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**Deprivation of Liberty
(Updated July 2015)**

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Deprivation of Liberty Analysis

Introduction

The right to liberty is identified in, amongst other treaties, Article 5 of the European Convention on Human Rights 1950 (ECHR). The State has an obligation to ensure that this right is respected and protected throughout the UK.

Scope of this guidance

This updated analysis and guidance¹ considers the right to liberty in the context of the care and treatment of adults with mental illness (including dementia), learning disabilities and other related conditions in Scotland (referred to as “individuals” throughout this analysis). Chapter One will consider how “deprivation of liberty” can be assessed and the requirements of the ECHR. Chapter Two will consider the law and practice in Scotland in situations where deprivation of liberty involving individuals may occur. Where applicable, suggested approaches will be given.

As a consequence of the European Court of Human Rights’ ruling in *Bournemouth*², the Scottish Law Commission consulted³ on the application of Article 5 ECHR to care arrangements of people who fall within the scope of the Adults with Incapacity (Scotland) Act 2000. This has now resulted in the Scottish Law Commission reporting on the matter and making recommendations for amendments to the Adults with Incapacity (Scotland) Act 2000⁴ (the Report). At the time of writing the Scottish Government’s response and any resulting changes to the legislation are awaited. However, aspects of such recommendations will be mentioned, where relevant, throughout this update in light of the current legal and human rights landscape.

In addition, in March 2014 the UK Supreme Court in its *Cheshire West*⁵ ruling provided further direction on what amounts to a deprivation of liberty in the context of persons who cannot give valid consent to their care and treatment arrangements. This judgment concerns English law and although the Scottish courts are not bound by decisions rulings relating to such law it is influential particularly where it involves the interpretation of ECHR rights. For this reason, this guidance takes the *Cheshire West* ruling into account.

¹This guidance updates Mental Welfare Commission for Scotland (2013), *Deprivation of Liberty*, Edinburgh. It also follows Mental Welfare Commission for Scotland (2008), *Autonomy, benefit and protection*, Discussion Paper prepared by Hilary Patrick, Edinburgh. See also Mental Welfare Commission for Scotland (1) (2004) *Authorising significant interventions for adults with incapacity*, Edinburgh; and (2) (2005) *When to invoke the Act*, Edinburgh.

² *HL v UK* (2005) 40 EHRR 32.

³ Scottish Law Commission (2012) *Discussion Paper on Adults with Incapacity*, Discussion Paper No 156, Edinburgh: The Stationery Office.

⁴ Scottish Law Commission (2014), *Report on Adults with Incapacity*, Report No.240, Edinburgh: The Stationery Office.

⁵ *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 (“*Cheshire West*”).

However, as was noted by the Supreme Court in this ruling, the European Court of Human Rights has not yet been invited to rule on a set of circumstances identical to those in this case. If it is in the future and its decision is different to that of the Supreme Court then it is the European Court of Human Rights ruling that must be followed by the UK courts⁶. Meanwhile, the *Cheshire West* ruling will be highly persuasive in Scottish cases involving deprivation of liberty of individuals who lack capacity to make full and informed decision about their care and treatment.

Persons considered in this report

This analysis considers deprivations of liberty issues that affect individuals who may require care or treatment which could amount to a deprivation of liberty. It looks at adults who lack capacity to validly consent to their care arrangements and at those who retain the capacity to take decisions about all or some of their care arrangements. All are protected under Article 5 ECHR.

To whom is this analysis addressed?

It is essential to be aware of when measures relating to the care and treatment of an individual may amount to a deprivation of their liberty that engages Article 5 and, where appropriate, to ensure its requirements are met. The main aim of this analysis is therefore to assist anyone involved in such care and treatment decisions and/or arrangements.

Who must comply with human rights law?

In Scotland, all devolved legislation (including secondary legislation) must be compatible with the ECHR⁷.

Importantly, all public authorities (including hospitals, local authorities and care regulators such as the Care Inspectorate) and “any person certain of whose functions are functions of a public nature”⁸ must act in a way which is compatible with ECHR rights. As already mentioned, courts and tribunals⁹ must also have regard to the jurisprudence of the European Court of Human Rights¹⁰.

Private individuals and bodies are not therefore subject to the Human Rights Act¹¹. However, such individuals and bodies may nevertheless subject someone to measures that

⁶ s.2 Human Rights Act 1998.

⁷ s.6 Human Rights Act 1998 and s.29(2)(d) and s.57 Scotland Act 1998.

⁸ s 6(3)(b). For instance, care homes acting under arrangements made under sections 12 and 13A of the Social Work (Scotland) Act 1968 (as amended by s145 Health and Social Care Act 2008) are now considered to be exercising a public function for the purposes of section 6 of the Human Rights Act.

⁹ s.6(3)(a) Human Rights Act 1998.

¹⁰ s.2 Human Rights Act 1998.

¹¹ *Nielsen v Denmark* (1989) 11 EHRR 175 at paras 63-64 and *YL (by her litigation friend the Official Solicitor) v Birmingham City Council and others* [2007] UKHL 27.

amount to a deprivation of liberty in circumstances where the State may still be held liable. For instance:

- i. The State has positive obligations to protect individuals against interferences of their rights, including unlawful deprivations of liberty, by private persons or bodies¹². This could be through registration and inspection requirements and/or access to the justice system; and
- ii. A public authority may directly collude with breaches of human rights by private individuals or bodies¹³. A State body (e.g. the police or a local authority) may, for example, place an individual in, or help return them to, a private care home or hospital.

Indeed, in Scotland, as the Scottish Law Commission points out¹⁴, care and treatment arrangements in Scotland are such that “...it is unlikely that there could be a deprivation of liberty in any residential establishment in Scotland which could not be imputable to the State.”¹⁵.

¹² See Article 1 ECHR (general State obligation) and Article 5(1) ECHR (positive obligation on the State to protect the right to liberty), and *Costello-Roberts v UK* (1995) 19 EHRR 112 at para 26 and *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 120.

¹³ See *X and Y v Netherlands* (1985) 8 EHRR 235 at para 23, *Storck v Germany* (2005) 43 EHRR 96 at para 89, and *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) at para 84. See also AIL Campbell (2006), “Positive obligations under the ECHR: deprivation of liberty by private actors”, 10(3) *Edinburgh Law Review* 339.

¹⁴ *Discussion Paper on Adults with Incapacity, op cit*, paras 6.13-6.14.

¹⁵ *Ibid*, para 6.14.

Chapter One: “Deprivation of liberty” and the requirements of the ECHR

A. Article 5 ECHR – the right to liberty and individuals

Article 5(1)- the right to liberty and security

“1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:...

...(e) the lawful detention... of persons of unsound mind...”

When considering whether a measure relating to a person’s care and treatment complies with Article 5 ECHR it is therefore necessary to ask:

1. Does/will the measure result in a deprivation of liberty amounting to detention that engages the State’s obligations under Article 5?; and, if so
2. Is such detention lawful?

(a) Is there a legal basis for it? Does it falls within the permitted exception to the right to liberty in Article 5(1)(e)? (in other words, is it justified under Article 5(1)(e)?); and

(b) Are the necessary Article 5(4) legal and procedural safeguards available?

B. What amounts to a ‘deprivation of liberty’ that engages Article 5?

1. Where and how can deprivation of liberty occur?

Apart from formal detention under mental health legislation or following a conviction for a criminal offence, deprivations of liberty may occur where there are restrictions placed on someone’s life during their care and treatment. For instance, they may occur in the course of placing the person in hospital for physical health or psychiatric care and treatment or in a care home and their continued stay there. Deprivations of liberty can also occur whilst the person is living in conditions that are very similar to a domestic home environment (see discussion of the *Cheshire West* ruling later).

A lack of definition of “detention” and “deprivation of liberty”

Somewhat confusingly, case law often alternates between references to ‘detention’ and to ‘deprivation of liberty’. Neither ‘deprivation of liberty’ nor ‘detention’ are actually defined in the ECHR. Nor are examples of what constitutes ‘deprivation of liberty’ engaging Article 5 given. However, what is clear is that Article 5 protects individuals from unlawful ‘deprivation of liberty’ but equally recognises that sometimes, in the course of their care and treatment and subject to safeguards, it is necessary to detain a person of ‘unsound mind’. Article 5 does not apply to someone who can give full, free and informed consent to particular care and treatment arrangements and gives such consent (bearing in mind that they may also validly withdraw such consent later).

For an indication of what constitutes deprivation of liberty we must look to case law to provide guidance. Such guidance has been rather general but, potentially, measures such as the use of force, restraint (physical or through medication), seclusion, ‘time out’, overly intrusive observation, using electronic devices, locked doors/wards and freedom to interact with others outside the institution may, in certain circumstances, amount to a deprivation of liberty. The *Cheshire West* ruling does, however, provide some more clarity but at the same time broadens the definition of deprivation of liberty with particular implications for persons with incapacity.

It should also be noted that there is a distinction between the right to liberty in Article 5 ECHR and the right to liberty of movement identified in Article 2, Protocol No.4 to the ECHR¹⁶. In particular, the right to liberty of movement specifically protects the right to choose one’s residence¹⁷ which is not the case where a person is deprived of their liberty.

2. A range of factors determine whether a deprivation of liberty exists

It is clear from case law that what amounts to a deprivation of liberty engaging Article 5 very much depends on a whole range of factors in each individual case. The European Court of Human Rights stressed this in its *Bournewood*¹⁸ ruling.

¹⁶ *Engel and others v Netherlands* (1979-1980) 1 EHRR 647 at para 58, *Guzzardi v Italy* (1980) 3 EHRR 333 at paras 92-93, *Austin v UK* (2012) 55 EHRR 14 at paras 55 and 57 and *Cheshire West* per Lady Hale at 20.

¹⁷ It should be noted that the UK has not ratified Protocol 4 to the ECHR.

¹⁸ *HL v UK* at para 89.

HL v UK (Bournewood)

A man with autism and severe learning disabilities, who was unable to take decisions about his treatment but who appeared to be compliant, was admitted under sedation to hospital under the common law of necessity (in other words, in the absence of statutory authority).

Once there, staff prevented him from leaving or from receiving visits from his carers (in case he left with them) for a period of three months after which he was detained under mental health legislation.

He did not attempt to leave the hospital but staff were quite clear that if he did he would be prevented from doing so.

The Court held that during the three month period he had been unlawfully deprived of his liberty in breach of Articles 5(1) and 5(4) ECHR. It accepted that it had been reliably shown that he had been suffering from a mental disorder that warranted compulsory confinement which persisted during his detention. However, the Court ruled that he had been effectively detained without the benefit of the necessary procedural safeguards.

The Court stated:

“...in order to determine whether there has been a deprivation of liberty, the starting-point must be the concrete situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance...” (para 89)

3. Objective and subjective elements of deprivation of liberty

When assessing whether or not someone has been deprived of their liberty engaging the State's obligation under Article 5(1), case law has also identified that there is an objective element and a subjective element (whether that person has validly consented to the confinement) to this.¹⁹

a. The objective element

This concerns a person's confinement in a particular restricted space for a not negligible length of time and taking the following into account:

¹⁹ *Storck* at para 74. See also *Stanev* at para 117, *JE v DE* [2006] EWHC 3459(Fam), per Munby J at para 77 and *Cheshire West* per Lady Hale at para 22.

i. ***Starting with the concrete situation of the individual concerned and considering a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.*** The distinction between a deprivation of and a restriction upon liberty is merely one of degree or intensity and not one of nature or substance²⁰. In other words, it is not what and/or where the measures take place. It is how they are applied.

ii. ***The KEY FACTOR is whether*** the person is under the continuous supervision and control of those responsible for their care and whether the person is free to leave.

This was made clear in the *Bournemouth*²¹ case and later in the *Stanev* case²². It was also reiterated in the *Cheshire West* ruling.

Stanev v Bulgaria

Restriction of movement at a care home - “complete and effective control”

Mr Stanev was found to be partially incapacitated, on the ground that he suffered from schizophrenia, and placed under guardianship. His guardian placed in him in a social care home without consulting or informing him beforehand.

The European Court of Human Rights commented:

”...the applicant was housed in a block which he was able to leave, but [the Court] emphasises that the question whether the building was locked is not decisive..... While it is true that the applicant was able to go to the nearest village, he needed express permission to do so... Moreover, the time he spent away from the home and the places where he could go were always subject to controls and restrictions.”
(para 124)

This level of restriction was a significant deciding factor in the Court’s finding of a violation of Mr Stanev’s Article 5(1) right.

²⁰ *Guzzardi* at para 92, *Nielsen* at para 67, *HM v Switzerland* (2002) 38 EHRR 314 at para 42, *HL v UK* at para 89 and *Storck* at para 42, *JE v DE* at para 77, and *Stanev* at paras 115-119.

²¹ *HL v UK* at paras 91-92. See also *JE v DE*, per Munby J at para 77.

²² *Stanev* at paras 124-128

“Cheshire West”

Deprivation of liberty - “under continuous supervision and control and not free to leave”.

This case involved two conjoined appeals, that of P and Q, also known as MIG and MEG, and of P. It 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 amount to a deprivation of liberty.

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 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. He currently lives in a staffed bungalow with other residents near his home having been placed there by the local authority. 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 pieces in his mouth he wears all-in-one underwear to prevent this.

The Supreme Court justices ruled unanimously that P had been deprived of his liberty and, by a majority of four to three, that MIG and MEG had been deprived of theirs.

Lady Hale, delivering the leading judgment, stated that what is pivotal in determining whether someone has been deprived of their liberty is whether the person concerned “was under continuous supervision and control and was not free to leave.” (para 49).

Free to leave

The European Court of Human Rights has found that there was a deprivation of liberty where the applicant, who had been declared “legally incapable” and then at the request of his guardian was admitted to a psychiatric hospital, had unsuccessfully attempted to leave

the hospital²³. It has also found a deprivation of liberty where the applicant had initially consented to her admission to a clinic but had subsequently attempted to leave²⁴. Moreover, as was made clear in the *Bournewood*²⁵ and *Cheshire West* cases, it does not matter that the individual makes no attempt to leave. All that is required is that those treating and managing that person intend that they will not be permitted to leave.

Degree and intensity of controls

The use of restraint

Restraint may involve physical or technological restraint (e.g. placing someone in seating or some other situation from which they cannot remove themselves or using “wandering devices”) or the use of medication²⁶. Restraint of itself does not necessarily amount to detention. It depends on the degree and intensity of any restraint used²⁷. However, repeatedly and regularly restraining a person from leaving the place where they are living may well be depriving that person of their liberty. Indeed, the *Code of Practice for Local Authorities Exercising Functions under the 2000 Act*²⁸, whilst acknowledging that the use of restraint to administer treatment or care would not necessarily of itself constitute a deprivation of liberty, states that it should be seen as an indicator that a person’s wishes may be being over-ridden.

Close observation or surveillance

There appear to be no cases specifically on close observation or surveillance and deprivation of liberty. However, it is likely that intrusive observation, for example, using surveillance cameras in bedrooms or bathrooms, that cannot be justified on specific safety grounds may amount to a deprivation of liberty²⁹. In addition, stating in care plans that CCTV surveillance must be used or that the individual cannot leave their place of residence without

²³ *Shtukaturov v Russia* (2008) ECHR 223 at para 108.

²⁴ *Storck* at para 76

²⁵ At para 91.

²⁶ Mental Welfare Commission for Scotland (2013), *Rights, Risks and limits to freedom*. Note also concern about over-prescription of anti-psychotic drugs for dementia patients which are known to be of little benefit and cause significant harm. See Bruce Guthrie *et al* (2010), ‘The burden of psychotropic drug prescribing in people with dementia: a population database study’, *Age and Aging* published online 12 July 2010, 6; Care Commission and Mental Welfare Commission for Scotland (2009), *Remember, I’m still me: joint report on the quality of care for people with dementia living in care homes in Scotland.*, 52-53; Mental Welfare Commission for Scotland (2014), *Visit Report: Dignity and Respect: Dementia Continuing Care Visits*, 17-20.

²⁷ *Guzzardi* at paras 92-93. The European Court of Human Rights has drawn a distinction in some cases between deprivation of liberty (Article 5 ECHR) and restriction of freedom of movement (Article 2, Protocol No 4 to ECHR). See *Guzzardi* at para 93, *HM* at para 42, *Stanev* at para 115 and *Austin* at paras 55 and 57). It should be noted that the UK has not ratified Protocol No 4 to ECHR, although the Court has evidently found the distinction helpful.

²⁸ Scottish Government (2008), *Code of Practice for Local Authorities Exercising Functions under the 2000 Act*, p117, <http://www.scotland.gov.uk/Publications/2008/03/20114619/17>.

²⁹ See *Autonomy, benefit and protection*, *op cit*, 25.

someone else, may result in a deprivation of liberty and it is therefore recommended that, where the person subject to such an intervention is able to give prior informed consent, that this is obtained.

Close observation or surveillance may also amount to a violation of a person's autonomy under Article 8 ECHR (respect for private and family life) and even be inhuman and degrading treatment under Article 3 ECHR (prohibition against inhuman and degrading treatment or punishment).

Seclusion

Seclusion is, by its very nature, an intended and planned measure and may therefore amount to a deprivation of liberty³⁰. Indeed, as stated by the Mental Welfare Commission for Scotland³¹, in psychiatric hospitals this should only be used as a last resort to deal with behaviour that challenges in formally detained psychiatric patients. In other cases, seclusion should never be used before formal provisions are put in place under appropriate legislative provisions (for example, emergency or short term detention under the Mental Health (Care and Treatment) (Scotland) Act 2003³²). In a community setting, if seclusion is a legitimate part of medical treatment, this could be authorised under Part 5 of the Adults with Incapacity Act.

The observations made above concerning a person's rights under Articles 3 and 8 ECHR are also applicable here.

“for a not negligible length of time”

How long any controls are likely to be required for is another relevant consideration³³. Where significant periods of time are involved, such as three months in *Bournewood* and indefinitely in *Stanev*, this does not present a problem. However, case law is otherwise rather unhelpful as to when particular controls become a deprivation of liberty. For example, a man being forcibly subjected to a blood test amounted to a deprivation of his liberty³⁴ as was the stopping and searching of two journalists under anti-terrorism law which lasted no more than 30 minutes³⁵. On the other hand, holding a 10 year old girl at a police station for questioning for two hours, for some of the time in an unlocked cell, was not³⁶ as was a police cordon during a demonstration in which the applicants were contained for six to seven hours³⁷. What

³⁰ Mental Welfare Commission for Scotland (2014), *The Use of Seclusion*, 9-10.

³¹ *The Use of Seclusion*, *ibid*, 3.

³² See *The Use of Seclusion* for greater guidance on this.

³³ *Storck* at para 74.

³⁴ *X v Austria* (1979) 18 DR 154.

³⁵ *Gillan and Quinton v UK* (2010) 50 EHRR 45 at para 57.

³⁶ *X v Germany* (1981) 24 DR 158.

³⁷ *Austin v UK* (2012) 55 EHRR 14 (although, interestingly, the three dissenting judges considered that it did).

becomes apparent from the various cases, however, is the need to take all the factors into account.

Locked or lockable facilities

As previously indicated, that someone is prevented from leaving the place where they are being cared for or would be if they tried is a very important factor in deciding whether or not there has been a deprivation of liberty. Whether the person is in a “locked” or “lockable” ward, or other facility, is relevant but not determinative³⁸.

The argument that restrictive measures that benefit a person may not be a deprivation of liberty

It has been argued that where restraints are used to give someone as much freedom as possible in light of a person’s particular disability case law lends weight to the view that such restrictions may not amount to deprivation of liberty engaging Article 5. For example, in *HM v Switzerland*, the placing by the authorities of an elderly woman in a nursing home for an unlimited period of time on the basis of “serious neglect” was held to not be a deprivation of liberty within the meaning of Article 5(1). Similarly, in *Nielsen v Denmark*³⁹ the placing of a 12 year old boy in a psychiatric hospital, at his mother’s instigation, for therapeutic purposes was not considered to be a deprivation of his liberty.

In *Austin v UK*⁴⁰, the European Court of Human Rights found that the use of a police cordon during a demonstration ‘to isolate and contain a large crowd, in volatile and dangerous conditions’ was the ‘the least intrusive and most effective means to be applied.’ In those particular circumstances this did not constitute a deprivation of liberty. A 2012 Sheriff Court case in Scotland, *AB v BR, Dr DM & MHTS*⁴¹, also appears to support this approach.

³⁸ *HL v UK* at para 92 and *JE v DE* at para 77.

³⁹ *Op cit*, n8.

⁴⁰ At para 66.

⁴¹ *AB v BR, Dr DM & MHTS*, 26 September 2012, unreported (Airdrie Sheriff Court).

AB v BR, Dr DM & MHTS
Compulsory patient – restrictions at care home

AB suffered from mental disorder caused by alcohol misuse and bipolar disorder.

The Mental Health Tribunal granted a Compulsory Treatment Order (CTO) requiring her to live at Z Care Home, a locked facility where residents can only leave and return using a keypad. She claimed that she did not know the code for the keypad and therefore she was in effect being detained there contrary to the Mental Health (Care and Treatment) (Scotland) Act 2003 Act which only allows detention under a CTO in hospital.

The court held that there was no deprivation of liberty.

The court stated that the overriding purpose of the 2003 Act is to provide appropriate care and treatment for persons with mental disorder. Medical evidence in this case demonstrated that a hospital-based order was not necessary but there were strong reasons supporting the use of the keypad at the care home. For instance, AB was a risk to road users and herself if she left the home unaccompanied, she had a history of leaving hospital and her own home and placing herself at significant risk and she was known to be vulnerable to exploitation. This was the minimum restriction required for her safety. Moreover, visits to her family were arranged fortnightly and she could go out locally provided she was supervised (and there appeared to be no delays or problem in organising this). She also had free access to the home's gardens during the summer. For these reasons, it was considered that the restrictions imposed on AB did not amount to legal detention and were proportionate in the circumstances.

However, the approach adopted in such cases has received some criticism in that 'to benefit the person' (in other words, the purpose of the restriction) does not form part of the assessment of whether a measure is a deprivation of liberty and to benefit someone is not a specified justification to limit the right to liberty in Article 5(1)⁴². Moreover, the European Court of Human Rights did reject the idea that purpose forms part of the assessment of whether there is a deprivation of liberty engaging Article 5 in *Austin*⁴³ and in *Creanga v Romania*⁴⁴. It should perhaps also be noted that the Court considered that in both *HM* and *Nielsen* valid consent to the restrictions had been given (albeit by the boy's mother in the latter case).

⁴² Much reliance has been placed here on the dissenting judgment of Judge Loucaides in *HM v Switzerland* (2002) ECHR 157. See also Scottish Law Commission *Discussion Paper on Adults with Incapacity, op cit*, paras 6.15- 6.36, which considers this.

⁴³ At para 58

⁴⁴ *Creanga v Romania* (2012) 56 EHRR 361 at para 93.

In any event, the *Cheshire West* ruling made it clear that purpose does not form part of the assessment as to whether or not there has been a deprivation of liberty⁴⁵. It is thus likely that the circumstances in the *AB v BR* case would now be considered to amount to a deprivation of liberty. However, Lord Neuberger, although he supported the majority judgment regarding MIG and MEG in the *Cheshire West* case, did indicate⁴⁶ that restrictions on children living at home with their natural or adoptive, as opposed to foster, parents are unlikely to amount of a deprivation of liberty engaging Article 5.

Similarly, the Scottish Law Commission in the aforementioned *Report on Adults with Incapacity* rejected purpose as forming a factor to be taken into account when assessing significant restriction of liberty⁴⁷. It also does not consider that isolation⁴⁸ should be included as a factor because it cannot envisage that this would form part of a care arrangement (see later comments regarding the exclusion of lack of social contact from an assessment of ‘significant restriction of liberty’).

What is normal?

It was suggested in an earlier English Court of Appeal judgment in the *Cheshire West* case that another factor that may be taken into account in assessing whether measures designed to benefit the person amount to a deprivation of liberty is that of ‘normality’.⁴⁹ In other words, in the case of an adult with disabilities this should be assessed by reference to “an adult of similar age with the same capabilities and affected by the same condition or suffering the same inherent mental and physical disabilities and limitations.”⁵⁰ However, this was later unanimously rejected by the Supreme Court when it considered this case⁵¹. Importantly, Lady Hale⁵² emphasised the universal nature of human rights and the importance of the right to liberty to all irrespective of mental or physical disability⁵³.

⁴⁵ Per Lady Hale at 28.

⁴⁶ At paras 71-72.

⁴⁷ See, for example, the Report, para 6.55. Although it acknowledges that the context of the restriction may potentially be relevant (see the Report, paras 6.56-6.57, referring to *Austin v UK* (2012) 55 EHRR 14, paras 58-59).

⁴⁸ In *Chosta v Ukraine* (35807/05) judgment 14 January 2014, the European Court of Human Rights stated “Relevant objective factors to be considered include the possibility to leave the restricted area, the degree of supervision and control over the person’s movements and the extent of isolation.” (para 1). However, this case did not relate to a care placement situation.

⁴⁹ See *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257, per Munby LJ at para 83. Note that this case is subject to appeal to the UK Supreme Court at the time of writing.

⁵⁰ *Cheshire West and Chester Council*, per Munby LJ at para 86.

⁵¹ See, for example, per Lady Hale at 47.

⁵² At paras 45 and 46.

⁵³ That being said, the European Court of Human Rights recently stated that relevant objective factors to be taken into account when assessing whether there has been a deprivation of liberty include “...the possibility to leave the restrictive area [in other words, freedom to leave] the degree of supervision and control over the person’s movements **and the extent of isolation.**” [emphasis added] (*Chosta v Ukraine* (Application No.

Other important considerations

The following factors should be taken into account when considering restrictions of an individual's liberty:

(i) ***The least restrictive treatment principle***

It is now an established principle under international human rights law that the least restrictive treatment option is adopted in care and treatment interventions involving individuals⁵⁴. Potential deprivation of liberty situations should thus be viewed in the context of this.

(ii) ***The relevance of Articles 3 (prohibition against inhuman and degrading treatment and punishment) and 8 (respect for private and family life) ECHR to deprivation of liberty***

When assessing whether or not a measure will result in a deprivation of liberty, factors that are relevant to those that engage Articles 3 and 8 may be indicative, although not necessarily determinative.

The *Code of Practice for Local Authorities Exercising Functions under the 2000 Act*⁵⁵ also identifies factors that affect a person's autonomy as being helpful in determining what amounts to a deprivation of liberty. These include being able to make daily choices (e.g. about meals, activities, etc), contact with the outside world (e.g. contact with spouses, partners, relatives, visits, use of the telephone, ease of access to the local community, etc), internal and external physical environment and accessibility.

b. The subjective element

When assessing whether or not someone has been deprived of their liberty of central importance is whether the person concerned has given valid consent to their confinement.

Case law indicates the following:

i. A person with capacity may give a valid consent to measures restricting their liberty, provided such consent is clear and unequivocal, and Article 5 is not

35807/05) judgment of 14 January 2014, at para 1). This arguably could bring us back to the concept of normality.

⁵⁴ Article 8 Council of Europe Recommendation Rec(2004) 10 *concerning the protection of the human rights and dignity of persons with mental disorder*; Principle 9.1 UN *Principles for the Protection of Persons with Mental Illness*, GA Resolution 46/119 (17 December 1991); and Principle 6.2 Council of Europe Recommendation R(1999) *on the Principles concerning the Legal Protection of Incapable Adults*. See also Article 14(1) UN Convention on the Rights of Persons with Disabilities 2006.

⁵⁵ Scottish Government (2008), *Code of Practice for Local Authorities Exercising Functions under the 2000 Act*, <http://www.scotland.gov.uk/Resource/Doc/216923/0058136.pdf>

engaged⁵⁶ (for example, admission as a voluntary patient to a psychiatric hospital with a locked ward policy). It therefore moreorless goes without saying that explicit refusal of consent by a person who has capacity will be determinative of this aspect of ‘deprivation of liberty’.⁵⁷

ii. Where a person has capacity, consent to their confinement may be inferred from the fact that the person does not object⁵⁸.

However, in either case:

iii. Later attempts to leave. If the person later tries to leave and is prevented from doing so then this may amount to deprivation of liberty⁵⁹.

iv. Consent is not conclusive. Simply because a person with capacity initially appears to agree to particular arrangements does not mean that such consent can be inferred for these being continued, increased or additional restrictions added at a later date when that person’s capacity is lost. The European Court of Human Rights has commented that just because someone lacks capacity does not mean that they did not understand the situation⁶⁰. In addition, when they first appeared to consent to the restriction they may have been sedated or subject to undue influence⁶¹.

v. A person who lacks capacity can never consent to particular arrangements⁶². In short, the fact that the person may have allowed herself/himself to be taken into detention does not mean that they have consented to their detention, whether or not she/he has capacity⁶³ or not⁶⁴. The European Court of Human Rights has repeated on numerous occasions that the right to liberty is too important in a democratic society for a person to lose the benefit of the ECHR protection for the single reason that he/she may have given himself/herself up to be taken into detention⁶⁵.

⁵⁶ *Storck* at paras 76-77, *JE v DE*, at para 77 and *Stanev* at para 117.

⁵⁷ *Storck* at para 77, *JE v DE* at para 77.

⁵⁸ *HL v UK* at para 93, *Storck* at para 77 and *HM v Switzerland* at paras 46-47.

⁵⁹ *Storck* at para 76.

⁶⁰ *Shtukatur* at para 108 and *Stanev* at para 130. This was reiterated in *Cheshire West* (per Lady Hale at para 31).

⁶¹ *Storck* at para 75, *HL* at para 90.

⁶² *HL* at para 93. There is now substantial support for a functional capacity approach to be adopted at all times when assessing capacity given the importance of respecting a person’s autonomy and associated presumption of capacity. This has clear implications when ascertaining whether or not someone is able to give consent to measures that amount to a deprivation of liberty. See Mental Welfare Commission for Scotland (2010), *Consent to Treatment*, 8-10, Law Commission (1995) *Mental Capacity, Consultation paper No 231*, The Stationery Office: London, World Health Organisation (2005) *Resource Book on Mental Health, Human Rights and Legislation*, 39-40, section 7.1, *Shtukatur v Russia* at paras 87-88 and 94 (regarding Article 8 ECHR), Principles 2, 3, 6 and 12 Council of Europe Recommendation R(1999) on the Principles concerning the Legal Protection of Incapable Adults and Article 12 UNCRPD.

⁶³ *Storck* at para 75.

⁶⁴ *HL* at para 90, *Stanev* at para 119 and *JE v DE*, at para 77.

⁶⁵ See, for instance, *De Wilde Ooms and Versyp v Belgium* (1971) 1 EHRR 373 at paras 64-65, *HL* at para 90 and *Storck* at para 75. This was also reaffirmed in *Cheshire West* (per Lady Hale at 24).

Substitute decision makers and consent to a deprivation of liberty

The question also arises as to whether or not someone else can consent to a deprivation of liberty of an individual with mental health issues and such consent be deemed to be that individual so that Article 5 is not engaged.

The European Court of Human Rights has stated:

“...there are situations where the wishes of a person with impaired mental faculties may validly be replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned...”⁶⁶

However, this concept has not yet been sufficiently developed so as to be wholly reliable and Articles 5(1) and 5(4) safeguards will still be required (see later). This is reinforced by the fact that the Court has also held that one should not necessarily imply from the fact that a person lacks capacity that they are unable to understand the situation they are in and have strong views about whether they wish to be in such situation⁶⁷. It is further reinforced by the aforementioned importance given by the Court to the right to liberty and enhanced weight recently afforded to recognition of legal capacity by the UN Committee on the Rights of Persons with Disabilities⁶⁸.

C. Lawful detention of individuals

Once it has been established that a measure amounts to a deprivation of liberty, various substantive and procedural requirements must be fulfilled in order that such detention on the basis of their mental disorder is lawful for the purposes of Article 5.

1. Substantive requirements

- a. **The deprivation of liberty must have a legal basis and be “in accordance with a procedure prescribed by law”**. In other words, be authorised under the law and not be applied arbitrarily; and
- b. **The existence of “unsound mind” must be “reliably shown” by “objective medical experts”**⁶⁹. Additionally, the definition of mental disorder should also not be so broad as to include behaviour that simply embarrasses or does not conform to societal norms⁷⁰; and

⁶⁶ *Stanev* at para 130. See also *Shtukurov* at para 108 and *Stankov v Bulgaria* (Application No. 25820/07) judgement of 17 March 2015 at paras 89-90.

⁶⁷ *Stanev* at para 130, *Storck* at para 144, *Shtukurov* at para 108 and *Stankov* at paras 89-90.

⁶⁸ Committee on the Rights of Persons with Disabilities, General Comment No. 1(2014) *Article 12: Equal recognition before the law*, adopted 11 April 2014.

⁶⁹ *Winterwerp v the Netherlands* (1979) 2 EHRR 387 at para 39.

⁷⁰ *Winterwerp* at p37.

- c. **Any measures must be a proportionate response to the situation.** The mental disorder (a) must be of a nature to justify detention (i.e. treatment is necessary to alleviate the condition and/or if the person needs control and supervision to prevent them causing harm to themselves or to others⁷¹); and (b) must persist throughout the period of detention⁷². This is supported by the least restrictive treatment principle⁷³. However, the European Court of Human Rights has yet to identify a right as such to community care under the ECHR⁷⁴.
- d. **The detention must be in an appropriate place so that they can receive the treatment they require.** In other words, in a hospital, clinic or other appropriate institution in order for Article 5(1)(e) ECHR not to be violated⁷⁵.

2. Procedural requirements

Article 5(4) ECHR

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

The right identified in this article, as developed by the Court, includes the following elements:

- a. **There must be an ability to challenge the deprivation of liberty through the courts**⁷⁶.

⁷¹ *Winterwerp* at para 39, and *Stanev* at para 146.

⁷² *Winterwerp* at para 39. See also *Shtukurov* at para 114 and *Stanev* at para 45.

⁷³ See, for example, *Reid v United Kingdom* (2003) 37 EHRR 9 at paras 48-52. See also Articles 8, 18-20 and 27-28 Council of Europe Recommendation Rec(2004) 10 *concerning the protection of the human rights and dignity of persons with mental disorder* (adopted by the Committee of Ministers on 22 September 2004). The principle is also reflected, in general terms, in Article 14 (right to liberty) of the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

⁷⁴ Disappointingly, it again recently missed the opportunity to do this in *Stanev*.

⁷⁵ *Ashingdane v. the United Kingdom* (1985) 7 EHRR 528 at para 44, *Aerts v. Belgium* (2000) 29 EHRR 50 at para 46, and, more recently, *Hadzic and Suljic v Bosnia Herzegovina* [2011] MHLR 367 at para 40, and *LB v Belgium* (Application No. 22831/08) European Court of Human Rights (Second Section), Judgment, 2 October 2012, at paras 89-105.

b. There must be regular reviews of the detention where the detention is lengthy or indefinite⁷⁷.

Special procedural safeguards and persons with incapacity

In the recent rulings involving persons who had been declared to lack capacity the European Court of Human Rights emphasised that whilst the form of such judicial review may differ between jurisdictions where such review is not automatic there must be the ability to apply periodically for judicial reviews of indefinite or lengthy periods of detention⁷⁸. Moreover, special procedural safeguards may be necessary where a person lacks capacity to fully act for themselves⁷⁹. This is particularly pertinent where a court did not initiate the placement⁸⁰.

The Court has stated that it is not its place to dictate what exactly these special safeguards will look like and that whilst automatic judicial review might be one way of providing such safeguards it is not necessarily the only way⁸¹. However, a person who lacks capacity may be unable to instigate judicial review and there may not be anyone else who is willing or able to do this on their behalf. Case law concerning Article 5(4) is very clear that the procedural safeguards must be real and effective⁸² and guarantees the right for an individual who lacks capacity “as nearly as possible as practical and effective...as it is for other detainees.”⁸³. It must not be an illusory and theoretical right but one which practically and actively assists the individual in the appeal process and allows equality of access to the court (for instance, permitting the opportunity to be heard in person or be represented, any legal representative must be actively engaged in the process on behalf of the individual and not requiring the individual to take the initiative to institute proceedings)⁸⁴. The individual must not therefore be reliant on the person who authorised the deprivation of liberty to challenge its lawfulness⁸⁵. Moreover, a third party may be able to initiate such judicial review provided only that they are subject to a non-discretionary duty to do⁸⁶. On this basis it may therefore be argued that automatic judicial review is in fact the only failsafe way of ensuring Article 5 compliance but consideration should be given as to other feasible means by which such compliance can be achieved.

⁷⁶ *Winterwerp* at para 55, *Stanev* at paras 168-171, *DD v Lithuania* [2012] ECHR 254 at paras 163-167 and *MH v UK* (2013) ECHR 1008 at para 77. This also involves not only access to a court but also the opportunity to be heard in person or, where necessary, be represented (*Megyeri* at para 22, *DD* at para 163 and *MH* at para 77).

⁷⁷ *Stanev* at paras 168-171, *DD* at paras 163-167 and *MH* at para 77.

⁷⁸ *Stanev* at paras 168-171, *DD* at para 163, *MH* at para 77 and *Stankov* at paras 11-115..

⁷⁹ *Stanev* at para 179, *DD* at para 163, *MH* at para 77 and *Stankov* at paras 111-115. See also *Megyeri v Germany* (1992) ECHR 49 at para 22.

⁸⁰ *DD* at paras 164-165 and *Stankov* at para 112.

⁸¹ *MH* at para 82.

⁸² *Stanev* at para 170, *DD* at para 165 and *MH* at paras 82-86.

⁸³ *MH* at para 82. See also *Stankov* at para 113.

⁸⁴ *MS v Croatia (No.2)* (2015) ECHR 196 at paras 152-160.

⁸⁵ *DD* at para 166, *Stanev* at paras 174-177 and *Stakov* at para 114.

⁸⁶ *Stanev* at para 174, *Shtukaturvov* at para 124 and *MH* at paras 92 and 94. The English and Welsh Court of Appeal ruling in *Re x (Court of Protection Practice)* [2015] EWCA Civ 599, per Lady Justice Black at 104, also indicated that the individual with incapacity must also be a party to the proceedings to ensure Article 5 compliance.

Emergency detention

The Court has held that emergency detention authorised by an administrative authority is compatible with Article 5(4) provided “provided that it is of short duration and the individual is able to bring judicial proceedings “speedily” to challenge the lawfulness of any such detention including, where appropriate, its lawful justification as an emergency measure”⁸⁷. However, once again, it is important to appreciate that measures allowing the individual to bring the judicial proceedings must be real and effective to ensure compatible with Article 5(4).

- c. **There must be a timely release of a person where their detention is found to be unlawful**⁸⁸(in other words, where it was never justified or ceases to be justified) .

DD v Lithuania

DD suffered from schizophrenia and was declared legally incapacitated. Her adoptive father, as her legal guardian, placed her in a social care home.

She claimed that her rights under Article 5(1) and (4) ECHR had been violated on the basis that she had been placed in the home without the opportunity to judicially challenge her detention there.

The Court found no violation of her Article 5(1) right. It considered that there had been a deprivation of her liberty but that this was justified under Article 5(1)(e) as she had been ‘reliably shown’ to be of “unsound mind”.

The Court did, however, find a violation of her Article 5(4) right. Under domestic law she was only able to challenge her detention through her legal guardian who was the person who had placed her in the home in the first place. It did not enable her to independently judicially challenge her involuntary detention (para 166).

⁸⁷ *Winterwerp* at paras 57–61, *X v. the United Kingdom* (1981) ECHR 6 at para 58 and *MH* at para 77.

⁸⁸ *Johnson v UK* (1999) 27 EHRR 440, *Kolanis v UK* (2006) 42 EHRR 12 and *HL*.

MH v United Kingdom

MH is a woman with Down Syndrome who was detained under the English Mental Health Act 1983. Her mother became her Nearest Relative (which is similar to a Named Person under Scottish mental health legislation). The mother attempted to exercise her right to order that her daughter be discharged from detention (s23 MHA) but the responsible medical officer issued a 'barring order' (s25(1) MHA) which certified that MH, if discharged, would be dangerous to herself or others.

The European Court of Human Rights was invited to consider whether sufficient procedural safeguards were present to satisfy the requirements of Article 5(4) ECHR for a person who lacked capacity to apply to the Mental Health Tribunal to challenge such detention.

Finding a violation of Article 5(4) in relation to part of MH's detention, the Court made it clear that for persons who lack the ability to personally exercise their right guaranteed by Article 5(4):-

1. Special procedural safeguards are necessary to ensure that the Article 5(4) right is "as nearly as possible as practical and effective for this particular category of detainees as it is for other detainees." (para 82); and
2. This may, but not necessarily, involve an automatic periodic review (although this, of course, is subject to the comment in 1 above); and
3. Third parties may assist with pursuing such a review but they must be under an obligation to assist. They must not be able to exercise discretion in this respect.

D. UN Convention on the Rights of Persons with Disabilities – adding weight to ECHR rights for individuals

The UK is also a party to UN Convention on the Rights of Persons with Disabilities 2006 (CRPD) and its protocol. This treaty strengthens the rights identified in, amongst other treaties, the ECHR in the context of persons with mental illness (including dementia), learning disabilities and other related conditions.

The rights in the CRPD are not incorporated into UK law in the same way as ECHR rights. However, the UK is still bound by its CRPD obligations under international law and Scottish Parliament legislation and acts of the Scottish Ministers can be set aside if they are

incompatible with the UK's international law obligations⁸⁹. However, importantly, we are now seeing the CRPD being used to reinforce ECHR rights in cases involving persons with mental disorder by the European Court of Human Rights.⁹⁰ For example, Article 14 CRPD identifies the right to liberty⁹¹, Articles 15 and 17, respectively, identify the prohibition against inhuman and degrading treatment and respecting the integrity of the person⁹² and equality of access to justice in Article 13.

Importantly, Article 12 CRPD recognises the right to equal treatment before the law (in other words, the equal right to exercise legal capacity) and Article 13 CRPD requires 'the provision of procedural and age-appropriate accommodations' to ensure effective access to justice. The UN Committee on the Rights of Persons with Disabilities, that oversees implementation of the treaty, has recently adopted a General Comment⁹³ interpreting this right identified in Article 12 CRPD.

The General Comment asserts that everyone possesses capacity and has the same right to have the exercise of that capacity respected. The ability to consent to treatment and restrictions on a person's liberty must not therefore be denied, restricted or exercised by someone else on the basis that the person has a mental disorder because this is discrimination. Even a functional capacity approach to assessing capacity, where this is equated with mental capacity, is unacceptable. Some individuals may need more support to exercise their capacity but this can be achieved through supported decision making⁹⁴ which must replace substituted decision making. Laws providing for guardianship and compulsory treatment for mental disorder – in other words, substituted decision making - must thus be abolished. The UN Committee has also issued a statement on Article 14 CRPD⁹⁵ which reinforces the approach adopted in the previously mentioned General Comment.

It can be seen, from earlier in this guidance, that in some respects this is a different approach to that adopted under the ECHR and it remains to be ascertained exactly what is required by the Committee on the Rights of Persons with Disabilities in terms of compliance with this right. However, in the meantime the legal framework in Scotland requires that the ECHR approach must be the one that is followed.

⁸⁹ Ss35 and 58 Scotland Act 1998.

⁹⁰ This started with *Glor v Switzerland* (Application no 13444/04), European Court of Human Rights, judgment, 30 April 2009 and has continued.

⁹¹ Article 14 UNCRPD was mentioned in connection with Article 5 ECHR in *Stanev and DD*.

⁹² Articles 15 and 17 UNCRPD were mentioned in connection with Articles 3 and 8 ECHR in *Dordevic v Croatia* (Application No. 41526/10), European Court of Human Rights, Judgment, 24 July 2012.

⁹³ Committee on the Rights of Persons with Disabilities, General Comment No. 1(2014) *Article 12: Equal recognition before the Law*, adopted 11 April 2014 <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement>

⁹⁴ For example, a trusted person or person, peer support, advocacy (including self-advocacy), assistance with communication, provision of clear and accessible information, and advance planning (General Comment, para 15).

⁹⁵ Committee on the Rights of Persons with Disabilities (2014) *Statement on article 14 of the Convention on the Rights of Persons with Disabilities*

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E>

Chapter Two: Care and treatment in Scotland of individuals and deprivation of liberty

In Chapter One, it was shown that in the context of care and treatment of individuals:

1. A deprivation of liberty can potentially occur in a number of different environments and in a number of different ways.
2. Assessment of whether a measure or measures amount to a deprivation of liberty requires a consideration of a number of different factors, including objective and subjective elements, relating to the particular circumstances⁹⁶.
3. Where a measure amounts to a deprivation of liberty in order to be lawful in terms of Article 5 ECHR requirements it must:
 - a) Have a legal basis;
 - b) Be a proportionate response to the particular situation;
 - c) Concern a person who has a genuine mental disorder;
 - d) Provide legal and procedural safeguards for the person deprived of their liberty.

This chapter will look at areas of law and practice in Scotland where a deprivation of liberty involving individuals engaging Article 5 ECHR may occur. Central to this analysis is (a) whether a deprivation of liberty engaging Article 5 may occur and be authorised under Scottish law; and (b) whether the necessary Articles 5(1) and 5(4) legal and procedural safeguards exist where such a deprivation of liberty occurs. Where relevant it will also consider the Scottish Law Commission's recommendations.

A. Emergencies

1. Treatment under the common law principle of necessity

This applies to emergencies only where someone is unable to give consent to treatment because they are unconscious, in pain or because of the effect of alcohol or drugs.

In these circumstances, doctors can treat that person and do what is reasonably required in that person's best interests until such time as they are able to take valid treatment decisions⁹⁷. 'Best interests' is if it is immediately required in order to save the person's life or improve/stop deterioration in physical or mental health.

⁹⁶ See Chapter One.

⁹⁷ *Re F (mental patient: sterilisation)* [1990] 4 BMLR 1 (HL), Scottish Law Commission, *Report on Incapable Adults* (1995) SLC 151, para 1.10.

Deprivation of liberty issue

The common law of necessity must be used sparingly. We know from *Bournewood* that the common law of necessity does not, insofar as Article 5 is concerned, ensure the required legal safeguards to challenge any deprivation of liberty arising under it.

If the person refuses treatment then either this refusal must be respected or use of the Mental Health (Care and Treatment)(Scotland) Act 2003 (“the 2003 Act”) should be considered if treatment for a mental disorder is required. Similar considerations should be applied in the case of a valid advance refusal which is potentially legally binding in such circumstances (see section on ‘The importance of advance statements’ below).

However, before a civil compulsion order under the 2003 Act⁹⁸ can be made it must be established that the individual’s ability to make decisions about medical treatment is significantly impaired because of their mental disorder (known as “significantly impaired decision making ability” or “SIDMA”⁹⁹). There is a distinction between significantly impaired decision making ability, which is not defined by the 2003 Act, and incapacity. Although assessing whether someone has significantly impaired decision making ability is similar to whether they are incapable of taking decisions under the 2000 Act, it must be emphasised that the latter relates to medical treatment in general and it is entirely possible that an individual with mental disorder might be able to take perfectly valid decisions about some aspects of their medical treatment but not about others because their mental disorder impairs their ability to do so¹⁰⁰. The need to take this into consideration in regard to every element of proposed and continuing medical treatment is therefore important because, in the context of this analysis, failure to obtain the necessary consent or obtain the necessary order may result in an unlawful deprivation of liberty.

In addition, in emergencies, the Adults with Incapacity (Scotland) Act 2000 Code of Practice advocates that where the required treatment can be authorised under this Act doctors use the general authority to treat under the Act, with its greater protections, rather than common law powers (see below). This is unless there is insufficient time to complete the necessary certificates under the Act¹⁰¹.

⁹⁸ Different criteria apply for mentally disordered offenders.

⁹⁹ *Consent to Treatment, op cit*, 8.

¹⁰⁰ *Consent to Treatment*, 8; H Patrick (2006), *Mental Health, Incapacity and the Law in Scotland*, 168-171.

¹⁰¹ Scottish Government, *Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act*, SG/2010/57, April 2010 (issued October 2010), paras 2.40-2.42.

2. Emergency detention

Under Part 5 of the 2003 Act¹⁰² a fully registered medical practitioner may grant a certificate that authorises the managers of a hospital to detain someone for 72 hours. That medical practitioner must consider that it is likely that the person has a mental disorder which causes their decision making to be 'significantly impaired' and:

- a. it is necessary as a matter of urgency to detain the person for assessment;
- b. the person's health, safety or welfare, or the safety of another person, would be at significant risk if they were not detained;
- c. making arrangements for the possible granting of a short-term detention certificate would involve 'undesirable delay'; and
- d. must obtain the consent of a mental health officer wherever practicable.

Deprivation of liberty issue

Article 5(4) ECHR requires, however, that a detained person has swift access to a court to challenge their detention. This is not available for a person subject to an emergency detention order. For this reason, it is imperative that emergency detention certificates are used sparingly and short term detention certificates should be the preferred route. The Mental Welfare Commission emphasises this too¹⁰³.

B. Care and treatment under the Adults with Incapacity (Scotland) Act 2000 generally

The Act applies to anyone of 16 years old or over who is assessed as being 'incapable'¹⁰⁴. Sub-section 1(2) to 1(4) set out the Act's underlying principles with sub-s 1(2) and 1(3) providing that no intervention in the affairs of the adult should occur unless it will benefit the adult, there is no reasonable alternative and the least restrictive option available should be used.

1. Respecting wishes

Section 1(4) requires that "the present and past wishes and feelings of the adult so far as they can be ascertained" must be taken into account when considering any intervention under the Act.

¹⁰² s36.

¹⁰³ Mental Welfare Commission for Scotland website, *Emergency Detention*, <http://www.mwscot.org.uk/the-law/mental-health-act/emergency-detention>. Please also note comments above about the distinction between impaired decision making ability under the 2003 Act and incapacity.

¹⁰⁴ Section 1(6).

Deprivation of liberty issues

a) *Appointment of guardians*

A criterion for ordering guardianship¹⁰⁵ is that the person is incapable of acting or making decisions to promote or safeguard their own interests. As will be discussed later, it is debatable whether, as the 2000 Act currently stands (or as amended in accordance with the Scottish Law Commission's recommendations), it would be compatible with Article 5 ECHR for a guardian to authorise the deprivation of liberty of an adult with incapacity. However, that being said, if a guardian is able to authorise such a deprivation of liberty the necessity to ensure that the adult is properly assessed as incapable is paramount. Otherwise, any deprivation of their liberty without their consent would be unlawful in terms of Article 5.

b) *The importance of advance statements*¹⁰⁶

Respecting the adult's wishes will include considering any valid and subsisting advance statements made by the person and the wishes expressed in them. An advance statement may be made by an individual with capacity concerning their treatment for physical and mental disorders. It becomes relevant when the individual no longer has capacity to make decisions about their care and treatment.

In Scotland, *advance statements concerning treatment for mental disorder* are recognised to some extent under the 2003 Act. Where treatment is being considered under the 2003 Act, the Mental Health Tribunal for Scotland and anyone authorised to give medical treatment under the Act or the Criminal Procedure (Scotland) Act 1995 must have regard to valid and subsisting advance statements although these can be overridden in certain circumstances¹⁰⁷. The 2003 Act does not specifically state when it is acceptable to override an advance statement. Its Code of Practice does, however, state that a valid advance statement "would be a strong indication of a patient's wishes about medical treatment" but that it must be considered alongside other factors¹⁰⁸.

Otherwise, advance statements do not have statutory force in Scotland¹⁰⁹. The 2000 Act makes no specific reference to them. That being said, valid advance refusals of medical treatment are potentially binding on medical staff¹¹⁰. Indeed, disregarding wishes expressed

¹⁰⁵ s.58(1)(a).

¹⁰⁶ See also Mental Welfare Commission for Scotland (2013), *Advance Statement Guidance* http://www.mwscot.org.uk/media/128044/advance_statement_final_version_jan_2014.pdf

¹⁰⁷ ss275-276 Mental Health (Care and Treatment)(Scotland) Act 2003.

¹⁰⁸ Code of Practice vol 1 ch 6, para 58.

¹⁰⁹ Unless the treatment is authorised under the 2003 Act which must have regard to but can override advance statements in some situations (s276, Mental Health (Care and Treatment)(Scotland) Act 2003).

¹¹⁰ Scottish Law Commission, *Report on Incapable Adults 1995*(No 151), para 5.46. See also Patrick, *Mental Health, Incapacity and the Law in Scotland*, *op cit*, 150 and Adults with Incapacity (Scotland) Act 2000: Code of Practice *For Practitioners authorised to carry out medical treatment or research under Part 5 of the Act* para 2.30.

in an advance refusal may amount to an assault and even be inhuman and degrading treatment under Article 3 ECHR and Article 15 UNCRPD and those involved could be subject to criminal prosecution or civil liability. Care or treatment that breaches a valid and subsisting advance statement (because it is an indication that the person is being treated against their will) will require court authorisation¹¹¹.

The making of advance statements relating to care and treatment in the event of future incapacity is highly recommended. They may give a clear indication as to whether or not an individual consents to particular restrictions of their activities and this can be taken into account when assessing whether there has been an unlawful deprivation of liberty.

C. Care and Treatment under the Adults with Incapacity (Scotland) Act 2000

1. General authority to treat¹¹²

A certificate issued under section 47 authorises a health professional (currently doctors, dentists, opticians and registered nurses)¹¹³ to give whatever medical treatment is necessary under the circumstances to safeguard or promote a person's physical or mental health¹¹⁴. Persons acting under the instruction or with the approval/agreement of the person to whom the certificate was issued may also carry out the treatment¹¹⁵.

It is important to note that if circumstances change and further treatment is required which is not covered by the certificate then a new one must be issued.

Deprivation of liberty issues

- a) The provisions governing how this general authority operates endeavour to avoid creating unlawful deprivation of liberty situations. For instance:
- b) Force or detention must not be used **unless** it is immediately necessary and **only** for so long as is necessary in the circumstances¹¹⁶. The use of force should be the minimum necessary in the circumstances¹¹⁷.

¹¹¹ On the other hand, the Mental Capacity Act 2005 (ss24-26), which affects England and Wales, requires that valid and applicable advance decisions refusing the carrying out or continuance of specified treatment must be respected. The Act provides statutory underpinning for a wider range of treatment choices in that it relates to refusals of treatment for physical and mental disorders. However, where the refusal relates to compulsory treatment for mental disorder under Part 4 of the Mental Health Act 1983 then the individual's wishes may be overridden (with the exception of refusal of ECT where a valid and applicable advance decision cannot be overridden (s58A Mental Health Act 1983) unless such treatment is necessary to save life or prevent serious deterioration in an individual's condition (s62)).

¹¹² See also Mental Welfare Commission for Scotland (2011), *The Right to Treat*, for further guidance here.

¹¹³ s.47(1)A.

¹¹⁴ s.47(2).

¹¹⁵ s47(3).

¹¹⁶ s.47(7)(a).

¹¹⁷ Code of Practice, paras 2.56-2.59.

- c) Health professionals must not admit someone to hospital for **psychiatric treatment against their will**¹¹⁸. 2003 Act procedures should be used instead so that the adult might benefit from the additional safeguards that this Act offers. It is acceptable to treat an adult with incapacity who is not formally detained under the 2003 Act under the Adults with Incapacity Act **unless they resist that treatment** and then the 2003 Act should be considered. Indeed, the Adults with Incapacity Act's Code of Practice¹¹⁹ encourages the use of the 2003 Act where an adult shows continued resistance to treatment for mental disorder.
- d) Where an adult lacks capacity and resists treatment for **physical disorder**, an intervention order¹²⁰ (where it is likely to be a one-off situation and the person may recover capacity) or welfare guardianship¹²¹ under Part 6 should be considered (see later).
- e) Someone already being treated for a mental condition under compulsory measures under the 2003 Act, may be treated for a physical condition under the Adults with Incapacity Act. However, it is permissible to treat that person under the 2003 Act where the physical disorder is a direct consequence of their mental disorder.

2. Treatments requiring special safeguards

These include drug treatment for more than 2 months, neurosurgery, deep brain stimulation, ECT, transcranial electromagnetic stimulation, medication to reduce sex drive, artificial nutrition and abortion.

Where a person is unable to consent to such a treatment, whether or not they are subject to the 2003 Act, the procedures and special safeguards involving second opinions set out in the 2003 Act must be followed. The section 47 Adults with Incapacity Act general authority cannot be used to treat that person. For a full description of such safeguards, see the Mental Welfare Commission's *Consent to Treatment* guidance¹²².

Deprivation of liberty issue

The special safeguards treatment listed under the Adults with Incapacity Act does not include long term drug treatment for mental disorder. Long term drug therapy may be justifiable and appropriate in many circumstances although there are concerns about the inappropriate use of some medication in certain situations¹²³. Where the sedative effects of

¹¹⁸ s.47(7)(c).

¹¹⁹ Para 2.56.

¹²⁰ s53.

¹²¹ s57.

¹²² Mental Welfare Commission for Scotland (2010), *Consent to Treatment*.

¹²³ See, for example, Care Commission and Mental Welfare Commission for Scotland, *Remember, I'm still me: joint report on the quality of care for people with dementia living in care homes in Scotland*, pp52-53; Bruce

drug treatment could be construed as a deprivation of liberty, compulsory treatment under the 2003 Act and/or welfare guardianship under the 2000 Act may be necessary (although whether the latter can authorise deprivation of liberty is currently unclear (see later)).

3. Carers and welfare attorneys

Clearly, on the basis of the principle of least restrictive option, it may often be preferable for a person to be cared for informally rather than going through the procedures of obtaining court orders. However, there are deprivation of liberty issues to be considered in this context.

Deprivation of liberty issues

Carers and welfare attorneys are private individuals and the ECHR does not apply to their actions. Problems therefore arise in protecting a person who may have been deliberately or inadvertently deprived of their liberty by their carer or welfare attorney¹²⁴.

However, the State has a duty to protect citizens from breaches of the ECHR rights (see Introduction). To this end, local authorities and the Mental Welfare Commission have powers under the Adults with Incapacity Act, 2003 Act and Adult Support and Protection (Scotland) Act 2007 where an adult is at risk, including where a person's rights were being breached by a carer or attorney. For example, local authorities have duties to investigate adults at risk and, if necessary, to apply for guardianship or intervention order¹²⁵ (again whether this authorises deprivation of liberty is unclear (see later)).

4. Carers without welfare power of attorney

Scottish Government guidance, whilst recognising that this might be necessary on a temporary basis to protect a vulnerable adult (under their duty of care), provides that a private carer, without a welfare power of attorney, would not have the requisite legal

Guthrie *et al* (2010), 'The burden of psychotropic drug prescribing in people with dementia: a population database study', *Age and Aging* published online 12 July 2010, <http://ageing.oxfordjournals.org/content/39/5/637.full.pdf+html>; Mental Welfare Commission for Scotland (2013), *Covert Medication*, 8, http://www.mwscot.org.uk/media/140485/covert_medication_finalnov_13.pdf; Mental Welfare Commission for Scotland (2014), *Visit Report: Dignity and Respect: Dementia Continuing Care Visits*, 17-20 http://www.mwscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf

¹²⁴ See, for example, Mental Welfare Commission for Scotland (2012), *Powers of Attorney and their Safeguards*.

¹²⁵ ss.10, 53(3) and 57(2) AWIA.

authority to move the adult to permanent residential care (even if it does not constitute a deprivation of liberty)¹²⁶.

This is a cautious approach that prevents unlawful deprivation of liberty situations occurring. The importance of not placing a person with incapacity in a situation where they will be deprived of their liberty is reinforced by the Mental Welfare Commission's guidance on the use of s.13ZA of the Social Work (Scotland) Act 1968 (see below).

5. Welfare attorneys

Welfare attorneys are appointed by a person in case of their future incapacity (under Part 2 of the Adults with Incapacity Act) and their powers come into effect when the granter is unable to take welfare decisions or the attorney reasonably believes this¹²⁷. The importance of adopting a functional capacity approach here is important (See Chapter One).

Deprivation of liberty issues

a) Commencement of powers

The Act does not specify what evidence of incapacity is required although some welfare powers of attorney will specify what is required to prove this. The document need only state that the granter has considered how this is to be determined. In the absence of any specific instruction in the power of attorney document itself, such as a medical assessment of capacity should trigger the use of powers, a welfare attorney can act on their powers in situations where they reasonably believe that the adult lacks capacity.

As mentioned above, the attorney should adopt a functional capacity assessment approach and also bear in mind the principles of the Act when considering when they may legitimately start to act on the powers granted.

b) Hospital treatment and care arrangements

The welfare attorney cannot place the granter in hospital for treatment for a mental disorder against their will¹²⁸.

Provided the power of attorney specifies, it is lawful and ECHR compatible (because it permitted under the Adults with Incapacity Act) for them to place an apparently willing adult

¹²⁶ *Interventions under the Adults with Incapacity (Scotland) Act 2000* Letter from Angus Skinner, Chief Social Work Inspector, to Chief Social Work Officers (Social Work Services Inspectorate 30 July 2004). This is in contrast to the Mental Capacity Act (s.5).

¹²⁷ s.16(5).

¹²⁸ s16(6)(a). Nor can attorneys give consent to procedures/treatments requiring second opinions although they should be consulted (s16(6)(b)).

to hospital for treatment of a physical condition or consent to care arrangements on their behalf.

However, unfortunately, the Adults with Incapacity Act is unclear as to the extent to which welfare attorneys may consent to arrangements that amount to deprivation of liberty where the adult appears to resist or oppose them (even where the power of attorney actually permits this), nor where an attorney can use/authorise restraint¹²⁹. Under these circumstances, it is highly recommended that a welfare attorney does not consent to such measures on behalf of an unwilling granter and, where they are uncertain about how to proceed, apply¹³⁰ to the sheriff for direction under section 3 of the Adults with Incapacity Act as to their powers as a welfare attorney. Alternatively they can seek welfare guardianship with the required powers (but please see discussion later).

6. Welfare guardianship

These may be granted to the Chief Social Work Officer (CSWO) of a local authority or to a private individual¹³¹ and can be full or partial, specific or general¹³². Where the CSWO is appointed welfare guardian they must specify to which responsible officer they are delegating the duties of the welfare guardian. The responsibility, however, remains with the CSWO.

When granting welfare guardianship orders, the Sheriff Court must ensure that the person is indeed incapable of making decisions about their welfare or is incapable of acting to safeguard their welfare and is likely to continue to be so and that the proposed guardian is suitable. Of course, it may be that a less restrictive option than a welfare guardianship will be more appropriate¹³³.

This enables the functional capacity assessment and least restriction alternative principles to be more easily respected.

Deprivation of liberty issues

a) Hospital for treatment of a mental disorder

A guardianship order cannot authorise a guardian to place the adult in a hospital for treatment of a mental disorder against their will¹³⁴. The 2003 Act must be used so that the adult is afforded the requisite Article 5 legal safeguards¹³⁵.

¹²⁹ s.11 Mental Capacity Act 2005 expressly excludes detention from the powers of attorneys and it permits the use of restraint (where this is necessary and proportionate).

¹³⁰ Under s3 Adults with Incapacity (Scotland) Act 2000.

¹³¹ s59(1) Adults with Incapacity (Scotland) Act 2000.

¹³² ss64(1) and 64(3).

¹³³ ss58(1)(a) and (b) and 58(3).

¹³⁴ s64(2)(a).

¹³⁵ They also cannot consent on behalf of that adult to 'second opinion' medical treatments (s64(2)(b)).

b) *Wide powers*

A guardianship order may include very wide powers which can include the power to arrange for the adult to live in a certain place and receive certain types of care which may amount to deprivation of liberty.

Some orders grant powers to effectively detain the adult concerned in care homes and even their own homes. These can include powers to restrain the adult concerned, control them, keep them under constant supervision and/or keep them in the place where they live or receive day care services.

It seems to have been accepted that Adults with Incapacity Act guardianship constitutes the lawful procedure required by the ECHR law to deprive an adult of their liberty on grounds of their mental disorder¹³⁶. However, this is open to dispute¹³⁷ as it is not specifically authorised by the Act. Nor does it appear to be something that was envisaged when the Act was enacted given that it specifically authorises other guardianship powers but not this and nor is it mentioned in the Act's Code of Practice. Welfare guardians should therefore exercise caution before implementing or agreeing to measures that place restrictions on the person that amount to a deprivation of liberty even where specifically authorised in the powers granted. If a welfare guardian is in doubt about the extent of their powers, then it is strongly advisable that they apply to the sheriff for direction¹³⁸ and, where the person requires treatment for a mental disorder, consider use of the 2003 Act.

c. *Unlimited guardianship and recall*

Unlimited guardianship

The default period for guardianship orders is three years under the Act. However, sheriffs may grant orders for longer, shorter or indefinite period¹³⁹.

An indefinite order may be justified in terms of the Act but it might, depending on the individual case, mean that the adult with incapacity is subjected to circumstances that amount to an indefinite deprivation of liberty. This would be in breach of Article 5 ECHR.

In particular, there must be regular reviews of detention¹⁴⁰ and this would not be the case here (although the adult or anyone with an interest can apply under section 71 of the Adults with Incapacity Act to a sheriff for the order to be recalled (but see below)).

¹³⁶ See, for example, *Muldoon, Applicant* 2005 SLT (Sh Ct) 52 at 58K,59B, *Doherty* (unreported), Glasgow Sheriff Court, 8 February 2005, *M, Applicant* 2009 SLT (Sh Ct) 185 at 84 and 87 and *Application in respect of R* 2013 GWD 13-293 .

¹³⁷ *Autonomy, benefit and protection, op cit*, 32, and *Discussion Paper on Adults with Incapacity, op cit*, para 6.5.

¹³⁸ s3 Adults with Incapacity (Scotland) Act 2000.

¹³⁹ s58(4).

¹⁴⁰ *Winterwerp* at para 55, and *DD* at para 163(a).

Recall

It is possible to appeal against a guardianship order to a sheriff¹⁴¹ on the basis that the grounds for guardianship are not fulfilled or the adult's interests can be promoted by other means. The Mental Welfare Commission or local authority may also recall a welfare guardian's powers¹⁴² on the same grounds although the Commission prefers that the local authority exercises this power given that the latter is normally better placed to monitor the operation of individual cases.

However, the appeal to a sheriff must be instigated by the adult with incapacity or someone claiming an interest in their welfare and there is no prescribed procedure under the Act that triggers the Commission and local authority recall powers. In this regard, it is important to note that ECHR case law makes it clear that the onus to challenge a deprivation of liberty should not be on the detained person¹⁴³.

Another issue when considering whether to recall a guardianship order is that there is a risk that the adult concerned may be left even more vulnerable. If the adult remains incapable of taking decisions and their care and treatment arrangements amount to a deprivation of liberty this will be unlawful in the absence of a legal framework that provides for the ability to regularly assess the need for detention and other legal safeguards.

7. Scottish Law Commission proposed amendments to Adults with Incapacity (Scotland) Act 2000

As mentioned in Chapter One, the Scottish Law Commission (SLC) has reported on the issue of deprivation of liberty and adults with incapacity. It has recommended some amendments to the Adults with Incapacity Act as follows:

a. Preventing an adult with incapacity from going out of hospital¹⁴⁴

A medical practitioner would be able to prevent an adult with incapacity who is in hospital and receiving medical treatment, or being assessed as to whether medical treatment is required, from going out of hospital or some part of an NHS or private hospital.

Certain safeguards will be in place for the protection of the adult concerned. For instance:

- i. Where such a measure is being considered assessment of the adult's capacity and the means employed to prevent them from leaving hospital, including use of any medication or use of force, must be in accordance with the definition of "incapable" in s.1(6) of the Act and its principles.

¹⁴¹ s71(1)(c).

¹⁴² s73(3)(b).

¹⁴³ *Reid* at paras 70-74.

¹⁴⁴ s.50A of the draft Bill accompanying the Report.

- ii. The medical practitioner is also under a duty to review this authorisation “from time to time”¹⁴⁵.
- iii. The patient or anyone claiming an interest in their personal welfare may apply to the sheriff for an order setting an end date for such a measure¹⁴⁶ or to review any action taken in reliance on the authorising certificate¹⁴⁷.
- iv. It is possible to challenge administration of medication for confining the person to hospital under s52 of the Act.

Article 5 ECHR issues

However, several aspects of the recommendation arguably require further consideration in terms of compatibility with Article 5 ECHR:

- i. Assessing whether deprivation of liberty engaging Article 5 ECHR exists - immobile patients*

The SLC considers¹⁴⁸ that this authorisation process will only be required where it is necessary to restrain the patient but that “in many cases it may not be necessary because of the state of their health”¹⁴⁹. However, as noted in Chapter One, the case law of the European Court of Human Rights and English courts indicates that even where the person does not try to leave a deprivation of liberty will occur if those responsible for them are clear that they will be prevented from leaving¹⁵⁰.

- ii. Compatibility with Article 5(1)(e) - Duration of authorisation – End dates and suitable alternative accommodation*

When considering whether or not to grant an order setting an end date, the sheriff is required to be satisfied that the treatment or assessment has ended, and that the patient is ready to return home or that suitable accommodation is available elsewhere. The SLC considers that¹⁵¹ inclusion of the suitable alternative accommodation provision - particularly as it envisages that local authorities will be required in the application, as well as being statutorily obliged, to provide full information about the availability of suitable accommodation¹⁵² - outweighs the risk that the court may not be able to set an end date.

¹⁴⁵ s.50B draft Bill.

¹⁴⁶ s.50C draft Bill.

¹⁴⁷ s.50A(6) draft Bill.

¹⁴⁸ Report, para 5.3.

¹⁴⁹ Report, para 5.3.

¹⁵⁰ *HL v UK*, para 91, *JE v DE* [2006] EWHC 3459(Fam), per Munby J at 77 and *Cheshire West*, per Lady Hale at 48-49.

¹⁵¹ Report, para 5.23.

¹⁵² Para 5.23.

However, the possibility exists that if no such alternative accommodation exists then the adult may remain in hospital for an extended period when it is not therapeutically justified and contrary to the Act's requirements regarding benefit, necessity and least restrictive alternative¹⁵³. Under such circumstances it is questionable as to whether the requirements of Article 5(1) would be met. In this connection, the use of legislation in ensuring that rights are real and effective assisting should be considered. Indeed, this was noted regarding s.264 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (relating to detention in conditions of excessive security at the State Hospital) where it has been noted that the underlying objective of the section was to drive forward the provision of sufficient medium-secure facilities¹⁵⁴.

iii. Article 5(4) safeguards - oversight of authorisation and subsequent review

As discussed in Chapter One, judicial authorisation may not be required for the initial deprivation of liberty but Article 5(4) ECHR does require that there must be an ability to challenge and review such deprivation of liberty by way of judicial review. Moreover, these safeguards must (a) be real and effective providing the same level of protection for a person lacking capacity as for others; (b) not be exercisable by the person/body who originally authorised the deprivation of liberty; and (c) if exercisable by a third party, be under a non-discretionary obligation.

The SLC recommendations do provide for the ability for interested persons to apply to the sheriff court. This is not, however, an automatic review. The recommendations relate to vulnerable adults who may not be able to pursue an application to the court and there may not be anyone who is able or willing to do this on their behalf. As stated in Chapter One, it is therefore arguable that automatic judicial review is required, at the very least, to enable a challenge of the lawfulness of the measure. This is particularly the case given the importance the European Court of Human Rights has placed on the right to liberty which is reinforced by the rights to equal recognition before the law (Article 12), access to justice (Article 13), liberty (Article 14), and personal integrity (Article 17) in the Convention on the Rights of Persons with Disabilities¹⁵⁵.

b. Authorisation of significant restriction of liberty in relation to (1) placement in a care home or accommodation arranged by an adult placement service¹⁵⁶; and (2) short term care¹⁵⁷

¹⁵³ However, it remains to be seen whether the integration of health and social care services, under the Public Bodies (Joint Working) (Scotland) Act 2014, will in fact reduce the risk of this occurring.

¹⁵⁴ *G(AP) v Scottish Ministers* [2013] UKSC 79.

¹⁵⁵ See Chapter One.

¹⁵⁶ By reason of vulnerability or need resulting from infirmity, ageing, illness, disability, mental disorder, or drug or alcohol dependency.

¹⁵⁷ s52 of the draft Bill accompanying the Report.

The SLC recommendations provide that “relevant person”, being the manager of the material premises, failing which the adult’s social worker, may determine whether a “significant restriction of liberty” for an adult with incapacity is required. This will then be authorised by the adult’s welfare attorney and guardian will then authorise such significant restriction of liberty (or a sheriff if they do not exist or do not agree) and such authorisation will be deemed to be the consent of the adult with incapacity. It will be assumed that with effect from commencement of the provision it will be assumed that this is included within their powers unless the contrary is expressly indicated¹⁵⁸.

Again, as with the previously mentioned authorisation to prevent an incapable adults from going out of a hospital, the adult must in each case be assessed to be incapable in terms of the Act and its underlying principles.

Such recommendations place new and serious responsibilities on managers to consider and assess for incapacity in residents.

Assessment of a deprivation of liberty engaging Article 5 ECHR - “significant restriction of liberty”

The SLC recommends the introduction of the concept of “significant restriction of liberty” rather than that of deprivation of liberty. It considers this to be clearer and easier to apply and will cover all situations involving deprivation of liberty in relevant care homes or placements without falling within the realms of a restriction of the right to liberty of movement¹⁵⁹. As mentioned above, the right to liberty of movement in Article 2, Protocol 4 to the ECHR specifically protects the right to choose one’s residence which is not the case where a person is deprived of their liberty.

A significant restriction of liberty will occur if two of the following listed factors are regularly present:

- “(a) the adult either—
 - (i) is not allowed, unaccompanied, to leave the premises in which placed,
 - or
 - (ii) is unable, by reason of physical impairment, to leave those premises unassisted,
- (b) barriers are used to limit the adult to particular areas of those premises,

¹⁵⁸ s.52E(3) draft Bill.

¹⁵⁹ Article 2, ECHR Protocol No.4.

(c) the adult's actions are controlled, whether or not within those premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication.”¹⁶⁰

Article 5 ECHR issues

However, it is not immediately apparent how a significant restriction of liberty is easier to discern than a deprivation of liberty. The recommendations may also raise potential Article 5 compliance issues:

i. Deprivation of liberty engaging Article 5 ECHR - Objective factors constituting a “significant restriction of liberty” - Lack of social contact

Although it acknowledged that Supplementary Code of Practice on the Mental Capacity Act 2005 for England and Wales¹⁶¹ includes this and that it has featured in the case law of the European Court of Human Rights¹⁶², the SLC took the view to not include a lack of social contact as a factor when assessing what will constitute a significant restriction of liberty. It considers that to include such a factor “is tantamount to creating a formal process for restriction of contact and communication”¹⁶³. It also notes that all care arrangement standards encourage contact with family and friends, that to restrict access with others may have implications for those other people's Article 8 ECHR rights, and that there may be situations where contact with others may be legitimate for the adult's protection¹⁶⁴. However, it should be possible to distinguish between normal healthy contact situations and situations where it would be legitimate to restrict contact. Consequently, a lack of social contact can and should be included as factor that must be taken into account when assessing whether or not there has been a deprivation of liberty engaging Article 5 ECHR.

ii. Deprivation of liberty engaging Article 5 ECHR (authorisation of such deprivation of liberty) and Article 5(4) procedural safeguards (challenge or review of deprivation of liberty)

Welfare attorneys or guardians will be able to consent to the significant restriction of liberty on behalf of the adult. Moreover, a sheriff must provide such authorisation where there is no welfare attorney or guardian, or they refuse to give the authorisation. In either

¹⁶⁰ S.52A(1) of draft Bill accompanying the Report. Note that measures that apply to all residents at the premises which are intended to facilitate the proper management of the premises and which do not disadvantage residents excessively or unreasonably do not amount to a significant restriction (s.52A(2) draft Bill).

¹⁶¹ Report, paras 6.17-6.20.

¹⁶² *HL v UK*, para 91, and *HM v Switzerland* (2004) 38 EHRR 17, para 45.

¹⁶³ Report, para 6.21.

¹⁶⁴ Report, paras 6.22-6.24.

case, the duration of the restriction lasts for one year only (but can be renewed). However, there will otherwise be no automatic authorisation or reviews by a court of the lawfulness of a restriction of liberty or duty imposed on anyone to refer the matter for judicial consideration. It should also be noted that, given the absence of automatic review, it may be that where welfare attorney or guardianship consent has been obtained it is feasible that the restriction arrangements can be renewed indefinitely.

Additionally, the “relevant person” may vary the significant restriction of liberty and implement such variation pending the outcome of any appeal against this¹⁶⁵. It is, of course, possible that the level of restriction may be increased by these means and, again, there is no automatic judicial authorisation of this.

As discussed above, there is an absence of the availability of automatic judicial review to challenge the legality of the measure. Whilst the ability to apply to the sheriff court exists it requires proactivity on the part of the individual concerned and others. For the reasons already given under 1(c) above this may not meet the requirements of Article 5(4).

c. Ability to apply to the sheriff in relation to an unlawful detention of an adult with incapacity¹⁶⁶

The SLC also recommends that the Adults with Incapacity Act be amended so that the sheriff may order that an adult who is, or may be, incapable is being detained in accommodation provided or arranged for by a care home service or an adult placement service is unlawful and that those detaining the adult must cease to detain the adult. The adult or any person claiming an interest in the adult’s personal welfare order may apply for such order. The Report and explanatory notes accompanying the draft Bill indicate that this provision will operate alongside s.3(1) of the Act so as to ensure that the adult with incapacity will not be left unsupported where the detention ceases but their care needs are such that they cannot live independently.

Article 5 ECHR issue

Again, given that this proposed provision requires either action on the part of the adult, which may not be possible, or is in the discretion of someone else would suggest that this may not be considered to be compatible with the special procedural safeguards required in relation to Article 5(4) for adults with incapacity.

In many cases, decisions to restrict the liberty of an individual who lacks capacity are made benevolently with the sole objective of benefitting that individual. However, we must also be mindful of the cases where this may not be the case and this is where the protective measures of Article 5 are of fundamental importance.

¹⁶⁵ By the adult, their welfare guardian or attorney and/or named person (if any), their primary carer and nearest relative. All of these persons must be told about the variation and why it is being made and are entitled to make such an appeal. The Mental Welfare Commission for Scotland must also be informed (s.52I draft Bill).

¹⁶⁶ S.52J draft Bill accompanying the Report.

C. Care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) generally

The compulsory measures (relating to civil and criminal matters) under the 2003 Act are available in certain clearly specified situations and the tests are more or less the same for all orders. The following must be considered before the compulsory powers may be used:

1. ***That the person has a ‘mental disorder’***¹⁶⁷ (i.e. mental illness, personality disorder or learning disability¹⁶⁸).
2. ***Treatability*** – this applies to long term orders and means that medical treatment is available that would benefit the person (i.e. to prevent the mental disorder worsening; or alleviate any of the symptoms, or effects, of the disorder).
3. ***Risk*** – without the treatment there will be a significant risk to the person’s health, safety or welfare or the safety of other people.
4. ***Significantly impaired decision-making ability (SIDMA)***¹⁶⁹ – that the person’s ability to take decisions about the treatment is significantly impaired as a result of mental disorder. The Act does not define this but it’s Code of Practice¹⁷⁰ states that in assessing SIDMA similar factors to that in the assessment of incapacity should be taken into account. However, it also permits the involuntary treatment of a person with capacity.

One difference between SIDMA and incapacity (as defined by the AWIA) is that SIDMA is as a result, only, of mental disorder whilst the AWIA definition of incapacity states that incapacity can be the result of mental or physical disorder.

A functional capacity approach should be adopted. It is therefore necessary to demonstrate that ***the person has or does not have significantly impaired decision-making ability because of their mental disorder thus making them incapable or capable of making a valid treatment choice in relation to that specific intervention/treatment.*** They may not have had insight about the original treatment but they may have such insight about other interventions¹⁷¹.

5. ***The order is ‘necessary’*** - that is, the patient cannot be treated voluntarily.

¹⁶⁷ s328.

¹⁶⁸ The Act does not define these terms.

¹⁶⁹ Note, again, that this applies only to civil compulsion.

¹⁷⁰ Vol 2, Chapter 1, paras 22-27.

¹⁷¹ See also note 53 above.

The above very much reflect the guiding principles formulated by the Millan Committee¹⁷² (which reviewed and made recommendations regarding mental health legislation in Scotland prior to enactment of the Act). These principles promote, where appropriate, a preference for informal care and the least restrictive alternative in terms of care and treatment.

Deprivation of liberty issues

The Act provides for short term detention¹⁷³ and hospital or community-based compulsory treatment orders¹⁷⁴ all of which will or might result in a deprivation of liberty. Although, clearly more formal in its approach than the previous measures the Act generally provides greater ECHR compliant safeguards in terms of challenge, review and oversight of the various measures.

At present, it does appear to be the only route if it is necessary to treat a person with incapacity for their mental disorder where their willingness to be treated is absent.

However, in Article 5 ECHR terms, medical staff must exercise caution in the following areas:

a. Emergency detention

a. See above.

b. Voluntary admission

Section 291 provides the ability for a patient to challenge unlawful detention when they are being detained other than under the 2003 Act. It does not mean, however, that the state can adopt a reactive approach or that hospitals or other institutions can simply wait for informal patients to mount challenges. They must be proactive here.

Note: The 2003 Act allows for a person subject to compulsion under the Act to challenge the conditions of their detention in state hospitals and non-state hospitals, under sections 264 and 268 respectively, on the basis that these are excessive. Because it is the conditions of the detention and not its lawfulness that are being challenged this is not an Article 5(1) ECHR issue. Instead, Article 3 (prohibition against inhuman and degrading treatment) and Article 8 (respect for private life (autonomy)) ECHR are relevant¹⁷⁵.

¹⁷² Millan Committee (2001), *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*, Scottish Executive, SE/2001/56.

¹⁷³ Part 6, ss44-56.

¹⁷⁴ Part 7, ss57-129. See also Part 20 authorising detention in hospital or a residence requirement (Part 20) and Part 19 containing entry, removal and detention provisions. See also s243 which authorising emergency treatment, subject to certain conditions, of persons subject to the Act or the Criminal Procedure (Scotland) Act 1995.

¹⁷⁵ *R v Ashworth Hospital ex p Munjaz* [2005] UKHL 58, *Munjaz v. The United Kingdom* (Application no. 2913/06) European Court of Human Rights (Fourth Section) judgment 17 July 2012, *Sheritt v NHS Greater*

c. Use of seclusion and observation

See Chapter One.

d. Nurses' holding power

S.299 of the 2003 Act permits a registered mental health or learning disability nurse¹⁷⁶ to detain a patient who is in hospital for a maximum period of two hours¹⁷⁷ in order for a medical examination to be carried out by a medical practitioner¹⁷⁸. It is important to appreciate that when nursing staff prevent someone from leaving the hospital they are effectively detaining them¹⁷⁹ and this is without the appropriate legal and procedural safeguards required by Article 5 ECHR and identified in this guidance. This power must therefore only be used where no other option exists and for as short a period of time as possible. Where at all possible, the patient's full, free and informed consent to remain at the hospital should be obtained. However, a patient must under no circumstances be under the belief that if they do not consent they will be detained¹⁸⁰ as this will amount to an unlawful deprivation of their liberty.

E. Social Work (Scotland) Act 1968, s13ZA

This provision expressly permits local authorities to move adults who lack capacity into residential accommodation where it is necessary to provide that person with appropriate community care services where there are no objections from the adult or anyone claiming an interest. The same guiding principles as those contained in the Adults with Incapacity Act should be adhered to.

Deprivation of liberty issue

The local authority must not take any action under section 13ZA that will result in a deprivation of liberty because this is not specifically authorised under the Social Work Act. Nor does the Act contain the legal and procedural safeguards required for Article 5 ECHR compliance.

Glasgow and Clyde Health Board [2011] CSOH 37, *G v Scottish Ministers* [2013] UKSC 79 and *RM (AP) (Appellant) v The Scottish Ministers (Respondent) (Scotland)* [2012] UKSC 58.

¹⁷⁶ Mental Health (Class of Nurse) (Scotland) Regulations 2005 (SSI 2005/446).

¹⁷⁷ The Mental Health (Scotland) Bill that is currently before the Scottish Parliament proposes to extend this period to three hours.

¹⁷⁸ The nurse must be satisfied that the patient has a mental disorder and that such detention is necessary for the protection of the health, safety and welfare of that patient or safety of another person. The nurse must also be satisfied that it is necessary to carry out the medical examination for the purpose of determining whether the granting of an emergency detention certificate or a short term detention certificate is warranted (s.299(3)).

¹⁷⁹ Mental Welfare Commission for Scotland (2014), *Advice Notes: Nurses power to detain*, 1,

http://www.mwscot.org.uk/media/140960/nurse_power_final.pdf

¹⁸⁰ See 2003 Act Code of Practice Vol 2, Chapter 7, para 18.

The Scottish courts and the Scottish Government have recommended different approaches regarding s.13ZA. In the cases of *Muldoon, Applicant, M, Applicant* and *Application in respect of R*¹⁸¹ the court advocated the use of a guardianship order whenever an adult without capacity is living in residential care. The Scottish Government guidance¹⁸², on the other hand, does not agree with this interpretation and emphasises that “all of the circumstances of the case have to be taken into account and that incapacity, of itself, does not automatically mean that there will be a deprivation of liberty in the provision of the care intervention/package to that adult.” However, it acknowledges that there is no easy test as to whether a particular care or treatment regime constitutes deprivation of liberty and all the facts have to be considered.

However, following the *Cheshire West* ruling it is clear that use of 13ZA will violate Article 5 ECHR if the person with incapacity is placed in circumstances where they are under constant control and supervision. For further guidance on the use of s.13ZA please see the Mental Welfare Commission’s *Response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision*¹⁸³.

¹⁸¹ *Op cit*, note 119.

¹⁸² See Scottish Government, *Guidance for local authorities: provision of community care services to adults with incapacity*, 30 March 2007, CCD5/2007, Annex A, para 4. This view appears to accord with that in *H.M. v Switzerland* and related cases (see Chapter One) which was rejected in the *Cheshire West*.

¹⁸³ Mental Welfare Commission for Scotland (2014), *Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision*
http://www.mwscot.org.uk/media/202163/cheshire_west_draft_guidance.pdf

Appendix A: Useful sources of guidance and information

1. Mental Welfare Commission for Scotland

Care Commission and Mental Welfare Commission for Scotland (2009), *Remember, I'm still me: joint report on the quality of care for people with dementia living in care homes in Scotland.*, pp52-53

http://www.mwcscot.org.uk/web/FILES/Publications/CC_MWC_joint_report.pdf.

Mental Welfare Commission for Scotland (2010), *Consent to Treatment*

<http://www.mwcscot.org.uk/media/51774/Consent%20to%20Treatment.pdf>

Mental Welfare Commission for Scotland (2011), *The Right to Treat*

<http://www.mwcscot.org.uk/media/51822/Right%20to%20Treat.pdf>

Mental Welfare Commission for Scotland (2012), *Powers of Attorney and their Safeguards*

http://www.mwcscot.org.uk/media/56140/powers_of_attorney_and_their_safeguards.pdf

Mental Welfare Commission for Scotland (2012) *The Use of Seclusion*

http://www.mwcscot.org.uk/media/191573/final_use_of_seclusion.pdf

Mental Welfare Commission for Scotland (2013), *Covert Medication,*

http://www.mwcscot.org.uk/media/140485/covert_medication_finalnov_13.pdf

Mental Welfare Commission for Scotland (2013), *Advance Statement Guidance*

http://www.mwcscot.org.uk/media/128044/advance_statement_final_version_jan_2014.pdf

Mental Welfare Commission for Scotland (2013), *Rights, Risks and Limits to Freedom*

http://www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf

Mental Welfare Commission for Scotland (2014), *Visit Report: Dignity and Respect: Dementia Continuing Care Visits*

http://www.mwcscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf

Mental Welfare Commission for Scotland (2014), *Advice Notes: Nurses power to detain,*

http://www.mwcscot.org.uk/media/140960/nurse_power_final.pdf

Mental Welfare Commission for Scotland (2014), *Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision*

http://www.mwcscot.org.uk/media/202163/cheshire_west_draft_guidance.pdf

2. Scottish Government

Adults with Incapacity (Scotland) Act 2000

Scottish Government, *Guidance for local authorities: provision of community care services to adults with incapacity*, 30 March 2007, CCD5/2007

<http://www.highland.gov.uk/NR/rdonlyres/901DEAE5-E233-4FA6-8B22-30F294882080/0/2007sgguidancewhentoinvoke.pdf>

Scottish Government (2008), *Adults with Incapacity (Scotland) Act 2000: Code of Practice: For Local Authorities Exercising Functions under the 2000 Act*

<http://www.scotland.gov.uk/Resource/Doc/216923/0058136.pdf>

Scottish Government, *Adults with Incapacity (Scotland) Act 2000: Code of Practice (Third Edition): For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act*, SG/2010/57, April 2010 (issued October 2010)

<http://www.scotland.gov.uk/Publications/2010/10/20153801/0>

Scottish Government (2011), *Code of Practice for persons authorised under intervention orders and guardians under the Adults with Incapacity (Scotland) Act 2000*

<http://www.scotland.gov.uk/Resource/Doc/347717/0115820.pdf>

Mental Health (Care and Treatment) (Scotland) Act 2003

Millan Committee (2001), *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*, Scottish Executive, SE/2001/56

<http://www.scotland.gov.uk/health/mentalhealthlaw/millan/Report/rnhs-00.asp>

Scottish Government (2005), *Mental Health (Care and Treatment) (Scotland) Act 2003: Code of Practice Volume I*

<http://www.scotland.gov.uk/Resource/Doc/57346/0017038.pdf>

3. Scottish Law Commission

Scottish Law Commission (2012) *Discussion Paper on Adults with Incapacity*, Discussion Paper No 156, Edinburgh: The Stationery Office.

<http://www.scotlawcom.gov.uk/news/discussion-paper-on-adults-with-incapacity/>

Scottish Law Commission (2014) *Report on Adults with Incapacity*, Report No.240, Edinburgh: The Stationery Office http://www.scotlawcom.gov.uk/index.php/download_file/view/1328/98/

Appendix B: Summary of considerations for all those wishing to implement or agree to care and treatment arrangements/measures

This should be read in conjunction with this analysis and relevant guidance in the documents referred to in Appendix A. Any examples given are illustrative and not exhaustive. If in doubt, further advice or guidance must be sought.

4. Has there been a deprivation of liberty?

Look at all the circumstances in each individual case.

Consider:

1. The degree and intensity of the controls

- Has/will restraint been/be used? (i.e. physical, technical or medication restraints).
- Is the individual subject to close observation or surveillance? (i.e. by persons or technological equipment).
- Has or will the individual be subjected to seclusion or “time out”?

2. Does/will anyone exercise complete and effective control over the individual?

- Is the individual free to leave?
- Will the individual be prevented from leaving if they try to leave?
- Locked or lockable facilities are relevant but alone are not determinative.

3. For how long have/will the measures been/be imposed?

4. Is the measure compatible with the least restrictive treatment principle?

5. Are any factors that would engage Article 3 (freedom from inhuman and degrading treatment or punishment) or Article 8 (respect for private and family life, including autonomy) ECHR present?

Note: A deprivation of liberty can potentially occur in a number of different environments and in a number of different ways.

6. Does the individual have capacity to consent to the *particular restrictive measure at the time it is used* and have they given full, free and informed consent to it?

- Adopt a functional capacity approach when assessing capacity.
- A person without capacity *can never give valid consent* to restrictive measures.
- Do not assume consent from apparent compliance (i.e. check that the individual's behaviour is not influenced by sedation or others, etc).
- Has the individual made a valid advance statement *consenting to the specific restriction?*

5. Where a deprivation of liberty has/will occur - is the measure lawful?

Consider

1. Is it authorised under the law?

- This is currently the Scots common law, Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment)(Scotland)Act 2003?
- If in doubt seek legal advice or, where appropriate, a direction from the Sheriff Court.

2. Is it a proportionate response to the particular situation?

- Note the least restrictive treatment principle and functional capacity approach.

3. Does the individual have a genuine mental disorder?

4. Are there provisions under the law allowing the individual to challenge the deprivation of liberty and to have such restrictive measure regularly reviewed?



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