts that mirrors those in this particular case. There is obviously no ability for *Cheshire West* to be appealed to the European Court of Human Rights but it is not beyond the realms of possibility that it may have to consider a similar case at some stage. In this case, UK courts would be obliged to follow its lead. However, for the time at least, it is clear that even in relatively informal care settings individuals who are under continuous supervision and control are deprived

[5] At para 49.
[6] At paras 45-46.
[7] *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257, *per* Munby LJ at paras 83 and 86.
[8] At para 71.
[9] At paras 72-74. This appears to accord with *A Local Authority v A (by her Guardian ad Litem, Judith Bennett-Hernandez), B A Local Authority v C (by her litigation friend the Official Solicitor), D, E* [2010] EWHC 978 (Fam).

of their liberty where they are unable to give valid consent to this. For such deprivation of liberty to be compatible with Article 5 ECHR must have a legal basis and there must be appropriate legal and procedural safeguards to allow that person to be able to challenge the legality of such deprivation of liberty.

Cheshire West and Scotland

What *Cheshire West* does not answer for Scotland is whether the consent of substitute decision-makers, such as welfare attorneys and welfare guardians, can or can be made to provide the necessary valid consent to restrictions that would otherwise amount to a deprivation of liberty[10] or lawful authority to a deprivation of liberty. This remains to be resolved regarding the Adults with Incapacity (Scotland) Act 2000. However, as mentioned in the January 2014 issue,[11] *Application in respect of R* indicates that provided the guardianship order permits a welfare guardian to deprive a person with incapacity of their liberty this constitutes the requisite lawful authority for the of Article 5, presumably because this is impliedly permitted by the 2000 Act. What is clear from *Cheshire West*, however, is that, as stated in *Application in respect of R*, s13ZA of the Social Work (Scotland) Act 1968 provides neither the lawful authority nor the necessary legal and procedural safeguards to be compliant with Article 5. See also Adrian Ward's discussion of s13ZA below for a further discussion of this.

The Scottish Law Commission's report and guidance is now eagerly awaited.

Jill Stavert

Cheshire West – the impact on s.135ZA Social Work (Scotland) Act 1968

Section 13ZA of the Social Work (Scotland) Act 1968 was inserted by the Adult Support and Protection (Scotland) Act 2007 to provide an alternative to a guardianship or intervention order where (in terms of section 13ZA (1)) a local authority determines under the 1968 Act that an adult's needs call for the provision of a community care service, and it appears to the local authority that the adult is incapable in relation to decisions about the service. In such situations the local authority may take any steps which they consider would help the adult to benefit from the service, and in terms of subsection (2) that expressly includes moving the adult to residential accommodation provided under the 1968 Act. Previously that outcome was achieved by way of guardianship or intervention orders. Sheriff Baird, in Glasgow, in *Muldoon, Applicant*, 2005 SLT (Sh. Ct.) 52, held that where an adult is compliant with a move into such a care regime, but legally incapable of consenting to or disagreeing with it, then to impose the regime deprives the adult of his or her liberty in breach of Article 5 of the European Convention on Human Rights. He held that such a step should not be taken without express authority, and that in such a situation the appropriate statutory intervention was a guardianship order, because in every case where the court is dealing with an incapable but compliant adult, the least restrictive option would be the granting of a guardianship order, provided that all the other statutory requirements are satisfied for it. Only in that way would the necessary safeguards and statutory regulatory framework to protect the adult (and the guardian)

[10] The European Court of Human Rights seems to have indicated that this may be possible. *Stanev v Bulgaria* (36760/06) judgment 17 January 2012, para 130.

[11] *Application in respect of R* 2013 G.W.D. 13-293.

come into play. The sheriff's reasoning would appear to apply equally to intervention orders.

Local authorities are required to exercise their functions under the 1968 Act under the general guidance of Scottish Ministers, and to comply with their directions (section 5 of the 1968 Act). The relevant guidance is *Guidance for Local Authorities (March 2007) Provision of Community Care Services to Adults with Incapacity*. It sets out the procedure to be followed under section 13ZA and addresses the question of when that procedure is and is not to be followed. It is not to be followed when "the person with impaired capacity is opposed to the proposed course of action as far as can be ascertained", nor where "in providing the care intervention needed, the circumstances amount to a deprivation of liberty". If Sheriff Baird were correct in *Muldoon* that such a move, without valid consent, is always a deprivation of liberty, then section 13ZA would not be applicable in the circumstances expressly described in subsection (2). The guidance, with scant regard for the respective roles of legislature, judiciary and executive, and without giving reasons, asserted that "*The Scottish Executive does not agree with this interpretation of the ECtHR cases*". Sheriff McDonald nevertheless agreed with and supported Sheriff Baird's views in *M, Applicant*, 2009 SLT (Sh. Ct.) 185. Adrian sought to break through this circularity by focusing upon Article 6 of the Convention rather than Article 5 in "Adults with Incapacity: Freedom and Liberty, Rights and Status (Part 1) 2011 SLT (News) 21. However, the debate has been re-opened by the decision of the Supreme Court in *P v Cheshire West and Cheshire Council and another* and *P and Q v Surrey County Council* [2014] UKSC 19. The guidance asserts that a guardianship or intervention order is appropriate where the adult is "opposed to the proposed course of action" but not where the adult is compliant. At least to that extent, Sheriff Baird's position has been vindicated by the Supreme Court. As Lord Neuberger pointed out (para 68): "*The notion that the absence of objection can justify what would otherwise amount to deprivation of liberty is contrary to principle*". It will remain necessary in any case to consider whether the circumstances into which an adult is transferred amount to deprivation of liberty, but currently the last word on how to determine that is to be found in *Cheshire West*, excluding many of the suggested grounds upon which the circumstances of an adult could be categorised as not amounting to a deprivation of liberty.

Section 13ZA was a response to perceived problems which never have existed. Local authorities were said to be overburdened with the volume of applications which they required to handle, and moves of adults typically from hospital into other accommodation were said to be subject to unacceptable delay. However, the financial memorandum accompanying the Bill which became the Incapacity Act predicted 1,500 applications per annum by local authorities, which would have produced 4,500 such applications in the three years up to the *Muldoon* decision. In fact, as pointed out in Adrian's commentary on *Muldoon* included in the SCLR Report, there were in fact only 996. The delays which are still being experienced, particularly in discharging adults from hospital, could be shortened substantially by more efficient procedures, such as were explored at a conference of health and social work professionals and administrators hosted in Glasgow City Chambers on 8th March 2013. Given that section 13ZA has the additional problems of non-compliance with Article 12 (4) of the United Nations Declaration on the Rights of Persons with Disabilities, the debate about section 13ZA is proceeding, even at the level of whether the procedure created by it is properly operable at all.

Adrian Ward

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

1. Background

a. Consultation and proposals for a Mental Health (Scotland) Bill

In December 2013, the Scottish Government published a consultation paper inviting comment on proposed amendments to the Mental Health (Care and Treatment)(Scotland) Act 2003 and to the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act"). It closed on 25th March 2014.

The consultation addresses some of the McManus Review recommendations[12] as well as other matters raised by service users and practitioners in response to the Scottish Government's own consultation on such recommendations.[13] It also proposes the introduction of a notification scheme for victims of mentally disordered offenders following consultation on this particular issue.[14]

a. Mental Health (Care and Treatment)(Scotland) Act 2003 ("the 2003 Act")

The 2003 Act governs the compulsory care and treatment of persons with mental disorder. It is designed to operate in an environment that supports the right to the highest attainable standard of physical and mental health and the recovery and rehabilitation of individuals with mental disorder[15]. Various principles, therefore, that reflect European Convention on Human Rights (ECHR) and other international human rights standards underpin its provisions and implementation. Indeed, any legislation of the Scottish Parliament and its implementation must be compatible with ECHR rights and those identified in other international human rights treaties such as the UN Convention on the Rights of Persons with Disabilities (CRPD).[16]

The Act directs that anyone exercising functions under it must 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-discrimination[17]. Additionally, the patient's wishes, background and circumstances and the views of named persons, carers, guardians and attorneys must be taken into account as well as encouraging patient participation.[18] For children or young persons under 18 years of age any functions must also be discharged in a "manner that best secures the welfare of the patient."[19] Moreover, and importantly, the presence of mental disorder alone is insufficient justification for compulsory treatment to be ordered by the

[12] Scottish Government, *Limited Review of the Mental Health (Care and Treatment) Act 2003: Report*, 2009 (accessed 26 February 2014). For the Scottish Government's response to this review see Scottish Government, *Mental Health: Legislation Scottish Government response to the "Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report*, 2010 (accessed 26 February 2014).

[13] Scottish Government, *Mental Health: Legislation: Consultation on the Review of the Mental Health (Care and Treatment)(Scotland) Act 2003*, 2009 (accessed 26 February 2014).

[14] Scottish Government, *Consultation : Disclosure of Information to Victims of Mentally Disordered Offenders*, 2010, (accessed 26 February 2010) and Scottish Government, *Disclosure of Information to Victims of Mentally Disordered Offenders: Analysis of Responses to the Consultation*, 2011 (accessed 26 February 2014).

[15] See Scottish Government, *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*, 2001("the Millan Report") that shaped the Act.

[16] ss29(2)(d), s.35(1), s.57 and s.58 Scotland Act 1988 and s.6 Human Rights Act 1998. Indeed, increasing reference to the CRPD is being made in European Court of Human Rights cases which is likely to ultimately influence interpretation of ECHR rights.

[17] ss1(3)(c)-(g) and 1(4).

[18] ss1(3)(a),(b) and (h).

[19] s.2(4).

Mental Health Tribunal under the Act. Issues of treatability, risk, the existence of significantly impaired decision making ability owing to mental disorder, and the necessity for such involuntary treatment, must also be considered.[20]

The Act also provides for the patient, their named person, primary carer and welfare attorney, amongst others, also have the right to make oral or written representations and to lead or produce evidence before the Mental Health Tribunal.[21]

Further, short-term and emergency detention is time-limited and it is possible to appeal short-term detention certificates and compulsory measures. Compulsory measures are also subject to periodic review.

The amendments proposed by the Draft Bill must therefore be assessed in light of their compatibility with the Act's principles and with European and international human rights standards. Articles 3 (freedom from torture and inhuman or degrading treatment or punishment) 5 (liberty), 6 (fair trial), 8 (privacy and family life, or autonomy) and 14 (non-discrimination) ECHR and the corresponding rights identified in the CRPD.[22]
It should also noted that at present the outcome, and its implications, of the recent consultation by the UN Committee on the Rights of Persons with Disabilities on its Draft General Comment on Article 12 CRPD (the right to equal treatment before the law)[23] is unclear. However, it is probably safe to assume that, at the very least, it will result in a reinforcing of patient autonomy in treatment situations.

1. Draft Bill proposals

Several proposals in the draft Bill are merely to remedy inconsistencies in the original legislation and are reasonable and logical. However, some other proposals are more worthy of comment from a mental capacity perspective. The following will briefly highlight these although it will not provide an in depth analysis of the law or human rights involved. A more detailed description of the draft Bill's proposals can, of course, be found in the consultation paper and draft Bill.

a. Advance Statements

Where a valid and subsisting advance statement relating to psychiatric care and treatment exists and the maker's ability to make informed decisions about treatment for their mental disorder is "significantly impaired" because of that disorder, then both the Mental Health Tribunal for Scotland[24] and persons giving medical treatment authorised under the 2003 Act or 1995 Act[25] are obliged to "have regard to the wishes specified in

[20] s.64(5). In the case of short-term detention, the presence of mental disorder, significantly impaired decision making ability, necessity, risk, absence of conflict of interest and the consent of a Mental Health Officer are conditions that must all be met before the approved medical practitioner before the certificate may be granted (s.44(3) and (4)).
[21] s.64(2) and (3).
[22] 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).

[23] UN Committee on the Rights of Persons with Disabilities *Draft General Comment on Article 12 of the Convention – Equal Recognition before the Law* (Adopted by the Committee at its tenth session (2-13 September 2013) (accessed 7 March 2014). In essence, the Draft General Comment interprets Article 12 CRPD in such a way 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.
[24] s276.
[25] s276(3).

the statement." Such regard must also be had in connection with treatments requiring second opinions.[26] The 2003 Act requires that reasons for disregarding the wishes expressed in such statements are recorded.[27]

Proposed amendments

The draft Bill obliges Health Boards to place a copy of any advance statements received in the patient's medical records and to send a copy to the Mental Welfare Commission. It also requires that the Mental Welfare Commission maintains a central register of advance statements, such register being accessible by the maker and anyone acting on their behalf. It is also accessible, in the course of treatment of the person, by their mental health officer, responsible medical officer and the relevant health board, and by the Mental Health Tribunal in connection with proceedings before it.

Comments on draft Proposals

These proposed amendments are to be welcomed. Psychiatric advance statements are an important expression of individual autonomy even in compulsory treatment situations where a patient's autonomy must be respected insofar as it is possible.

Advance statements also arguably 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 ECHR has occurred or they have been subject to inhuman or degrading treatment (Article 3 ECHR).[28] Moreover, they are an important element of supported decision making advocated the UN Committee on the Rights of Persons with Disabilities (see above).

The problem is, however, that few advance statements are actually made. This is due to several factors but often owing to a lack of awareness or patient belief that they are ineffective.[29] General information and awareness-raising is obviously of use here but the placing of a statutory duty on specified medical staff to discuss the making of advance statements and explain their effectiveness as part of after-care plans would certainly be beneficial.

b. Named Persons

Named persons tend to be relatives, carers or someone close to the patient and therefore possess valuable information about a patient that will assist in the tailoring of their care and treatment plans. As with advance statements, where a patient nominates a named person this is an expression of autonomy and fits well with the supported decision-making model.

At present, a patient may nominate or prevent someone from being their named person.[30] Where there is no named person, the Mental Health Tribunal may appoint one and may also remove a person as named person if it is satisfied that is not appropriate that they act or replace them.[31]

[26] s276.

[27] s276. See also J. Stavert "Added value: using human rights to support psychiatric advance statements" (2013) 17(2) *Edinburgh Law Review* 210 for a discussion of the role of advance statements under Scottish law.

[28] Stavert, *ibid*.

[29] Mental Welfare Commission for Scotland, *Advance Statements Guidance*, 2013, p5.

[30] ss250 and 253.

[31] s257. Note that the Draft Bill does provide that this Tribunal power will operate subject to any declaration that the individual does not wish to appoint a named person.

Proposed amendments

The draft Bill provides that a person aged 16 years or older will be able to make a written and witnessed declaration that they do not wish to have a named person appointed. It also provides that anyone nominated as a named person must give written consent to acting as such.

Comments on draft proposals

The proposed amendments to the 2003 Act seem to be reasonable but certain issues warrant further consideration.

Firstly, the 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.[32] It would therefore be useful if a definition of "named person" were included in the draft Bill.

Secondly, the Bill does not remove the default provision permitting the Mental Health Tribunal to appoint a named person where one has not been appointed.[33] This requires closer scrutiny. On the one hand, such a provision may in some circumstances provide a protective safeguard of the patient's interests. On the other, in these particular circumstances the named person is not being appointed with the patient's consent and this is a restriction of their right to autonomy (Article 8(1) ECHR) which would be difficult to justify under Article 8(2).

Finally, the draft Bill provides for the removal of the current automatic right of a named person to be involved in Tribunal proceedings and a requirement that leave must be applied for to be involved. The consultation document is unclear about how the Tribunal's discretion will be exercised in these circumstances (although this will subsequently be dealt with, it would appear, in secondary legislation). Refusal to permit a named person to automatically be included in proceedings to represent the patient's interests, where that person has been nominated by the patient, is contrary to the exercise of the patient's right to autonomy. It removes an important additional patient safeguard which, again, is difficult to justify under Article 8(2).

c. Removal of requirement for a second medical report in Compulsory Treatment Order (CTO) applications

Proposed amendments

The proposed amendments provide for only one report, from the approved medical practitioner, to accompany the application. However, the patient or the Mental Health Tribunal may request that a second independent report is obtained.

Comment on draft proposals

The consultation paper justifies this amendment on the basis of concern about the involvement of GPs, a perceived lack of independence between the two reports and of conflicts of interest[34]. This is at odds with the McManus Report[35] which indicated widespread support for the involvement of primary care in long term compulsory treatment[36] and little support for CTOs being accompanied by a single medical report. The

[32] This was also noted in Scottish Government, *Limited Review of the Mental Health (Care and Treatment) Act 2003: Report*, 2009 ("the McManus Report").

[33] s257(1).

[34] Para 14.

[35] *Op cit,* pp28-31.

[36] Even though it also identified that GPs were requested to provide the second report in less than 50% of cases (*op cit,* p.28).

consultation paper does not mention resourcing issues as justification for this amendment but the McManus Report did state that a lack of availability of GPs should not be justification for preventing them from providing such report.[37]

Given the implications for a person who is subject to a CTO application, particularly in terms of restriction of an individual's autonomy and liberty, this clearly of concern. It is therefore hoped that the Scottish Government will not pursue this amendment when the Bill is introduced into the Scottish Parliament.

d. Nurse's holding power under s299, 2003 Act

The draft Bill contains a proposal to extend the maximum period for a nurse's holding power[38] from two to three hours although the consultation document gives no reason for this. Given the implications this has for a patient in terms of their liberty and autonomy, and the inability of a patient to challenge this, it is essential that any proposal of this nature is specifically explained and justified before its acceptability is properly determined.

e. Mental Health Tribunal: timescales for referrals and disposals

The draft Bill proposes an amendment that the Tribunal "must do its utmost" to comply with timescales within which it must deal with various disposal. Where such timescales are not met, the Tribunal must record the failure and the reason why.[39]

Comment on draft proposal

The Tribunal will be well aware of its obligations under Articles 5(4) and 6 ECHR. However, given the significance of the matters to be considered, the requirement on the Tribunal should be imperative.

f. Victim Notification Scheme

As mentioned at the outset, the draft Bill provides for the introduction of a notification scheme for victims of mentally disordered offenders.

It should be noted that 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.

It is also proposed that the right to receive information will be extended to receive information about offenders subject to compulsion orders. 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 which may be difficult to justify (under Articles 8 and 14 ECHR).

g. Increased responsibilities for Mental Health Officers (MHOs)

The draft Bill contains several provisions what will increase the workload for MHOs, for example, in connection with extending a CTO and being consulted in connection with a proposed Treatment Transfer Directions to name but two. Local authorities will need to ensure that adequate resourcing is made available if this is to

[37] *Op cit*, p28.
[38] s299.
[39] Clause 15, Draft Bill.

work effectively. MHPs are already stretched in terms of their duties under the 2003 Act. However, human rights recognition and protection must not be compromised by inadequate resourcing. This is reinforced by state duties in the ECHR and other international treaties identifying civil and political rights and by the human rights observance duties imposed on the Scottish Parliament and Scottish Government in the Scotland Act. It was also fully recognised in the Millan Report.[40]

2. Additional Matters

The introduction of the Bill into the Scottish Parliament also provides a useful opportunity to attend to other matters that have come to light since the enactment of the 2003 Act.

a. s268, 2003 Act – detention in conditions of excessive security in non-state hospitals

Following the 2012 Supreme Court ruling in *RM v The Scottish Ministers*,[41] the Scottish Government, via consultation, sought views on appeals against excessive security for psychiatric patients in non-state hospitals.[42] An analysis of the responses was published in December 2013.[43] The necessary regulations or legislative changes now need to be effected to ensure that this right can be effectively exercised given that individuals detained in conditions of excessive security engages Article 8 ECHR and, potentially, even Article 3 (with corresponding Articles 17, 22 and 15 CRPD).

b. 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. 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. For further discussion of this issue see *Covert medication: Scottish legislation, human rights and the Mental Welfare Commission for Scotland's updated guidance* in the February 2014 issue of this newsletter.

c. Deaths of psychiatric patients

It is questionable whether the investigative framework relating to deaths of psychiatric patients in Scotland is fully compliant with Article 2.[44] This was partially explored in the 2009 Report of Findings of Review of Fatal Accident Inquiry Legislation[45] and subsequently brought into sharper relief by the Savage and Rabonne rulings[46] and the Mental Welfare Commission for Scotland's recent monitoring report Death in detention monitoring that reinforces this need.[47] The necessary legislative changes and any

[40] *Op cit*, pp378-382.
[41] *RM v The Scottish Ministers* [2012] UKSC 58.
[42] Scottish Government, *Mental Health (Care and Treatment) (Scotland) Act 2003 Consultation in relation to section 268 appeals against conditions of excessive security*
[43] Scottish Government, *Consultation in relation to section 268 appeals against conditions of excessive security: Analysis of Responses Report*
[44] For a full discussion of this issue see H Patrick, J Stavert and J Malcolm "*The right to life, and to proper inquiries on death: A human rights perspective on the investigation of deaths of psychiatric patients in Scotland*" (2012) 1 *Juridical Review* 51 and J Stavert, "Deaths of Psychiatric Patients, Article 2 ECHR & Proper Investigation: a case for reform in Scotland?" (2012) 419 *Scolag Legal Journal* 206.
[45] Scottish Government, *Report of findings of Review of Fatal Accident Inquiry Legislation: An independent review*, 2009 (accessed 7 March 2014) paras 4.15- 4.17. See also
[46] *Savage v South East Partnership NHS Foundation Trust* [2010] EWHC 865 (QB); *Rabonne v Pennine Care NHS Foundation Trust* [2012] UKSC 2.
[47] Mental Welfare Commission, *Death in detention monitoring*, 2014 (accessed 25 March 2014).

outstanding procedural measures must be made in order to give full effect to the requirements of Article 2.

d. Incompatibility between s242 of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000: Ability of substituted decision-makers to consent to treatment under the 2003 Act

Essentially, s.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, s242 (relating to treatment for mental disorder other than that requiring special safeguards) it is unclear as to whether such consent is permitted. For a more detailed discussion of the issues involved see Substituted decision makers and the interaction between the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003 in the February 2014 issue of this newsletter.

A full consideration of any areas of incompatibility between the two Acts may be more productive following the forthcoming Scottish Law Commission report on adults with incapacity and deprivation of liberty. However, clarification on this particular issue, in the 2003 Act, would be useful now.

e. 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[48] making several recommendations to reinforce the right to independent advocacy.[49] It is therefore disappointing that no provision is made in the draft 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.

3. Conclusion

The 2003 Act has been internationally regarded as an example of good practice in terms of patient-centred and human rights compatible legislation. However, this is not an excuse for complacency and it must be kept under review in light of developments in European and international human rights law and practice. It is therefore hoped that the Bill that will be eventually introduced into the Scottish Parliament will take these and the Act's principles fully into account.

Jill Stavert

"*Who benefits?*" The investigation into the case of Ms E

The last investigation on Dr Donald Lyons' watch as Chief Executive of the Mental Welfare Commission stands - all us of suggest – both as a testament to the power of the work that the MWC has done under his stewardship in Scotland and also as a clear example of the type of work that a Mental Capacity Act Commission could do if established in England and Wales to champion the MCA 2005.

The MWC investigated the case of a woman who took her own life in December 2011. She had recently had a work capability assessment following which the Department for Work and Pensions (DWP) decided her benefits were going to be reduced. She was on incapacity benefit and was told she would not be able to be transferred

[48] pp10-11.

[49] Paras 3.1-3,6, p12.

to Employment and Support Allowance so would receive Jobseekers allowance

Ms DE was a woman in her fifties who had worked for most of her life but had been experiencing mental and physical health issues so was signed off work and receiving incapacity benefit. She intended to return to work when she was able to. Ms DE had a teenage son and was engaged and planning to get married in 2012. She had been receiving care and support from her GP and her psychiatrist for over 20 years. Her doctors had never been worried during this time about her taking own life.

During the MWC's investigation the MWC spoke with people who were involved with Ms DE's care and treatment. The MWC discussed the case with relevant officials from the DWP. The MWC also conducted a survey of psychiatrists to find out how they felt the system was affecting their patients.

The MWC found that the decision was made on the basis of an assessment that contained insufficient information about her mental health. It found that the work capability assessment needed to be more sensitive to mental health issues. The MWC was also disappointed at how the DWP communicated with Ms DE. The MWC felt that not enough effort was made to contact Ms DE and this meant she was not given the opportunity to fully engage with the process. The MWC found that she was not treated as a vulnerable claimant and so was not given any additional support to help her with the process around the assessment by the DWP.

Importantly, the MWC was then involved in useful discussions with the DWP about the recommendations it had made in the report, discussions which remain ongoing.

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Conferences at which editors/contributors are speaking

5th anniversary conference for the National Preventive Mechanism (Optional Protocol to the Convention against Torture)

Jill is chairing the session on de facto detention at this conference to mark this important anniversary, being held in Bristol on 8 April. Details are available here.

The Assisted Suicide Bill: Does Scotland Need to Legislate?

Adrian is speaking at a medico-legal seminar at the Mason Institute of the University of Edinburgh Law School on the subject of assisted dying on 24 April 2014 at the Royal College of Physicians in Edinburgh. Details can be found here and initial details can be found here.

A Deprivation of Liberty: Post Cheshire West and P and Q

Neil is speaking with Jenni Richards QC at the conference arranged by Langleys on 1 May on the *Cheshire West* judgment. Full details are available here.

Annual private law conference convened by the Royal Faculty of Procurators

Adrian will be speaking at the annual private law conference convened by the Royal Faculty of Procurators in Glasgow on 29 May 2014. Full details are available here.

Hot topics in adult incapacity law

Adrian will be speaking on hot topics in the incapacity field at the Solicitors' Group Wills, Trust & Tax conference in Edinburgh on 7 May 2014. Full details are available here.

The Deprivation of Liberty Procedures: Safeguards for Whom?

Neil is speaking at the conference arranged on 13 June by Cardiff University Centre for Health and Social Care Law and the Law Society's Mental Health and Disability Committee. The conference will focus on the implications of the ruling of the Supreme Court *Cheshire West* as well as the likely impact of the Report of the House of Lords Committee on the

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Mental Capacity Act. Other speakers include Richard Jones, Phil Fennell, Lucy Series, Professor Peter Bartlett, Sophy Miles and Mark Neary. Full details are available here.

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Chambers Details

Our next Newsletter will be out in early May. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Newsletter in the future please contact marketing@39essex.com.

David Barnes
Chief Executive and Director of Clerking
david.barnes@39essex.com

Alastair Davidson
Senior Clerk
alastair.davidson@39essex.com

Sheraton Doyle
Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Practice Manager
peter.campbell@39essex.com

London 39 Essex Street, London WC2R 3AT
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

Manchester 82 King Street, Manchester M2 4WQ
Tel: +44 (0)161 870 0333
Fax: +44 (0)20 7353 3978

Singapore Maxwell Chambers, 32 Maxwell Road, #02-16,
Singapore 069115
Tel: +(65) 6634 1336

For all our services: visit www.39essex.com

Editors

Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Anna Bicarregui

Scottish contributors

Adrian Ward
Jill Stavert

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

Alex Ruck Keene
alex.ruckkeene@39essex.com

Alex is frequently instructed before the Court of Protection by individuals (including on behalf of the Official Solicitor), NHS bodies and local authorities, in matters across the spectrum of the Court's jurisdiction. His extensive writing commitments include co-editing the Court of Protection Law Reports, and contributing to the 'Court of Protection Practice' (Jordans). He also contributed chapters to the second edition of 'Mental Capacity: Law and Practice' (Jordans 2012) and the third edition of 'Assessment of Mental Capacity' (Law Society/BMA 2009). To view full CV click here.

Victoria Butler-Cole
vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen
neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Anna Bicarregui
anna.bicarregui@39essex.com

Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view full CV click here.

Contributors: Scotland

Adrian Ward

adw@tcyoung.co.uk

Adrian is a practising Scottish solicitor, a partner of T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

Jill Stavert

J.Stavert@napier.ac.uk

Dr Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.