Scottish Law Commission

promoting law reform

(SCOT LAW COM No 240)

Report on Adults with Incapacity

report

Scottish Law Commission

promoting law reform

Report on Adults with Incapacity

Laid before the Scottish Parliament by the Scottish Ministers under section 3(2) of the Law Commissions Act 1965

October 2014

SCOT LAW COM No 240
SG/2014/180
The Stationery Office

The Scottish Law Commission was set up by section 2 of the Law Commissions Act 1965[1] for the purpose of promoting the reform of the law of Scotland. The Commissioners are:

The Honourable Lord Pentland, *Chairman*
Laura J Dunlop, QC
Patrick Layden, QC TD
Professor Hector L MacQueen
Dr Andrew J M Steven.

The Chief Executive of the Commission is Malcolm McMillan. Its offices are at 140 Causewayside, Edinburgh EH9 1PR.

Tel: 0131 668 2131
Fax: 0131 662 4900
Email: info@scotlawcom.gsi.gov.uk

Or via our website at http://www.scotlawcom.gov.uk/contact-us

NOTES

1. For those wishing further copies of this paper it may be downloaded from our website or purchased from TSO (http://www.tsoshop.co.uk/).

2. Please note that all hyperlinks in this document were checked for accuracy at the time of final draft.

3. If you have any difficulty in reading this document, please contact us and we will do our best to assist. You may wish to note that the pdf version of this document available on our website has been tagged for accessibility.

[1] Amended by the Scotland Act 1998 (Consequential Modifications) (No 2) Order 1999 (SI 1999/1820).

SCOTTISH LAW COMMISSION

Item No 7 of our Eighth Programme of Law Reform

Report on Adults with Incapacity

To: Kenny MacAskill MSP, Cabinet Secretary for Justice

We have the honour to submit to the Scottish Ministers our Report on Adults with Incapacity.

(Signed) PAUL B CULLEN, *Chairman*
LAURA J DUNLOP
PATRICK LAYDEN
HECTOR L MACQUEEN
ANDREW J M STEVEN

Malcolm McMillan, *Chief Executive*
12 September 2014

Contents

Contents (cont'd)

Contents (cont'd)

Abbreviated forms of reference

Organisations and bodies

The Association of Directors of Social Work in Scotland is referred to as "the Association of Directors of Social Work".

The Mental Health and Disability Sub-committee of the Law Society of Scotland is referred to as "the Law Society".

The Mental Health Tribunal for Scotland is referred to as "the Mental Health Tribunal".

The Mental Welfare Commission for Scotland is referred to as "the Mental Welfare Commission".

NHS Greater Glasgow and Clyde Health Board Mental Health Clinical Governance Legislation Sub-group is referred to as "NHS Greater Glasgow and Clyde".

People First (Scotland) is referred to as “People First.”

Royal College of Psychiatrists in Scotland: Faculty of Old Age Psychiatry is referred to as "RCPS (OAP)".

Royal College of Psychiatrists in Scotland: Faculty of Psychiatry of Intellectual Disabilities and Faculty of Child and Adolescent Mental Health is referred to as: "RCPS (ID/CAMH)".

Scottish Court Service and Office of the Public Guardian is referred to as "the Public Guardian".

West Dunbartonshire Community Health & Care Partnership (a Strategic Partnership between NHS Greater Glasgow & Clyde and West Dunbartonshire Council) is referred to as "West Dunbartonshire Partnership".

Statutes and other instruments

The Adults with Incapacity (Scotland) Act 2000 is referred to as "the 2000 Act"

The Mental Health (Care and Treatment) (Scotland) Act 2003 is referred to as "the 2003 Act".

The European Convention on Human Rights is referred to as “the ECHR” or “the Convention”.

The Deprivation of Liberty Safeguards provided for in the Mental Capacity Act 2005 are referred to as "DoLS".

Publications

The Scottish Law Commission Discussion Paper on *Adults with Incapacity* (Scot Law Com Discussion Paper No 156, 2012), available at: http://www.scotlawcom.gov.uk/law-reform-projects/adults-with-incapacity/ is referred to as "the Discussion Paper" or "DP No 156".

Cases

The cases of *P v Cheshire West and Chester Council; P and Q v Surrey County Council,* [2014] UKSC 19 are, together, referred to as "*Cheshire West*".

Individuals referred to in the Report

David Cobb is a member of the Faculty of Advocates.

Professor Tom Guthrie is a Professor at the University of Glasgow, School of Law, who submitted a response in a personal capacity.

Hilary Patrick is an Honorary Fellow at the University of Edinburgh, School of Law.

Dr Lucy Series is a Research Associate at Cardiff Law School, Cardiff University. At the time of submitting her response she was a postgraduate researcher in the Department of Law at the University of Exeter.

Dr Jill Stavert is a Reader in Law, Edinburgh Napier University, School of Accounting, Financial Services and Law.

Chapter 1 Introduction

Background

1.1 This Report addresses a legal problem which has been evident in the United Kingdom since the *Bournewood* case, a decision involving the law of England and Wales.[1] The details of the case will be familiar to many readers, and are set out fully in our Discussion Paper.[2] In summary, the case determined that the admission to a psychiatric hospital and continued residence there of a person with learning difficulties such that he could not consent to being where he was represented a deprivation of his liberty, could not be characterised as "voluntary" and needed to take place under a lawful process in order to comply with Article 5 of the European Convention on Human Rights.

1.2 We included this issue in our Eighth Programme of Law Reform, after it had been suggested to us by the Mental Welfare Commission for Scotland, ENABLE Scotland and the Mental Health and Disability Sub-committee of the Law Society of Scotland. All these bodies felt that the implications of the decision for Scots law needed to be examined.

Structure of the Report

1.3 This Report takes into account judicial decisions on deprivation of liberty since the publication of our Discussion Paper. These are decisions by the European Court of Human Rights and by the courts in Scotland as well as in England and Wales, including the decision of the Supreme Court in *Cheshire West*.[3] The Report considers the responses to our Discussion Paper and the conclusions drawn from it. It gives a short overview of our reform proposals before providing more information on the relatively straightforward process for authorising measures adopted to prevent an adult without capacity from going out of a hospital and on the more detailed process for significant restriction of liberty of an adult in certain types of care setting in the community. Lastly, it describes the provision of a remedy in the form of an application to the courts for release from care arrangements in non-hospital settings for which the State has responsibility.

1.4 This is followed by a list of the recommendations and a draft Bill. The Impact Assessment of our recommendations, should they be implemented, is published on our website.

Background to the Adults with Incapacity (Scotland) Act 2000

1.5 It may be of assistance at this point to set out some information about the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"), and to explain some of the terminology which features in the Act and in this Report.

---

[1] *HL* v *United Kingdom* (2005) 40 EHRR 32.

[2] DP No 156 paras 2.4-2.24, available at: http://www.scotlawcom.gov.uk/law-reform-projects/adults-with-incapacity/ .

[3] *P v Cheshire West and Chester Council; P and Q v Surrey County Council,* [2014] UKSC 19.

1.6 The Act was based on a draft Bill annexed to the Scottish Law Commission's Report on Incapable Adults, published in 1995.[4] The Act was intended to protect adults who lack capacity and to provide support to their families and carers. It introduced new arrangements for making decisions about personal welfare and managing the property and finances of adults with incapacity.

1.7 The principles set out in section 1 of the 2000 Act are also a product of the recommendations of the Scottish Law Commission.[5] Their overarching function is to ensure that any intervention that takes place under the 2000 Act will benefit the adult, and that it does not impinge on the adult's freedom to any greater extent than is necessary to achieve that benefit**.** In the recommendations we make, we envisage that the same principles would be applicable to any intervention taking place under the provisions of our draft Bill, if enacted.

Relevant parts of the Adults with Incapacity (Scotland) Act 2000

1.8 In the context of the current project, Parts 2, 5 and 6 of the 2000 Act are of greatest relevance. Part 2 deals with continuing and welfare powers of attorney. A power of attorney is a legal document used by a person to authorise another individual to take financial, medical or welfare decisions on his or her behalf in certain specified circumstances.[6] A continuing power of attorney authorises the taking of decisions relating to the property or financial affairs of the granter.[7] Where an attorney is to have power in relation to decisions as to medical treatment, this will fall within the scope of a welfare power of attorney. It is possible, also, to have a single instrument which confers both a welfare power of attorney and a continuing power of attorney.

1.9 Part 5 of the Act deals with medical treatment of adults who lack capacity to consent to such treatment. A mechanism is provided whereby medical practitioners and certain other health professionals have authority to do what is reasonable in the circumstances to safeguard or promote the physical or mental health of the adult. Under the applicable provisions, a certificate is issued by the relevant professional to the effect that he or she is of the opinion that the adult is incapable in relation to a decision as to the treatment in question.[8] In general the authority conferred by the certificate may last for a maximum of one year.[9] However, where any of the conditions or circumstances prescribed by the Scottish Ministers in Regulations made under section 47(5) pertain, the authority may last for up to three years.[10] Section 47(4) imposes certain constraints on the scope of the authority conferred by a section 47 certificate. These include that the certificate does not cover placing an adult in hospital for treatment for mental disorder against his or her will.

---

[4] Report on Incapable Adults (Part 1), (Scot Law Com No 151 (1995)), available at: http://www.scotlawcom.gov.uk/publications/reports/1990-1999/.

[5] See again Part 1 of the Report on Incapable Adults, paras 2.47 – 2.73.

[6] Hilary Patrick and Nicola Smith, *Adult Protection and the Law in Scotland* (2009), para 9.24.

[7] Section 15(1) of the 2000 Act.

[8] Section 47 of the 2000 Act.

[9] Section 47(5)(b)(i) of the 2000 Act.

[10] The Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Treatment Certificates)(Scotland) Regulations 2007 (SSI 2007/100) were made in exercise of the powers under s 47(5)(b) and (6)(b). The conditions and circumstances prescribed are incapacity to make a decision in relation to medical treatment because of a severe or profound learning disability, dementia or a severe neurological disorder.

1.10 Part 6 of the Act makes provision for guardianship and intervention orders to be granted by the court, authorising the making of decisions for those who lack capacity in whole or in part.[11] Both guardianship and intervention orders can be made in respect of welfare or property/financial affairs of the adult. Intervention orders are intended to deal with specific, often one-off situations, such as signing a tenancy agreement on behalf of the adult. By contrast, guardianship is thought to be better suited to the situation where continuous involvement in the affairs of the adult is required, on a more long-term basis. A guardianship order might cover a combination of welfare and financial matters.

Other relevant actors referred to in the draft Bill

1.11 The draft Bill included in this Report makes reference to "named person", "nearest relative" and "primary carer." In relation to "named person" and "nearest relative", the approach of the 2000 Act is to adopt, in almost identical terms, the definitions and modes of identification to be found in the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act").[12] Broadly, the roles of named person and nearest relative under the 2000 Act are as obligatory consultees in certain processes and as recipients of intimation of particular applications. A named person is someone who has that role in accordance with any of sections 250 to 253 or section 257 of the 2003 Act. Section 254 of the 2003 Act sets out a list of relatives; the person coming highest in the list is normally the nearest relative of an individual. The list begins with a person's spouse or civil partner, going down to the person's niece or nephew, and finally someone who has been living with them for at least 5 years, or had done so before the person was admitted to hospital or care.

1.12 The 2000 Act defines a primary carer as the person or organisation primarily engaged in caring for the adult.[13] Neither the 2003 Act nor the 2000 Act contains a definition of "care" or "carer".

Legislative competence and human rights

1.13 The provisions of the draft Bill do not relate to matters reserved to the United Kingdom Parliament in terms of Schedule 5 to the Scotland Act 1998. Any legislation to amend the 2000 Act arising from this Report would be within the legislative competence of the Scottish Parliament.

1.14 The proposals and questions covered by this Report involve issues of human rights and in particular Article 5 of the European Convention on Human Rights. The UK is obliged to secure the rights and freedoms in the Convention to persons within its jurisdiction. We have endeavoured to assess whether Scots law in relation to incapacity is compatible with Article 5 and to identify any changes which might require to be made in order to secure the rights and freedoms concerned.

1.15 Reflecting what the rights and freedoms require in domestic law is therefore at the heart of this project. In view of the ECHR focus of the project, it is worth looking briefly at the domestic enforcement of human rights.

---

[11] Sections 53 and 57 of the 2000 Act respectively.
[12] See s 87(1) of the 2000 Act.
[13] Section 87(1) of the 2000 Act.

1.16 If a claim were to be made in a Scottish court for a breach of Article 5, that court would require to take account of relevant decisions of the Strasbourg court. Section 2 of the Human Rights Act 1998 states

> "2.— Interpretation of Convention rights.
>
> (1) A court or tribunal determining a question which has arisen in connection with a Convention right must take into account any—
>
> (a) judgment, decision, declaration or advisory opinion of the European Court of Human Rights,
>
> .....
>
> whenever made or given, so far as, in the opinion of the court or tribunal, it is relevant to the proceedings in which that question has arisen."

1.17 Sometimes, the position of Strasbourg in relation to a claim advanced in a UK court on the basis of human rights is clear and constant. Then the court may have no choice but to follow it. As Lord Rodger of Earlsferry observed,

> "Argentoratum locutum, iudicium finitum".[14]

1.18 Necessarily, the approach is different when there is a gap between what appears to be the position of the Strasbourg court on a particular human rights point and a claim relating to that point which comes before a UK court. Various possible responses to this dilemma have been expressed. It has been said that, if Strasbourg has not yet had to deal with the point which is before the UK court, the UK court should do no more but certainly no less than keep pace with Strasbourg,[15] or do no less but certainly no more than keep pace with Strasbourg,[16] or leave novel contentions invoking principles which are not clear to be resolved in Strasbourg.[17]

Impact assessment

1.19 In 2010, the Scottish Government introduced new requirements aimed at achieving enhanced regulatory impact assessments of primary legislation, secondary legislation, codes of practice and guidance. In line with these, we have prepared a Business and Regulatory Impact Assessment in relation to our recommendations and have published it on our website. The overall conclusion of the Assessment is that our recommendations pave the way for the minimum possible level of intervention in the lives of individuals required to ensure that the rights and freedoms guaranteed by Article 5 of the ECHR are given their proper effect. Accordingly, any costs incurred would be at the lowest possible level. In particular, we envisage that the schemes for authorisation of deprivation of liberty in both

---

[14] "Strasbourg has spoken, the case is closed". *Secretary of State for the Home Department v AF and others* [2009] UKHL 28 at para 98. Arguments in favour of the existence of choice are set out in "Strasbourg has Spoken", Lord Phillips of Worth Matravers in *Judge and Jurist: Essays in Memory of Lord Rodger of Earlsferry,* edited by Andrew Burrows, David Johnston and Reinhard Zimmermann (2013), p 111.
[15] *R (Ullah) v Special Adjudicator* [2004] 2 AC 323 at para 20.
[16] *R (Al-Skeini and others) v Secretary of State for Defence* [2007] UKHL 26; [2008] 1 AC 153 at para 106.
[17] *R (Smith) v Secretary of State for Defence and another* [2010] UKSC 29. Cf *P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19 at para 86.

hospitals and community settings would operate in such a way as to minimise the need for resort to the court.

1.20 Although not strictly connected to assessment of the impact of our proposals, there is another resources issue on which we consider it is appropriate for us to comment.

1.21 It is sometimes said that, as this is a question of fundamental rights, resources are irrelevant. This seems to us to be too absolute a proposition. This project is about the right to liberty and that is indeed a fundamental right. But it is also connected to the care of some of the most vulnerable people in our society. If we recommend legal processes that are not essential to comply with the ECHR and they take money or time away from the care of individuals without providing an equivalent benefit, that appears to us to be highly relevant. It is appropriate to include an observation made by the Mental Welfare Commission in their response to our Discussion Paper:

> "An over-reliance on judicial procedures whereby a universalist approach is taken to seeking welfare guardianship whenever individuals lack capacity to make any decisions about their care and treatment will result in an unsustainable demand on the statutory services involved in implementing the legislation. The net result will be a process of professional assessment, application and judicial decision-making which is cursory, routine and overly bureaucratic. It will provide only the semblance of the rights of the individual being protected."

1.22 There is evidence that, in some places, the care of those with dementia, in particular, is of a worryingly low standard.[18] And, in a few instances, so-called care for people with learning difficulty has involved outright cruelty.[19] It is vital that resources go towards tackling these problems.

1.23 If our recommendations are to be implemented, the Scottish Government may wish therefore to explore how resources, especially the time of doctors and mental health officers, can be released from elsewhere in guardianship processes. Financial and property guardianship is one area where this might be possible. The Public Guardian has already examined this, in her paper on graded guardianship.[20]

Advisory group; other meetings

1.24 During the course of developing our policy and preparing the Report and draft Bill we have continued to have the benefit of input from our advisory group, established at the beginning of the project. The current members of the group are Professor June Andrews, Director of Dementia Services Development Centre, University of Stirling; Simon Collins QC; George Kappler, Executive Director (Social Work), Mental Welfare Commission for Scotland; Mhairi Maguire, Legal Counsel, Trustee Service Manager, ENABLE Scotland; Jim Pearson, Deputy Director of Policy, Alzheimer Scotland-Action on Dementia; Nicola Smith, Solicitor; Jan Todd, Solicitor, South Lanarkshire Council; Adrian Ward, Solicitor and Convener of the Mental Health and Disability Sub-Committee of the Law Society of Scotland. We are most grateful for the assistance we have received from the members of the group.

---

[18] http://www.heraldscotland.com/news/health/senior-nurse-in-hospital-conspiracy-of-silence-warning.24441425; http://www.edinburghnews.scotsman.com/news/health/bupa-pentland-hill-care-home-to-close-1-3449400 .

[19] http://en.wikipedia.org/wiki/Winterbourne_View_hospital_abuse .

[20] http://www.publicguardian-scotland.gov.uk/docs/graded%20guardianship%20paper.pdf .

1.25 We have also been very fortunate that many who are involved in working with or caring for those with incapacity have been willing to meet us to discuss our ideas and help us to refine them. Meetings were held with the board of People First, and with consultant psychiatrists and specialists in the medicine of elderly people, as well as with individuals from Glasgow City Council, Edinburgh City Council, CrossReach,[21] the Scottish Independent Advocacy Alliance and the Scottish Consortium for Learning Disability. We endeavoured to avoid a central belt bias, but this was difficult as all who attended had to travel far enough. They each attended as individuals rather than as spokespersons for their organisations, and we pay tribute to them all.

[21] The social care arm of the Church of Scotland.

Chapter 2 Recent case law

Introduction

2.1 At the heart of this project is Article 5 of the European Convention on Human Rights, and its application in relation to people who do not have capacity to consent to their own living arrangements. Article 5 provides:

> "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 for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants;
>
> …
>
> 4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.
>
> …".

2.2 In Chapter 2 of our Discussion Paper, we set out relevant case-law on Article 5 from the European Court of Human Rights. We also discussed case law from courts in England,[1] where the Deprivation of Liberty safeguards ("DoLS") apply and where "deprivation of liberty" has the same meaning as in the Convention.[2] Lastly, we referred to case law in Scotland.[3] This collection of material was compiled in Spring 2012. It is therefore necessary to bring the discussion of case law up to date.

Strasbourg

General principles

2.3 The key purpose of Article 5 is "to prevent arbitrary or unjustified deprivations of liberty".[4] The paradigm case of deprivation of liberty is being in prison, in the custody of a gaoler.[5] Obviously, however, there may be deviation from the standard case without its ceasing to be a deprivation of liberty.[6]

---

[1] In ch 4.
[2] Section 64(5) of the Mental Capacity Act 2005.
[3] In ch 3.
[4] *McKay v UK* (2007) 44 EHRR 41 at para 30.
[5] As observed by Lord Hoffmann in *Secretary of State for the Home Department v JJ and others* [2007] UKHL 45; [2008] 1 AC 385 at para 36.
[6] Ibid at para 38. The same point about the "paradigm case" being prison is made in *Austin v United Kingdom* (2012) 55 EHRR 14 at para 59.

2.4 In cases alleging breach of Article 5, the European Court of Human Rights has required to assess a range of different factual situations to determine if deprivation of liberty has actually occurred. In some of these cases, deprivation of liberty, if present, is capable of justification under Article 5(1) and in others not. But the Court has not suggested that the approach to determining whether there is a deprivation of liberty should be affected by this feature.[7]

2.5 In determining if deprivation of liberty has occurred, it is necessary to begin by examining the concrete situation of the individual. In so doing, account must be taken of a whole range of factors such as the type, duration, effects and manner of execution of the penalty or measure in question.[8] In the case of *Storck v Germany*[9], the Court identified factors which must be present in order for deprivation of liberty in terms of Article 5 to occur. Firstly, there must be "the objective element of a person's confinement in a particular restricted space for a not negligible length of time".[10] In addition, there is a subjective element: a person can only be considered to have been deprived of his liberty if "he has not validly consented to the confinement in question".[11] Before there could be a breach of Article 5, however, it is also necessary for the deprivation of liberty to be imputable to the State.

2.6 Once deprivation of liberty is found to have occurred, the question of justification will arise. By virtue of Article 5(1)(e), the lawful detention of "persons of unsound mind" is permitted, provided it is in accordance with a procedure prescribed by law. Thus, any requirements of domestic law must be followed.

2.7 Satisfaction of the requirements of domestic law will not be sufficient, however, because deprivation of liberty on the basis of mental disorder must also satisfy the criteria set out in the case of *Winterwerp v Netherlands*.[12] The *Winterwerp* criteria consist of three requirements:

- The individual must have been reliably shown to be of "unsound mind", according to medical evidence from an objective expert.
- The mental disorder must be of a kind or degree warranting compulsory confinement.
- Such a mental disorder must persist throughout the period of confinement.

2.8 Since the Discussion Paper was published there have been some further decisions of the European Court of Human Rights in which these principles have been considered.

---

[7] See discussion of this point in *P v Cheshire West and Chester Council; P and Q v Surrey County Council,* [2014] UKSC 19, at paras 43 and 44. In *Chosta v Ukraine* Application no. 35807/05, 14 January 2014, cases involving deprivation of liberty potentially justifiable under Article 5(1) were discussed in the context of an alleged deprivation which could not be thus justified.
[8] See the initial enunciation of these factors in *Engel and others v Netherlands* (1979-80) 1 EHRR 647 at para 59, followed in many subsequent cases, eg *Guzzardi v Italy* (1980) 3 EHRR 333. Both were Plenary Court decisions.
[9] (2006) 43 EHRR 6.
[10] *Storck* at para 74.
[11] Ibid.
[12] (1979-1980) 2 EHRR 387 at para 39.

Kedzior v Poland[13]

2.9 In this case, the applicant was a man who had been undergoing psychiatric treatment since the age of 16. In 2000, when he was in his mid forties, he was diagnosed with schizophrenia. In proceedings resulting in a partial deprivation of legal capacity, his brother was appointed as his guardian; subsequently, at the instance of his guardian, he was declared totally incapacitated.

2.10 Between 2002 and 2012, the applicant was placed in a social care home from which, eventually, he was allowed long leaves of absence in order to visit his family. Throughout his stay, he complained about the placement and attempted to obtain restoration of his legal capacity. In 2009, after refusal of an application for restoration of capacity, a court officer was appointed as guardian and the applicant was transferred to a new care home. The applicant then complained to the European Court of Human Rights of breaches of Article 5.

2.11 In its decision, the court again referred to the need for an assessment of the particular situation of the individual concerned. 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.[14] In determining whether there had been a deprivation of liberty, the key factor was "whether the care home's management ha[d] exercised complete and effective control over his treatment, care, residence and movement". In this case, that objective element of deprivation of liberty was satisfied.[15] Insofar as the subjective element was concerned, it was plain that the applicant had never consented to his stay in the home.[16] The care home was run by the State, and therefore the element of responsibility on the part of the State was also met.[17]

2.12 In considering whether the deprivation of liberty was justified under Article 5(1), the Court accepted that it had been in accordance with domestic law. But the *Winterwerp* criteria were not satisfied. The examination by a psychiatrist which had preceded the applicant's admission to the care home in 2002 had not addressed whether his state of health required him to be placed in a home for people with mental disorders, and was also deficient in its assessment of whether the disorders warranting his confinement persisted.[18] Thus the Court concluded that the applicant's deprivation of liberty was not justified by paragraph (e) of Article 5(1). Moreover, there had not been any regular review of the applicant's confinement and, therefore, Article 5(4) had also been breached.

Mihailovs v Latvia[19]

2.13 The applicant, who had been born in 1947, was admitted to psychiatric hospital in 2000. He was diagnosed as suffering from epilepsy, with psychotic symptoms. With effect from June 2000, he was ruled to be "not legally capable".[20] His wife was appointed as his guardian. He was placed on a waiting list for admission to social care and, in January 2002, was admitted to the Ile Centre in Ile parish. In 2010, the Ile Centre moved to Auru parish,

[13] [2013] MHLR 115.
[14] At para 54.
[15] At para 57.
[16] At para 58.
[17] At para 59.
[18] At para 68.
[19] Application No 35939/10, 22 January 2013.
[20] At para 13.

and the applicant relocated with it. Since 2007, the applicant had been attempting to obtain restoration of his legal capacity. There were also applications in relation to guardianship, with the applicant attempting to have his wife replaced by another individual as his guardian. This finally occurred in September 2011.

2.14 By an application to the European Court of Human Rights lodged in 2010, the applicant complained of breaches of the Convention in a number of respects. He alleged, among other things, that he had been held against his will in a State social care institution for more than ten years, that he could not obtain release, and that he had been fully dependent on his wife, who had been his guardian, who had not represented his interests, and had opposed all attempts by him to defend his rights.[21]

2.15 The government challenged the argument that the applicant had been deprived of his liberty in the Ile institution, and there was a dispute as to the nature of conditions there. The court considered first the regime in the institution when it had been located in the Ile parish.[22] It had been argued by the government that in that location, the Ile Centre was an open institution, with unfenced grounds, some freedom of movement and the ability for residents to receive guests.[23] The applicant disagreed. He pointed out that at that time the centre was a closed-type social care institution, where he had lacked freedom of movement within and outwith the premises. If patients left without permission, the police were informed and the patients forcibly returned.

> "Moreover, the applicant submitted that the Īle Centre had limited space and was surrounded by a stone wall, which was topped with barbed wire. He provided some photographs, taken in 2012, that corroborated this submission. It could be seen from these photographs that the premises, although no longer in use, indeed were surrounded by a stone wall. The Īle Centre had been located on a hill in the middle of a forest, and was completely inaccessible by car in winter, autumn and spring".[24]

2.16 In assessing if the applicant had been deprived of his liberty in these conditions, the Court reiterated the need to consider the person's actual situation, and to take account of a range of criteria such as the type, duration, effects and manner of implementation of the measure in question. The Court further observed that the notion of deprivation of liberty within the meaning of Article 5(1) comprised both the objective and subjective elements, as recognised in previous cases.[25]

2.17 The Court added

> "129. In the context of deprivation of liberty on mental-health grounds, the Court refers to the general principles recently reiterated in the *Stanev* case.[26] In particular, it reiterates that it has found that there has been a deprivation of liberty in circumstances such as the following: (a) where the applicant, who had been declared legally incapable and admitted to a psychiatric hospital at his legal representative's request, had unsuccessfully attempted to leave the hospital[27]; (b) where the applicant had initially consented to be admitted to a clinic but had subsequently attempted to

[21] At para 3.
[22] At para 131.
[23] At para 104.
[24] At para 107.
[25] At para 128.
[26] *Stanev v Bulgaria* (2012) 55 EHRR 22 at paras 116-120.
[27] *Shtukaturov v Russia* (2012) 54 EHRR 27 at para 108.

escape;[28] (c) where the applicant was an adult incapable of giving his consent to admission to a psychiatric institution which, nonetheless, he had never attempted to leave;[29] and (d) where the applicant, a mentally incapacitated individual, who had been placed in a social care home in a block which he was able to leave, was nevertheless under constant supervision and was not free to leave the home without permission whenever he wished so.[30]"

2.18 In the present case, in relation to the applicant's residence in the Ile Centre in Ile parish, the key factor was whether the management "exercised complete and effective control over his treatment, care, residence and movement".[31] Bearing in mind the restrictions on freedom to leave the institution (and the lack of evidence that the applicant had ever left it between January 2002 and April 2010), the limits on social contacts and the fact that the police were involved in returning residents to the Centre, the Court concluded that the applicant had been under constant supervision and was not free to leave. The applicant, despite being legally incapable, had been *de facto* able to indicate his wishes; he had made clear his opposition to the placement and there had been no consent. The home had been State-run. The applicant had therefore been deprived of his liberty within the meaning of Article 5(1).[32]

2.19 Turning to consider the applicant's residence in the Ile centre in Lielbērze, in Auru parish, the Court expressed doubt that this could be considered a deprivation of liberty. Observing that the applicant had acknowledged that the establishment there had been an open one; that the applicant had refused to move to another centre, saying he was satisfied with where he was; that he had been able to leave to spend time with his new guardian and that, in contrast to his spell at Ile parish, he had made no approach to domestic authorities to seek his release, the Court concluded that the government had demonstrated that the applicant had tacitly agreed to stay where he was.[33] The Court therefore accepted that the applicant had not been deprived of his liberty while in the Ile Centre in Auru parish.[34]

2.20 In relation to the *Winterwerp* criteria, the Court observed that neither the psychiatric report prepared at the time of the declaration of incapacity nor the report prepared in connection with the applicant's admission to the Ile Centre in 2002 was adequate. The former report had noted that he suffered from epilepsy, with psychotic symptoms, but had recorded that he did not have a mental illness. The latter report had concluded that in view of the applicant's state of mental health, he could be placed in an institution for people with mental disorders. Whilst noting that the welfare of a person with mental disorder could be a factor to be taken into account in relation to his placement in an institution, this would be in addition to medical evidence: "the objective need for accommodation and social assistance must not automatically lead to the imposition of measures involving deprivation of liberty".[35] The Court referred to the need for it to be reliably shown that an individual was suffering from a "true" mental disorder at the time he was placed in the institution.[36] Given the inadequacy of the assessment in relation to mental disorder, the Court found that the

[28] *Storck v Germany* (2006) 43 EHRR 6 at para 76.
[29] *HL v United Kingdom* (2005) 40 EHRR 32 at paras 89-94.
[30] *Stanev v Bulgaria* (2012) 55 EHRR 22 at paras 124-130.
[31] At para 131.
[32] At para 137.
[33] At para 139.
[34] At para 140.
[35] At para 145.
[36] At para 147.

remaining two *Winterwerp* criteria were also not satisfied[37] and that the deprivation of liberty was therefore not justified by Article 5(1)(e).[38] Finally, the lack of automatic review while the applicant was in the centre in Ile parish led to a breach of Article 5(4).[39]

Chosta v Ukraine[40]

2.21 Although this case does not involve a person detained on the basis of mental disorder, it does address deprivation of liberty in circumstances unlike those previously considered by the European Court of Human Rights.

2.22 The applicant was an employee of a steel company in Ukraine. The company had decided to take measures to address the problem of employees attending for work in an intoxicated condition. Company guards were to apprehend anyone at work in an apparently intoxicated state and take them to an office for a report to be prepared. Employees who disagreed with the report were to be escorted to a clinic for an alcohol test. On 3 August 2002, at about 10 pm, guards saw the applicant leaving work and suspected that he was drunk. They would not allow him to leave the premises. The report prepared in accordance with the procedure outlined stated that he was drunk. The applicant disagreed with the report. At about 11.30 pm, he underwent a test at a local clinic and was found to be sober. A further similar incident involving the applicant occurred on 6 February 2003. An alcohol test on that occasion generated two reports on his condition, which came to opposite conclusions. The applicant complained of breaches of Article 5(1).

2.23 The European Court of Human Rights declared the complaint to be inadmissible, on the basis that the responsibility of the State was not engaged. The State can be responsible for detention by private persons if, having been aware of such detention, the State acquiesces or takes no action to end it. In addition, responsibility may attach for failure to prevent the deprivation of liberty of a vulnerable person of which the State has or ought to have knowledge. In the present case, however, the applicant had not shown that the State was aware of or agreed to his confinement while it lasted. Moreover, despite argument to the contrary by the applicant, he could not be considered "vulnerable".

2.24 The Court also made observations on the question of whether there had been deprivation of liberty within Article 5. In its assessment, it reiterated the need to start with "the concrete situation" of the individual and to take account of the type, duration, effects and manner of implementation of the measure in question. The Court added that

> "The notion of deprivation of liberty within the meaning of Article 5 § 1 contains both an objective element of a person's confinement in a particular restricted space for a not negligible length of time, and an additional subjective element in that the person has not validly consented to the confinement in question (see *Stanev v. Bulgaria*[41]). 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

[37] At paras 149-151.
[38] At para 152.
[39] At paras 154-8.
[40] Application No 35807/05, 14 January 2014.
[41] At para 117.

and the extent of isolation (see, for example, *Guzzardi v. Italy*[42]; *HM v. Switzerland*[43], *HL v. United Kingdom*[44], and *Storck v. Germany*[45])."

England and Wales

Two key cases

2.25 In our Discussion Paper, we analysed two cases concerning deprivation of liberty which had recently been decided by the Court of Appeal. These cases were appealed to the Supreme Court, which heard the appeal in October 2013 and issued its decision in March 2014.[46]

2.26 The first case, *Surrey County Council v CA, LA, MIG and MEG*, involved two young women in the care of a local authority.[47] They were sisters, each suffering from moderate to severe learning difficulty of unknown origin. When the case began, MIG was 18 and was living with a foster carer in the carer's home. MEG was 17 and living in a residential home for those under the age of 19; the home was small, with only four residents. Both sisters attended the same further education unit daily. By the time the case reached the Court of Appeal, the care arrangements for both sisters had changed, but since it was "neither practicable nor appropriate" for the Court of Appeal to conduct a detailed examination of the new arrangements, the focus was on the circumstances as they had existed at first instance.[48] Likewise, the analysis in the Supreme Court addressed the circumstances as they had been at first instance.

2.27 The second case, *Cheshire West and Chester Council v P*, involved a man who had cerebral palsy and Down's Syndrome and required 24 hour care.[49] He lived in a bungalow with two other residents and attended a day centre during the week. Because of challenging behaviour, he required certain forms of restraint, including the wearing of a special garment.

2.28 In each case, the Court of Appeal had determined that the care arrangements did not result in deprivation of liberty. In the case of MIG and MEG, the court was influenced by the "relative normality of the living arrangements", where the two young women could for example go to school or college, and contrasted that with people living in a hospital designed for compulsory detention like Bournewood.[50] In P, the Court of Appeal was particularly influenced by the reason and the purpose, assessed objectively, underlying the care regime, and by a notional comparison between P's situation and that of any other person with his disabilities receiving necessary care.[51]

---

[42] At para 95.
[43] At para 45.
[44] At para 91.
[45] At para 73.
[46] *P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19.
[47] [2010] EWHC 785 (Fam); [2011] EWCA Civ 190. The judgements were discussed at paras 4.38-4.42 of the Discussion Paper. In the Supreme Court, the individuals MIG and MEG were referred to as P and Q respectively but in the following discussion they are referred to as MIG and MEG.
[48] *MIG and MEG v Surrey County Council, CA and LA* [2011] EWCA Civ 190, at para 6 (Lord Justice Wilson).
[49] [2011] EWHC 1330 (Fam); [2011] EWCA Civ 1257. The judgements were discussed at paras 4.49-4.64 of the Discussion Paper.
[50] [2011] EWCA Civ 190 at paras 28-29 (Lord Justice Wilson).
[51] [2011] EWCA Civ 1257 at paras 110-111 (Lord Justice Munby).

The decision of the Supreme Court

2.29 The decisions in both these cases were appealed to the Supreme Court by the Official Solicitor, acting on behalf of the individuals concerned. The appeals were heard by a seven judge Bench.[52]

2.30 Lady Hale, who gave the leading judgement, rejected the idea that the concept of deprivation of liberty was different for the appellants, because of their disabilities and their consequent need for care:

> "45. In my view, it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities."

2.31 The "relative normality" approach was also rejected, although Lady Hale expressed "much more sympathy" with the comparison between MIG and MEG and other teenagers living at home with their families than with the comparison between P (the individual in the *Cheshire* case) and another person with the same level of disability.[53]

2.32 Turning to consider how to obviate "the minute examination of the living arrangements of each mentally incapacitated person for whom the state makes arrangements which might otherwise be required", Lady Hale wondered if there is "an acid test" for deprivation of liberty in these cases. Her view was that the key element is that the person concerned is "under continuous supervision and control and [is] not free to leave".[54] Freedom to leave was explained as the ability "to move away without permission".[55]

2.33 Applying this analysis to the case of P, Lady Hale concluded that the judge at first instance had in substance applied the correct test. It therefore followed that his judgement should be restored. In relation to MIG and MEG, the life lived by MEG was very similar to that of P in *Cheshire*. By contrast, MIG was living in an ordinary family home, but the reality was that her situation was very similar to that of her sister: her foster mother and others responsible for her care exercised complete control over every aspect of her life. For MIG and MEG, therefore, a declaration that they were being deprived of their liberty fell to be made.

2.34 Lords Neuberger, Kerr and Sumption agreed with Lady Hale. Lords Clarke, Carnwath and Hodge agreed with Lady Hale in relation to P, but dissented on whether MIG and MEG were deprived of their liberty. Lords Carnwath and Hodge noted that there was no Strasbourg case in which detention had been found in circumstances comparable to the present.[56] They did not consider that the cases in which the European Court had considered deprivation of liberty in the context of mental disorder provided sufficient support for the

---

[52] Lord Neuberger, Lady Hale, Lord Kerr, Lord Clarke, Lord Sumption, Lord Carnwath and Lord Hodge.
[53] At para 47.
[54] At para 49.
[55] At para 46.
[56] At para 97.

general test proposed by Lady Hale.[57] They were concerned that "nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty".[58] Moreover, it was noteworthy that the suggestion had not been made by anyone (including the court) in the case of *HL* that *HL* was deprived of his liberty when he was in the care of his foster parents.[59]

2.35 For Lord Clarke, the European Court had not held that there was only one question (or acid test). Its approach was more nuanced.[60] He expressed particular agreement with the views of Lords Carnwath and Hodge that "nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty".[61] In each case, the decision of the judge at first instance should determine the matter.

Scotland

2.36 In Scotland, the issue of deprivation of liberty arose in the case of *AB v Bernarda Rodriguez and others*, a decision of the Sheriff Principal of South Strathclyde.[62]

2.37 The Mental Health Tribunal had made a compulsory treatment order under the 2003 Act in relation to a woman, AB, who suffered from amnesic syndrome secondary to alcohol abuse and a bipolar disorder. One of the requirements of the order was that AB reside at Z care home, a facility where there was a keypad locking system governing access to and egress from the premises. In an appeal against the order, it was argued that the conditions at Z care home involved deprivation of liberty, and that this was outwith the provisions of the 2003 Act, which provided only for detention in hospital.

2.38 In refusing the appeal, the Sheriff Principal held that the overriding purpose of the 2003 Act was to provide care and treatment. There were sound reasons for the keypad locking system at Z care home, in general and in relation to AB. There was no evidence before the tribunal of any concern about her having to wait for a staff member to accompany her when she wanted to go out. The Sheriff Principal considered that it was not appropriate to consider such an arrangement as amounting to legal detention.

---

[57] At para 98.
[58] At para 99. Lord Neuberger also expressed agreement with this observation, although he considered it of little weight (para 71).
[59] At para 100.
[60] At para 105.
[61] At para 108.
[62] Sheriff Principal Lockhart, Airdrie, 26 September 2012, 2012 GWD 34-702. The name of the Mental Health Officer is shown in the Opinion as "Rosriguez", under which name the case is searchable on Westlaw. In the Scottish Courts database, the case is indexed under "Rodriguez".

Chapter 3 Discussion Paper: Responses

Introduction

3.1 In our Discussion Paper, published in July 2012, we posed questions on issues pertaining to deprivation of liberty in the context of incapacity. Those who sent responses constituted a broad range of stakeholders: statutory bodies; local authorities; health boards; groups representing those with learning difficulty and groups representing carers; advocacy organisations; academics; professional bodies; judges and individuals. In this chapter, we set out the gist of the responses we received. The names of those who responded are set out in Appendix B. As the questions we asked can be grouped according to their subject-matter, it is convenient to discuss the responses under six general headings.

Family care

3.2 In our Discussion Paper, we observed that a number of cases in England and Wales had involved deprivation of liberty in the context of someone not being permitted to return home to live with their family.[1] In particular, we highlighted the case of *London Borough of Hillingdon v Neary,*[2] where a young man, S, with childhood autism and severe learning difficulty was maintained in a behaviour support unit by a local authority against his own wishes and those of his father, at whose request S had originally entered the unit for short-term respite. It was held that deprivation of liberty had occurred. The statutory deprivation of liberty procedures had been utilised after S had been in care for about four months, but the Court of Protection held that the situation prior to that had also amounted to deprivation of liberty. Features of the arrangement during that earlier period which the Court described as "key" in reaching the view that there was a deprivation of liberty were "[S's] objection to being at the support unit, the objection of his father and the total effective control of S's every waking moment in an environment that was not his home".[3]

3.3 We referred also to the earlier case of *JE v DE and Surrey County Council*,[4] where Munby J (now Munby LJ) had to determine whether an adult (DE) who had suffered a stroke and also had dementia was, or had been at any time since his move to a residential home, deprived of his liberty by the local authority which had placed him there. There was evidence that DE had a considerable amount of freedom in the care home and few restrictions on his contact with the outside world. But Munby J accepted the submissions made on behalf of DE and his wife that his concrete situation was that he was not free to leave "in the sense of being able to remove himself permanently in order to live where and with whom he chooses".[5] Accordingly, he was deprived of his liberty within the meaning of Article 5 of the Convention. Finally, we also observed that in the *Bournewood* case itself, HL

---

[1] At paras 6.48 - 6.51.
[2] [2011] EWHC 1377 (Fam); [2011] 4 All ER 584.
[3] Para 161.
[4] [2006] EWHC 3459 (Fam).
[5] Para 115. Cf the dicta in *Austin v UK* (2012) 55 EHRR 14 at para 55 regarding the importance of not interpreting Article 5 to effect the incorporation of Protocol 4 for those countries which have not incorporated it. Article 2 of Protocol 4 protects the freedom to choose one's residence.

was in effect detained in a psychiatric hospital during a period when his carers were seeking his return home.

3.4 In the light of these decisions, we included two questions in the Discussion Paper concerning possible amendment of the 2000 Act to include a principle supporting a presumption in favour of family care:

> "11. Would there be benefit in a statutory provision to the effect that the family or carers of a person with incapacity who are willing and able to provide a home for that person should not be prevented from doing so?
>
> 12. If so, should that provision be an additional principle in section 1 of the Act?"

3.5 Almost all consultees responded to these questions, but a large majority were against the proposal in question 11. The reasons for opposition were varied. A number of the consultees queried the extent to which such a provision would be beneficial or indeed was necessary, given the current legal position. The Mental Welfare Commission observed that, at present, there would need to be a good reason (risk from family or carers to an adult who lacked capacity to look after their own interests, for example) for the State to intervene and prevent the family of an adult from caring for him or her. This was echoed by several local authorities, who observed that if a family is willing and able to care for an adult, they will not be prevented from doing so.

3.6 For a proposed intervention in an adult's affairs related to place of residence, the principles set out in section 1 of the 2000 Act would apply, so that there would require to be benefit from the intervention. The proposed intervention would need to be compared with other possible approaches. Moreover, account would have to be taken of the wishes and feelings of the adult, and the views of their nearest relative, named person and primary carer. The adult's rights under Article 8 of the European Convention would also require to be recognised.[6] It was therefore difficult to see what an additional principle in section 1 of the Act would add to existing provision.

3.7 Most consultees who were opposed to the creation of a principle of this nature also pointed out drawbacks. As David Cobb observed, it cannot be assumed that accommodation within a family is necessarily benign. Even where there appear to be no risks of abuse, there could be a danger of families feeling obliged or being pressurised to offer care which is in fact beyond them. The Public Guardian pointed out that families can be unrealistic in their expectation of the level of care that will be necessary for someone, with consequent lack of adequate care for that person when they return to the family home.

3.8 For these reasons, we are persuaded that we should not recommend any provision of the nature of a presumption in favour of family care. That does not mean, however, that we have disregarded the points made, in the *Neary* case in particular, about the undesirability of an adult being in residential care when they could and should be at home. The importance of respect for an adult's home is a matter to which we return in Chapters 4 and 6.

---

[6] Professor Tom Guthrie pointed out that there may in any case be a tension between the protection under Art 8 of 'family life' and the protection of 'private life', which implies an ability to develop an independent life away from the family.

Hospital admission

3.9 In assessing the implications of the *Bournewood* case for Scotland, we considered whether certain types of regime – primarily in psychiatric hospitals – should be regarded as always involving deprivation of liberty for a person with incapacity. On this basis, there would be no voluntary or informal admission for such a person, due to their inability to consent to the regime concerned. We asked:

> "9. Should Scots law provide that there cannot be informal admission to a hospital for the treatment of mental disorder of people who lack the capacity to consent to that admission?"

3.10 Our suggestion of a prohibition on informal admission generated responses which covered a number of different issues.

3.11 Many of those who responded specifically acknowledged the effect of the *Bournewood* case: that in relation to a period as an in-patient in a psychiatric hospital, lack of objection from a person who does not have capacity to consent will not prevent the particular regime in operation from being found to constitute a deprivation of liberty.

3.12 Consultees also recognised that admission to hospital under the formal procedures of the 2003 Act affords certain benefits, principally in conferring rights of challenge and periodic review, which are absent if the person has been admitted informally. The Law Society commented:

> "It is the experience of some of the committee members that there are still a fair number of initial informal admissions (usually in an effort to engage the patient on a voluntary basis and to avoid formal measures being used too quickly), which then progress to formal measures. While these may be well intentioned, and actually often appropriate, there are no legal protections in place to safeguard these individuals' interests. There is a lack of oversight of the interests of the incapable person in these situations."

3.13 People First agreed that there should not be informal admission to hospital; in addition, they expressed the view that the definition of mental disorder should be reviewed to exclude intellectual or cognitive impairment or learning difficulty. They considered that there must be formal legal decisions and explanations for admission to hospital and that learning difficulty (on its own) should not be a sufficient ground.

3.14 Others pointed out that the formal detention of individuals who have cognitive impairment can be perceived very negatively. The Association of Directors of Social Work and North Lanarkshire Council both made the point that formal detention would be likely to be of concern to carers and patients who have not previously been the subject of such measures. Connecting Carers described any increased use of measures such as Compulsory Treatment Orders as being "of particular concern" for older adults with dementia.

3.15 Those who opposed prohibition of informal admission included the Sheriffs' Association, the Mental Welfare Commission and the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists in Scotland ("RCPS(OAP)").

3.16 In relation to the idea that all admissions should be formal, the Mental Welfare Commission said:

> "We would strongly object to such a change in the legislation. This would be a significant departure from established law and practice which would be distressing for many relatives, confusing for some patients and very demanding on the time of MHOs, consultant psychiatrists, and the Mental Health Tribunal as well as creating a further demand on the Legal Aid budget - all without any tangible benefit for these adults.
>
> …
>
> What is not addressed here is the question of admission of people to hospital for physical healthcare reasons who lack capacity to consent. There needs to be clarity as to the authority under which such care is provided. It would be helpful to examine the parameters of Part 5 of the Act re the nature of treatments allowed, the setting in which it is delivered and the arrangements for transporting adults to where the treatment is to be provided."[7]

3.17 RCPS (OAP) commented that, logically, all hospital admissions of people who lack capacity to consent to admission, but who are assenting, should be governed by incapacity legislation. They described this as a *reductio ad absurdum*.

3.18 We have considered at length the points made to us concerning hospital admission. We recognise that there are a number of relevant aspects, and that the circumstances which may result in those who have a degree of incapacity being admitted to hospital are varied.

3.19 We have concluded that there does not require to be an express prohibition of informal admission to a hospital for the treatment of mental disorder of people who lack the capacity to consent to that admission. The position is already regulated by the terms of Article 5, as it was held to apply in *HL v United Kingdom*.[8] The jurisprudence of the European Court of Human Rights in relation to Article 5(1)(e) also includes the *Winterwerp* criteria,[9] so that deprivation of liberty on the basis of mental disorder should not occur solely on the basis of the existence of a mental disorder; as previously discussed, there must also be evidence that the disorder warrants compulsory confinement, and it must persist throughout the period of confinement.[10] The 2003 Act can be used to provide the necessary safeguards in relation to admission to hospital for psychiatric treatment of those who are unable to consent.

3.20 We also appreciate, however, that many people with cognitive impairment, especially dementia, are admitted to hospitals for attention to their physical health. In Scotland, in the financial year 2012-13, there were 232,269 emergency hospital admissions of those over 65.[11] Of course, only a proportion of such admissions will have been of people with any

---

[7] We address the issue of transport below at paras 4.9-4.11.
[8] (2005) 40 EHRR 32.
[9] *Winterwerp v Netherlands* (1979-1980) 2 EHRR 387 at para 39; see Discussion Paper at para 2.3.
[10] See para 2.7 above.
[11] Available at http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/
In one study, all those over 70 with unplanned acute admission to the medical acute assessment unit (i.e. excluding surgical specialities) of a large general hospital in London over a 6 month period were investigated. Of the 77% who could be assessed, 42.4% had dementia: Sampson et al, "Dementia in the Acute Hospital Setting: prospective cohort study of prevalence and mortality" British Journal of Psychiatry, 2009, 195, 61-66. As at the end of 2010 it was estimated that people aged over 65 with dementia were occupying 25% of beds in acute

cognitive impairment. Hospital admission of a person with cognitive impairment can be because of fractures or infectious illness, but it can also involve a requirement for attention to nutrition and personal care due to the effects of dementia. Many such admissions are short-term.

3.21 Where a patient is receiving medical treatment in relation to which they do not have the capacity to make decisions, the provisions of section 47 of the 2000 Act must be utilised to supply the necessary consent. But this part of the Act relates only to consent.[12] We have ascertained that measures are also being adopted to prevent patients, usually those who have dementia, from leaving hospital wards. These measures can include electronic tagging or close monitoring of ward exits to prevent departure. Notwithstanding the benevolent motivation underlying such measures, the consequences of confining a patient to a hospital ward by use of such measures appears to us to be *de facto* detention, therefore incapable of authorisation under section 47,[13] and to require an authorisation process. We discuss this further in chapters 4 and 5.

Definitions

3.22 Any discussion of deprivation of liberty and incapacity will confront issues of definition and recognition: what is a deprivation of liberty in this context? As early as 1681, Viscount Stair characterised restraint used in relation to a person of unsound mind as something which is "not against any act of his lawful liberty and is done as a duty in us of love and mercy".[14] Today, it is accepted that duties may be owed by the State to people who are vulnerable because of mental disorder.[15] The provision of necessary care in such a situation may involve restriction of liberty. But the concepts of restriction of liberty and provision of care may no longer be seen as mutually exclusive.

3.23 In our Discussion Paper, we asked a series of questions about defining deprivation of liberty in the context of incapacity. We were concerned that simply to direct those who require to recognise that state of affairs, especially in their daily activities, to the Strasbourg jurisprudence on Article 5 would not offer sufficient practical guidance.[16]

3.24 We asked:

> "7. Do consultees agree that the present lack of clarity on deprivation of liberty in Scots incapacity law is unsatisfactory?
>
> 8. Would it be desirable for there to be greater specification in Scotland on what is to be regarded as deprivation of liberty, beyond a cross reference to Article 5?
>
> …

---

wards in general hospitals in Scotland. This figure was contained in a report published by the Mental Welfare Commission: http://www.mwcscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf As at the end of March 2014 there were 16,484 staffed beds in acute specialities across all the NHS hospitals in Scotland. Applying the 25% estimate would generate a figure of 4,121 people with dementia in acute wards in general hospitals in Scotland at that time.

[12] See p 7 of MWC report http://www.mwcscot.org.uk/media/127960/section_47_report.pdf

[13] Section 47(7) provides that the authority conferred by s 47 "shall not authorise the use of force or detention" other than on the basis of immediate necessity.

[14] Stair, *Institutions of the Law of Scotland* I, 2, 5 (first edition, 1681). See Discussion Paper at para 3.93.

[15] See Discussion Paper at paras 2.64-2.69.

[16] Discussion Paper at paras 6.15-6.17 and 6.40-6.41.

13. Do consultees agree that provision to the effect that certain measures do not constitute deprivation of liberty would be of assistance?

14. If so, what should those measures [negative definition] be?

…

16. Would there be benefit in provision to the effect that deprivation of liberty occurs whenever the management of a facility exercise complete and effective control over the assessment, treatment, care, residence and movement of an adult?"

3.25 We also asked whether any such specification should be provided in legislation or in guidance.

3.26 Twenty three of twenty five consultees who answered question 7 agreed that there was a lack of clarity as to the meaning of deprivation of liberty in incapacity law and that this was unsatisfactory. Some of those who responded doubted the wisdom and/or practicability of defining the term for Scotland. Tom Guthrie drew attention to observations in a decision of the Court of Protection in England, where it is suggested that it is not in the best interests of the adult at the centre of a case if the courts "get tied down in the difficult, time consuming and unnecessary task of deciding whether or not the implementation of a care regime constitutes a deprivation of liberty".[17] In their response to question 7, RCPS (OAP) said that they agreed "emphatically" with the proposition that the current lack of clarity was unsatisfactory. They added:

> "The lack of definition of what constitutes deprivation of liberty virtually precludes assessment of mental capacity in respect of this. For such an assessment to be specific to purpose, there requires to be clarity as to what that purpose is."

3.27 In answering question 8, most consultees favoured greater specification of what constitutes deprivation of liberty, and the majority of them said that guidance containing examples would be useful.

3.28 In observations on the approach adopted in England and Wales of anchoring the statutory definition to the Strasbourg jurisprudence, Lucy Series pointed out that this had resulted in "an extremely unstable application" of the DoLS. She commented that it was difficult to see how this could be avoided given that Article 5 jurisprudence both domestically and at the level of the European Court was in a very fluid state. Uncertainty over what constituted a deprivation of liberty was reflected in the significant variations between local authority areas as to the number of DoLS authorisations and applications that had been made. Instead of focussing on the meaning of deprivation of liberty in Article 5, she suggested attending to the real social risks when safeguards are not in place, such as highly restrictive institutional regimes and risks of inappropriate and excessive restraint, seclusion and sedation.

3.29 The principal concern among those who were opposed to attempts to achieve a definition of the concept of deprivation of liberty within any scheme of safeguards for Scotland was the fluidity of the jurisprudence. Any definition for Scotland would require

[17] *A local authority v PB & P* [2011] EWHC 2675 (Fam), para 64 (vi)(f).

accurately to reflect that jurisprudence as it evolved, leading to difficulties of formulation and maintenance which several consultees considered insurmountable.

3.30 Similar observations were made in relation to the idea of a "negative definition" (question 13) although, overall, consultees were almost equally divided as to whether this was a good idea or not. People First thought that such a provision could be useful, but they observed that reference to the question of motive or intent or assessment of professionals "would leave us still at the mercy of those professionals and their uncontested views".

3.31 The Sheriffs' Association thought that any attempt to codify some aspects of Strasbourg jurisprudence would be likely "to further complicate and confuse an already complex situation".

3.32 Those who saw some potential for assistance from such a list suggested what it might comprise. The Mental Welfare Commission suggested (in response to question 13) measures which in and of themselves would not be likely to constitute a deprivation of liberty:

- "Restraint to prevent harm to a person who lacks capacity where this is proportionate to the likelihood and seriousness of the harm;
- Preventing a person from leaving a care home or hospital unaccompanied because there is a risk that they would try to cross a road in a dangerous way;
- A locked door on a ward or unit, in itself, is not as important as the ability of the adult to exercise a right of egress;
- A temporary refusal to let a patient leave hospital or a care establishment without an escort for the purpose of safeguarding the patient, not the public;
- Placing reasonable limitations on the visiting of the patient by relatives or carers;
- Dissuading or distracting a confused patient/resident from attempting to leave the ward or unit, using more than non-coercive insistence and direction in non-emergency situations to ensure that a resisting patient receives necessary treatment."

3.33 Aberdeen City Council thought that where decisions about care are promoting the principles of the 2000 Act, no deprivation of liberty should be taken to arise. The Association of Directors of Social Work and North Lanarkshire Council suggested that apart from measures mentioned in the case law, measures to protect the life, health and wellbeing of the individual should be considered as not constituting deprivation of liberty. David Cobb suggested as relevant factors the ability to leave the place of residence, to receive visitors and to communicate with the outside world as well as confinement to certain locations within the residence.

3.34 Hilary Patrick pointed out that, if such a list were to be prepared, consideration would have to be given to:

- The appropriate inspection regime to protect the person against abuse;

- Ensuring appropriate procedures for review;

- Ensuring that the adult and relevant proxy decision makers were aware of their legal rights to challenge the proposed arrangements.

3.35 In our question 16, we put forward as a suggested definition the words frequently used in the Strasbourg case-law when a finding of deprivation of liberty is made in relation to a person with mental disorder. Ten consultees supported the idea of utilising such a provision as a definition, six considered it a good starting point with some modification and twelve were against it. The Senators of the College of Justice supported such a provision on the basis that it could be applied in a practical way by those involved in the care of adults with incapacity living in residential care, on a case-by-case basis. They were also attracted by the wording being derived from the decision of the European Court of Human Rights in the *Bournewood* case. Others in favour included Aberdeen City Council, Dr Jill Stavert, Scottish Independent Advocacy Alliance, North Lanarkshire Council and the Scottish Consortium for Learning Disability.

3.36 Several consultees, including People First, West Dunbartonshire Partnership, North Ayrshire Council and the Faculties of Psychiatry of Intellectual Disability and Child and Adolescent Mental Health of the Royal College of Psychiatrists in Scotland ("RCPS(ID/CAMH)") expressed concern that it would be very difficult to achieve consensus as to the meaning of terms such as "complete", "effective", "control" and "management of a facility."

3.37 Finally in relation to questions of definition, we asked about the preferred vehicle for any greater specification. Responses were split, with all options (legislation alone, legislation plus guidance or guidance alone) attracting some support. Arguments against the various options tended to be mirror images of each other, with those who were opposed to legislation being concerned that it would be too inflexible in what is perceived to be a dynamic area, and those who expressed reservations about guidance referring to its uncertainty.

3.38 Although a majority of consultees thought guidance had some role to play, we noted that People First, the Scottish Independent Advocacy Alliance, the Patients' Advocacy Service and the Equality and Human Rights Commission were all in favour of definition in legislation. People First commented that guidance is "still open to exercise of professional judgement". The Equality and Human Rights Commission said:

> "Any provision in relation to what amounts to a deprivation of liberty (and therefore what does not) should be in legislation rather than guidance, although guidance would provide useful assistance in providing practical examples of such measures. This would ensure that the provisions have statutory weight and would promote greater consistency."

Process for deprivation of liberty in community settings

3.39 In our Discussion Paper, we also addressed the question of what should happen regarding deprivation of liberty in non-hospital settings. We were thinking primarily of care homes, including small group facilities, and adult care placements where people with cognitive impairment may live. At present, there is no process designed to authorise any deprivation of liberty in such settings. As the State is almost always involved in the

arrangements concerned, whether in running the facilities, in funding the person's care or in inspecting the service, we considered that a specific process would probably be required to ensure compliance with Article 5. Thus, we asked questions designed to assist in determining the content of such a process.

3.40 We asked:

> "21. Do consultees consider that the Adults with Incapacity (Scotland) Act 2000 should make clear that an attorney acting under a welfare power of attorney has the power to deprive, or authorise others to deprive, an adult with incapacity of his or her liberty?
>
> 22. If so, should the existence of such a power depend on whether there is provision to that effect in the power of attorney document?
>
> 23. If such a power can be conferred upon and exercised by a person acting under a power of attorney, what steps could be introduced to enable the adult to access prompt review of the deprivation by a Court, and periodic review thereafter?
>
> 24. Do you agree that the Adults with Incapacity (Scotland) Act 2000 should be amended to provide that a guardian with welfare powers may deprive an adult of his or her liberty, or authorise another person to do so, if such a power is expressly conferred by the Court?
>
> 25. Do consultees agree that the existing provisions regarding intervention orders should be amended to provide for deprivation of liberty to be authorised by the Court, by a specific type of intervention order?
>
> 26. What procedures and evidential requirements should apply to any new form of court order authorising deprivation of liberty for a person with incapacity?"

Authorisation by an attorney

3.41 Twenty seven consultees answered question 21. Fourteen were in favour of an attorney having such a power, eight were against and five were equivocal. Nine of those who answered in the affirmative were careful to emphasise that their answers were given on the basis of such a power having been expressly granted by the adult in the original power of attorney document, as referred to in question 22. The Equality and Human Rights Commission specifically supported such a proposal as "promoting the principles of autonomy and self-determination", two objectives also specifically referred to by the Law Society. Others thought there would need to be additional safeguards if authorisation by an attorney were to be permitted.

3.42 Among the consultees who were opposed to an attorney having this power, the Sheriffs' Association explained that, in principle, they oppose any deprivation of liberty without clear authority derived from a judicial act (unless it is by a medical practitioner subject to judicial oversight). The Mental Welfare Commission were opposed to the idea. They said:

> "[T]his is too dangerous a step to take because it will always be too difficult to guard against and/or establish the existence of undue influence on the person granting the power of attorney."

3.43 West Dunbartonshire Partnership expressed similar concerns, but recognised that

> "[I]t is entirely consistent with the ethos of the legislation that an adult who has capacity can opt to grant authority to their spouse, family member, carer, or friend who they trust to make decisions on their behalf in the event of a loss of capacity."

3.44 Among those who were equivocal, the Association of Directors of Social Work referred to the case of Mr and Mrs D which, at least in part, underpinned the Mental Welfare Commission response.[18] Hilary Patrick also referred to the Mr and Mrs D case, but expressed her support for the proposal.

3.45 The majority of consultees who answered question 22 thought that such powers should be explicit in the power of attorney document before this could be a valid route to authorisation. NHS Greater Glasgow and Clyde suggested, however, that authority to sanction deprivation of liberty "could be implied by the general powers granted for welfare decision-making", although the granting of explicit authority "would be a safer approach".

3.46 Question 23 reflected the need for any administrative process to be buttressed by the availability of prompt access to a court.[19] Sixteen consultees made substantive suggestions. These fell into the following broad categories:

- A right of appeal by the adult to the sheriff court;
- Notification of the exercise of the power (to the Office of the Public Guardian/Mental Welfare Commission/the appropriate local authority);
- Introduction of a time limit, so that after a certain period there would require to be a review (possibly by the sheriff court) and regular reviews thereafter;
- The Mental Health Tribunal proposed a right of challenge by the granter, with reviews at regular intervals thereafter; and
- The establishment of a new body with a review function, with NHS and local authority representation but a majority of independent members.

Authorisation by a guardian

3.47 Twenty two of the twenty six consultees who answered question 24 were in favour of a guardian being empowered to deprive an adult of their liberty. The Faculty of Advocates observed that the power to make such decisions "should only be operable where the Court has expressly conferred same and detailed in an appropriately framed Order that the decision may be made", with detail as to circumstances, time limit for implementation, procedural safeguards regarding *Winterwerp*[20] criteria, assessment, monitoring and review. The Legal Services Agency also wanted to see additional safeguards in this scenario, including provision for periodic review. Three consultees mentioned the possible involvement of the Mental Health Tribunal. The Scottish Consortium for Learning Disability considered

---

[18] The Mr and Mrs D case concerned abuse of a power of attorney. It was the subject of an investigation and report by the Mental Welfare Commission and generated the preparation of fresh guidance by the Law Society of Scotland. This guidance applies to any solicitor instructed or consulted with a view to certifying or preparing a continuing or welfare power of attorney. See further at para 4.60 below.

[19] See our Discussion Paper at paras 2.84-85.

[20] *Winterwerp v Netherlands* (1979-1980) 2 EHRR 387 at para 39.

that a guardian should only be able to deprive a person of their liberty, or authorise this, if an express power is conferred by a court. They supported only specific authorisation, that is relating to a particular place and length of time, and would like to see additional provisions governing review or appeal.

3.48 Two consultees were against this change. One said that no such amendment should be made and that it could not practicably be applied. They did not explain their view. The other did not agree that blanket powers of this kind should be conferred on anyone, be they guardians, attorneys or responsible medical officers. The remaining two consultees were equivocal about guardians being able to authorise deprivation of liberty.

Intervention orders

3.49 As far as utilisation of intervention orders was concerned (question 25), there was a range of responses. The Equality and Human Rights Commission and the Public Guardian both responded that the existing provisions governing intervention orders could be used to cover the authorisation of deprivation of liberty. Six consultees thought that the existing provisions could be amended to make express provision for deprivation of liberty to be authorised by means of an intervention order, subject to the necessary safeguards being put in place. The Law Society wanted to see a requirement that where an intervention order was intended to cover authorisation of a deprivation of liberty, this should be provided for expressly. The Mental Health Tribunal also took that view. North Ayrshire Council took the view that, in order for deprivation of liberty to fall within the scope of existing provision for intervention orders, what would be needed would be a definition of “deprivation of liberty” in the 2000 Act. This would then apply automatically to any orders providing for such deprivation.

3.50 Seven consultees supported a new specific type of intervention order: the Faculty of Advocates reiterated the necessity for specified procedural safeguards reflecting the *Winterwerp* criteria; independent assessment; monitoring and automatic periodic review. NHS Greater Glasgow and Clyde wanted orders to be cheaper and speedier to obtain. RCPS (ID/CAMH) wanted courts which are highly accessible to families in this situation. People First agreed with the proposal, if the result was that there must be a court order before anyone can be deprived of their liberty. The Sheriffs' Association also supported the principle that a person should only be deprived of his or her liberty with the authority of the court, but made reference to problems of definition and of resources.

3.51 Six consultees had reservations about the proposal, due to the perception that intervention orders are for "one off" situations whereas deprivation of liberty requires continuing authorisation/supervision/reporting/accountability.

Procedures and evidential requirements of new court order

3.52 Fifteen consultees made responses which were specific in detailing material and/or processes they thought were required.

3.53 There was support for the view that the reports instanced in the Discussion Paper should be provided (medical report plus report from social worker or manager of care facility) as well as for adherence to the principles set out in section 1 of the 2000 Act. The Faculty of Advocates suggested a fast track summary application to a specialist division of the sheriff

court. They thought the order would require to be specific as to method of implementation, duration, place and review. The Legal Services Agency favoured a medical report prepared by a Relevant Medical Practitioner[21] and a report from a mental health officer. The Mental Welfare Commission supported provision of the same reports as are provided at present for guardianship applications – two reports from doctors, one of whom is a "relevant practitioner", plus a report from a mental health officer.

3.54 Other consultees suggested that the requirements be similar to those for compulsory treatment orders.[22] RCPS (ID/CAMH) wanted a process as similar as possible to one of the existing processes. They thought that an application made by managers of the establishment where the adult lives could generate a conflict of interest. The Senators of the College of Justice, on the other hand, thought a duty on the managers to make an application "would seem an appropriate safeguard". The Sheriffs' Association expressed concern about new forms of court order, but if these were to be introduced, then the procedures and evidential requirements should not be significantly different from those which currently apply**.**

3.55 Hilary Patrick thought that in addition to the requirements for medical reports and reports from mental health officers, certain additional requirements should be met before an adult could be deprived of his or her liberty. In particular, she referred to the need for any authorisation to be restricted to measures which have become necessary, not those which 'may be needed in the future', but which would not necessarily be implemented. She mentioned also the use of safeguarders, and access to independent advocacy, as well as the need to avoid granting orders for an indeterminate time, and the need for review and continued justification.

Consent by surrogate decision maker

3.56 The Discussion Paper also contained three questions based on a comment by the European Court in the *Stanev* case:

> "The Court observes in this connection that 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".[23] (emphasis added).

3.57 The reference to "valid replacement" had led us to wonder if it might be possible to construct provisions of domestic law based on the premise that consent by a surrogate decision-maker (an attorney or guardian) prevents a given set of restrictions from amounting in law to deprivation of liberty. This would occur because the “valid replacement” would constitute consent. Thus, the subjective requirement before there can be a deprivation of liberty, according to the jurisprudence of the Strasbourg Court, would not be met.

3.58 The relevant questions were:

---

[21] This is a reference to s 57(6B) of the 2000 Act, linking to approved medical practitioners under s 22 of the 2003 Act.
[22] By s 63, read with ss 57 and 61, of the 2003 Act, two reports from medical practitioners and one from a mental health officer are required before a compulsory treatment order can be made.
[23] *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 130.

"18. Should Scots law define circumstances in which the consent of a substitute decision-maker would represent sufficient authorisation for an adult lacking capacity to be accommodated in conditions which would otherwise amount to deprivation of liberty?

19. If so, what should those circumstances be?

20. Should there be circumstances in which such consent would not be sufficient?"

3.59 We did not receive any responses which favoured development of provisions based around this observation from the European Court of Human Rights. Having reflected further on the matter, we do not think it would be sensible to base recommendations on this isolated passage from the European Court. In practice, it would have no real effect on guardians, since guardianship would probably require to include an appropriate power (perhaps "to consent to residence in conditions which would otherwise amount to a deprivation of liberty"). Little would be gained by such a provision, and confusion would be likely. In the longer term, if models of supported decision-making become more established in the domestic laws of the Member States of the Council of Europe, it may be that the European Court of Human Rights will explore the extent, if any, to which the subjective element of deprivation of liberty (consent by the person) can fit with these other models, but that will take time to address and develop.[24]

3.60 As far as powers of attorney are concerned, the idea of taking people whose circumstances would otherwise amount to deprivation of liberty out of all independent authorisation and monitoring arrangements is not immediately attractive. It is also debatable that the European Court would sanction such an approach, even if based on its own dicta. For these reasons, we have not taken the ideas behind questions 18 to 20 any further forward.

Release provision

3.61 The 2003 Act includes a provision which was intended to deal with the type of situation which had occurred in England in relation to HL, the individual at the centre of the *Bournewood* case, namely *de facto* detention in a psychiatric hospital. Section 291 of the Act provides:

"… **291 Application to Tribunal in relation to unlawful detention**

(1) This section applies where, otherwise than by virtue of this Act or the 1995 Act, a person ("the patient")–

(a) has been admitted to a hospital; and

(b) is being given treatment there primarily for mental disorder.

(2) A person mentioned in subsection (4) below may apply to the Tribunal for an order requiring the managers of the hospital to cease to detain the patient.

(3) On an application under subsection (2) above the Tribunal shall–

[24] These models are largely derived from Art 12 of the UN Convention on the Rights of Persons with Disabilities.

(a) if satisfied that the patient is being unlawfully detained in the hospital, make the order mentioned in subsection (2) above; or

(b) if not satisfied about the matter mentioned in paragraph (a) above, refuse the application.

(4) The persons referred to in subsection (2) above are–

(a) the patient;

(b) the patient's named person;

(c) if the patient is a child, any person who has parental responsibilities in relation to the patient;

(d) a mental health officer;

(e) the Commission;

(f) any guardian of the patient;

(g) any welfare attorney of the patient; and

(h) any other person having an interest in the welfare of the patient.

(5) Subsection (2) above is without prejudice to any right that a person has by virtue of any enactment or rule of law.

(6) In subsection (4)(c) above, *"child"* and *"parental responsibilities"* have the same meanings as they have in Part I of the Children (Scotland) Act 1995 (c.36)."

3.62 In our Discussion Paper, we queried whether there should be a like provision in relation to *de facto* detention in facilities other than hospitals.[25] We asked:

"27. Would there be benefit in a statutory provision entitling an adult or other persons acting on his or her behalf to apply to the sheriff court for an order requiring the managers of residential premises to cease unlawful detention of the adult?"

3.63 Twenty-two of 26 consultees who responded to this question were in favour of a provision along the lines proposed. NHS Greater Glasgow and Clyde and the Sheriffs' Association were of the view that such a provision would provide an additional and important safeguard. The Faculty of Advocates and David Cobb mentioned that such a provision may satisfy part of the requirements of Article 5(4) of the ECHR. The Faculty also pointed out that such a provision would provide a valuable review process in circumstances where, for example, review of a decision to detain someone had not taken place (despite being so required), or where there had been a significant change in the capacity of the adult**.**

3.64 Several of the consultees mentioned that such a provision should be similar to section 291 of the 2003 Act. The Mental Health Tribunal asserted that section 291 "appears to operate well in practice" but other comments implied that section 291 is not often used. This appears to be borne out by data we have obtained from the Mental Health Tribunal.

[25] Section 291 refers simply to "hospital" which, by s 329(1) means any health service hospital so, for the provision to be available, treatment would not have to be in a psychiatric hospital, although it would, by s 291, require to be primarily for mental disorder.

We understand that between 2006 and 2013 a total of 29 applications were made to the Tribunal under section 291. The Tribunal refused the application in 15 cases and made an order in 14 cases. Some of these cases reflected resort to the provision in circumstances where an irregularity in purported detention had occurred, rather than a situation of *de facto* detention without any formal process taking place.

3.65 Questions of forum were raised by consultees; because of the similarity with section 291, it might be that any applications in relation to non-hospital *de facto* detention should also go to the Mental Health Tribunal. On the other hand, this could be said to create an anomaly in incapacity law, were other applications to continue to be made to the sheriff court. It was also observed that there was the potential for a divergence of approaches between the Mental Health Tribunal and the sheriff courts as to when a deprivation of liberty is unlawful.

3.66 The Mental Welfare Commission suggested that the provision should not only apply in residential premises but also in small domestic units within the community.

3.67 Those consultees (four in number) who were not in favour of the proposed provision were, for the most part, of the view that existing legislation offered sufficient protection.

Chapter 4 Overview of proposed reforms

Introduction

4.1 As we explained in the previous chapter, we have become aware that, primarily in relation to treatment for physical illness or the need to safeguard physical health as a consequence of dementia or other cognitive impairment, people are being confined to hospital wards without any underlying legal process. Despite the benevolent motivation underlying such measures, this appears to us to be *de facto* detention, therefore incapable of authorisation under section 47 of the 2000 Act.[1] An authorisation process is required. Separately, there are people in residential facilities in Scotland who are subject to considerable restriction in their daily lives. We consider that there needs to be a process whereby such restriction takes place only if justified and authorised. Finally, we are concerned at the asymmetry of having a fallback measure to allow the cessation of detention to which someone is *de facto* subject in a hospital where they are being treated primarily for mental disorder but no such provision addressing *de facto* detention in other contexts.[2] In this chapter, we present an overview of our proposals for reform to address these issues.

Hospitals

Inpatient care

4.2 In the last chapter, we highlighted points made to us in response to our questions about hospital admission of people with cognitive impairment. We noted that admissions which are not covered by the provisions of the 2003 Act may involve *de facto* detention. Most often, this is because the admission is for reasons connected to an individual's physical health. There is no bright line between physical and mental health, however. For example, a person with dementia may need medical treatment for an infection and care to alleviate the effects of the dementia on their physical well-being.

4.3 The breadth of the range of health problems which may require the involvement of professionals is recognised in the definition of "treatment" in Part 5 of the Adults with Incapacity (Scotland) Act 2000. Section 47(4) provides:

> "(4) In this Part *"medical treatment"* includes any procedure or treatment designed to safeguard or promote physical or mental health."

4.4 Part 5 is, however, directed to the provision of authority for the giving of medical treatment. It does not deal with arrangements which may be required to keep a patient safe while they undergo that treatment. This is not always understood. In their 2013 report on Part 5, the Mental Welfare Commission stated:

---

[1] Section 47(7) provides that the authority conferred by section 47 "shall not authorise the use of force or detention" other than on the basis of immediate necessity. Further detail on the scheme contained in part 5 of the 2000 Act is set out at para 1.8 above.

[2] We acknowledge that, in some circumstances, remedies may be available through judicial review.

> "We found one Section 47 certificate in a general hospital setting which stated that the patient was incapable in relation to "the decision to leave the hospital against medical advice". The Section 47 certificate does not give authority to detain someone on this basis. Section 47 of the Act does not permit the use of force or detention "except where immediately necessary and only for as long as is necessary". This means that in an immediate situation it is reasonable to prevent a person from leaving hospital for his/her own safety. If the person continually expresses a desire to leave or attempts to leave and has to be prevented from doing so then we do not think that the certificate gives authority for that level of intervention.[3]"

4.5 We share that view, although it is possible that the completion of a section 47 certificate in that case reflected unease concerning the legal basis on which such measures could be taken, and an attempt to regularise the position.

4.6 In the previous chapter, we drew attention to comments made in response to our Discussion Paper about the safeguards which accompany formal detention. The benefits of detention under the 2003 Act relate primarily to the conferring of rights of challenge and periodic review. [4] Indeed, periodic review is not merely a benefit for those who are detained; it is a requirement of Article 5(4) of the ECHR.

4.7 On the other hand, to introduce a system for admission to general hospitals which mirrored the provisions of the 2003 Act would be overly complex. As we have already observed, many admissions for acute treatment are short-term and take place in order to provide, in whole or in part, physical care. Many such admissions are in response to urgent need. Measures adopted to prevent people thus admitted from leaving hospital wards are designed to protect them from the risk of accidental injury. The need to take such measures may be pressing, albeit not of the immediate nature justifiable by the principle of necessity.[5] Such measures may even be required by Articles 2 and 3 of the ECHR.[6] Any process should be relatively simple and straightforward, whilst also protecting the Article 5 rights of the individuals involved. We recommend:

1. There should be a simple and straightforward process to authorise the use of measures to prevent an adult with incapacity who requires treatment for physical health from leaving a hospital unaccompanied.

4.8 As the rationale for this process is to fill a gap in current legislative provision for people who do not have capacity to take decisions in relation to treatment they are considered to require, such a process should be connected to section 47, which already supplies the authorisation for the treatment itself. The process will need to cover more than active treatment however, as individuals may need to remain in hospital for assessment. There should be rights of challenge. We recommend:

2. The process should authorise the use of measures during inpatient assessment as well as actual treatment, and should include rights to challenge the decision to take such measures.

---

[3] http://www.mwcscot.org.uk/media/127960/section_47_report.pdf at p 7.
[4] See discussion in ch 3 at para 3.12 above.
[5] We consider that preventing a patient from leaving a casualty department would be likely to be covered by this principle.
[6] See discussion of the positive duties on the State in the Discussion Paper at paras 2.64-2.69.

Taking people to hospital

4.9 It was also drawn to our attention that concern is sometimes expressed about whether authority exists to transport to hospital those who lack capacity to agree to go there. Accordingly, we have considered whether there should be a specific process for the authorisation of conveying people to hospital, or transporting them from one hospital to another for further treatment. It is our view, however, that this is already covered.

4.10 We can envisage a spectrum of situations, with one end representing a medical emergency where an ambulance is summoned. In such circumstances, the principle of necessity would clearly cover conveying the person to hospital. At the other end of the spectrum, there may be need for an investigation, perhaps a scan or biopsy, to investigate symptoms which may indicate a serious or even life-threatening illness, but the need is not quite so urgent. In those circumstances, Part 5 of the Act appears to us to offer a solution.

4.11 First, as we have observed,[7] section 47 contains a broad definition of medical treatment. This would be wide enough to cover a scan or biopsy, which is a procedure designed to safeguard or promote health.[8] Secondly, the issuing of a certificate under section 47 confers authority to do "what is reasonable in the circumstances in relation to the medical treatment in question".[9] Transporting a person to hospital in order to have the scan, biopsy or other assessment would fall within this description. Thus, the adoption of reasonable means to convey a person to hospital appears to us already to be within the terms of the section, provided a section 47 certificate already exists in relation to the investigation concerned. It is not possible to be prescriptive as to what reasonable means might include, but it is clear that the use of force cannot occur unless there is no other option; any force would require to be immediately necessary and used for the shortest possible period.[10]

Discharge from hospital

4.12 We realise that some of those who are admitted to hospital for what is envisaged as short-term care may remain for much longer than anticipated. In particular, people with dementia may be admitted to hospital as a result of a crisis of some sort, and it may then be appreciated that they can no longer cope at home. Residential care is required. But there may be difficulty in identifying suitable provision. A suitable home, once identified, may not have any vacancies. Funding may need to be arranged. Within the past few years, anxiety about the legal basis for a decision to move someone to a care home has also developed. Any or all of these problems may lead to a phenomenon of delayed discharge, sometimes described by the media as "bed-blocking".[11]

4.13 The Scottish Government has a target, which came into effect in April 2013, that no patient should wait more than four weeks in hospital from the date when they are clinically

---

[7] At para 4.3 above.
[8] See para 81 of the Policy Memorandum to the Adults with Incapacity (Scotland) Bill, http://www.scottish.parliament.uk/S1_Bills/Adults%20with%20Incapacity%20(Scotland)%20Bill/b5s1pm.pdf
[9] Section 47(2).
[10] Section 47(7).
[11] See for example http://www.thetimes.co.uk/tto/news/uk/scotland/article4016507.ece; http://www.express.co.uk/scotland/461775/Bed-blocking-crisis-putting-strain-on-Scottish-NHS

ready for discharge. The most recent figures show that on the bed census date in July 2014, 274 patients had been delayed for more than four weeks after the date when they were clinically fit for discharge. This figure includes 175 patients who were delayed for more than six weeks; 518 patients were delayed for more than 2 weeks.

4.14 There is a separate category of patients, to whom the discharge target does not apply. At the census date in July 2014, there were 308 patients in this category. For 58% of these patients, the delay was attributed to the Adults with Incapacity Act. The glossary to the statistics provides the following elaboration:

> "**Adults with Incapacity (AWI)**
>
> Patients who are deemed clinically ready for discharge but need to remain in hospital because they are going through the Guardianship Order process are recorded as 'Adults with Incapacity Act' (Code 9/51X) within the Delayed Discharges Census. It is recognised these patients may generally experience a delay longer than that which would normally be expected due to the required legal processes and procedures encountered in these cases."

4.15 It is concerning that individuals are remaining in hospital when their medical condition does not require them to be there. It is particularly concerning if the reason for this is connected to legal process. This is not the best use of NHS resources. More importantly for the individual, the conditions under which they may be being kept are unlikely to be optimal, simply because hospitals, particularly those offering acute care, are not designed as places to live. If measures to keep them there, such as electronic tagging, are being used, there may even be a breach of Article 5.

4.16 As we noted above, one of the reasons for delayed discharge appears to be a perception that an adult who does not have capacity cannot be moved into a care home without guardianship being in place. We consider this proposition goes too far. First, the European Court of Human Rights has not expressed the view that the very act of moving someone to a care home is itself a deprivation of liberty. Secondly, we do not consider that, under current Scots law, choosing a residence for someone of 16 or over who cannot make the decision on their own is unlawful unless it is authorised by formal means.

4.17 On the first point, as the European Court of Human Rights has repeatedly observed, for the purposes of Article 5, deprivation of liberty in the context of mental disorder requires an objective element of a person's confinement in a particular restricted space for a not negligible length of time.[12] More recently, the Court has confirmed that the factors it will examine in determining if deprivation of liberty has occurred are the possibility the person has of leaving the restricted area, the degree of supervision and control over the person's movements and the extent of isolation.[13] Thus, it is concerned with the conditions under which someone is living. It is reasonable to proceed on the basis that the taking of a decision by A as to where B should live, when B cannot make the decision him or herself, is not, of itself, a deprivation of B's liberty.[14] The distinction between decisions as to where

---

[12] *Storck v Germany* (2006) 43 EHRR 6 at para 74; *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 117; *DD v Lithuania* [2012] MHLR 209 at para 145; *Kedzior* v *Poland* [2013] MHLR 115 at para 55; *Mihailovs v Latvia* Application No 35939/10, 22 January 2013 at para 128.
[13] *Chosta v Ukraine* Application No 35807/05, 14 January 2014.
[14] See Discussion Paper at para 6.12.

someone should live and how they should live is an important one, and we return to it in relation to deprivation of liberty in community settings.

4.18 On the second point, there are young people in Scotland who have reached the age of 16 but who do not have capacity to decide on their own where they wish to live. They continue to live with their parents, and sometimes to move house with the family, without guardianship orders being in place. At the other end of the age range, there are people with dementia who may have lost the capacity to make their own accommodation decisions unsupported. They are cared for by their partners or other members of their family in their own homes but there is no power of attorney or guardianship in place. It does not appear to us to be correct to describe these arrangements as unlawful on the grounds that they have not been reached through formal legal process.

4.19 Further, we are attracted by the approach of the Victorian Law Reform Commission in Australia, which recently completed a meticulous and detailed review of the law of guardianship in Victoria. As we noted in our Discussion Paper, the Commission discussed in its Report the fact that some of those living in residential care cannot make their own accommodation decisions because they have impaired decision-making ability due to disability.[15] Often, these decisions are taken by relatives and carers. The Commission suggested that the Attorney-General should keep under review the practice of relying largely upon informal arrangements for admission to residential care, but owing to the increasing number of people with impaired decision-making capacity who move to residential care, the Commission did not propose any change to these practices.[16]

4.20 Plainly, people requiring some form of residential care should be given as much support as practicable in order to enable them to take their own accommodation decision if possible. But if this cannot be achieved, there should still be a role for family members in making the decision. Ideally, people who have capacity should grant a welfare power of attorney in favour of the person they choose to make the accommodation decision for them should they lose capacity to make it themselves. If not, and informal arrangements are made by relatives or friends, the principle of *negotiorum gestio* could supply the basis in legal principle for authorisation of what has occurred.[17] In practice, a place is most unlikely to be chosen without some involvement of the local social work department, even if only because of the entitlement to total or partial funding of the care. This offers an opportunity for independent review of the suitability of a particular placement.

4.21 The Scottish Government Guidance entitled "Discharging patients who may lack capacity" (June 2010) states:

> "Sometimes, patients already in hospital will be identified as lacking capacity to make decisions for themselves. In most of these cases, although the adult lacks capacity to take decisions about their own welfare they and their relatives and carers do agree to the care suggested to meet their needs – such as moving to a care home. In these

[15] At para 5.42.
[16] Paras 15.117-15.120 of the Final Report of the Victorian Law Reform Commission on Guardianship.
[17] See comment to this effect in Gloag and Henderson, *The Law of Scotland* (13th edn, 2012) at para 24.24-25.

cases the adult's lack of capacity should not delay them moving on from hospital and an application for guardianship may not be necessary."[18]

4.22 We agree with these views.

4.23 Alternatively, it may be that there is no attorney or family member able to make arrangements for accommodation for a person with incapacity. In that case, and where all concerned are content with suggested arrangements, section 13ZA of the Social Work (Scotland) Act 1968 may be available. This allows a local authority to provide services which an adult with incapacity has been assessed as needing, including residential care, and to move the adult to such accommodation if necessary.

4.24 Lastly, it may be that there is no guardian or welfare attorney and that there is a difference of view as to where a person should live. This may involve a difference between family members and a local authority, or within a family. The person themselves may be unhappy with the proposed arrangements, despite care being taken to select an appropriate resource. In such circumstances, an intervention order could be sought to permit the sheriff to take a decision that the person should live in a particular care home or other facility.[19] Alternatively, and on a more limited approach, an intervention order could be sought to allow the person to move to the care home for a period of assessment or for short term care.

4.25 At present, the requirements for an intervention order are the same as for a guardianship order, including the requirement for reports from two doctors.[20] It is possible that, where there is a dispute confined to whether a person should move to a care home, or a choice between two homes, an intervention order would suffice to resolve the dispute. In such circumstances, the requirement for two medical reports could be seen as excessive.

4.26 We note that the Scottish Government has recently completed a consultation on whether a report from one doctor should be sufficient for a compulsory treatment order under the 2003 Act.[21] We have not consulted on whether a report from one doctor should, in some circumstances, be sufficient for an intervention order under the 2000 Act and we do not therefore make a recommendation to this effect. But we recommend that it be considered, especially for decisions which do not relate primarily to medical matters (in the narrow sense).

4.27 We also note that, as a result of the definition currently set out in section 57(6B) of the 2000 Act, there has to be a report from a psychiatrist in every application for an intervention order. In section 57(6B)(c) there is a power to widen the range of those who can be seen as "relevant medical practitioners" for this purpose, by prescribing other individuals by reference to "skills, qualifications, experience or otherwise". This power does

---

[18] Page 7 of guidance, available at http://www.scotland.gov.uk/Resource/Doc/924/0100330.doc

[19] This was specifically contemplated as a situation in which an intervention order (then termed a "personal order") could be used in our Discussion Paper *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* at para 2.75. See Scot Law Com DP No 94, 1991 available at http://www.scotlawcom.gov.uk/publications/discussion-papers-and-consultative-memoranda/1990-1999
See also *Report on Incapable Adults* at para 6.14. Scot Law Com No 151, 1995 available at: http://www.scotlawcom.gov.uk/publications/reports/1990-1999/This Report was the precursor to the 2000 Act.

[20] Section 53(4) of the 2000 Act, as read with section 57.

[21] Consultation document at http://www.scotland.gov.uk/Resource/0044/00441187.pdf

not appear to have been exercised thus far. It may be that doctors who specialise in medicine of elderly people should be specified under this provision. We recommend:

3. The Scottish Government should consider whether a single report from a medical practitioner should be sufficient for the granting of an intervention order under the Adults with Incapacity (Scotland) Act 2000.

4. Consideration should be given to widening the range of medical practitioners from whom a report can be obtained for the purposes of an application for an intervention order.

4.28 If, in a particular case, an intervention order appears unlikely to provide a satisfactory resolution of a difficult accommodation decision, guardianship will probably be required.

4.29 Questions have also been posed to us about how, as a matter of law, an adult with incapacity can physically be transported from a hospital to a care home or other residential facility. It appears to us that if an accommodation decision has been reached by informal means – and by "informal" we mean using a power of attorney, or a family making its own arrangements or by the social work department under section 13ZA – then the actual transport of the person is similarly acceptable. If there is dispute and an intervention order or a guardianship order is required along the lines suggested above, or if the decision is being taken by a guardian previously appointed, then an ancillary order concerning transport arrangements could be made by the sheriff under section 3 of the 2000 Act.

Duration of authorisation

4.30 The introduction of a process to authorise the use of measures to prevent an adult from leaving hospital will require to include consideration of how long the authorisation should last. We considered whether we should recommend a fixed maximum period for the duration of any such authorisation. But uncertainty is a feature of the delayed discharge phenomenon, and achieving good accommodation arrangements for individuals can take time, even where all concerned are devoting their best efforts to the matter. A certain amount of flexibility appears to us to be necessary.

4.31 We looked at two possible models in developing a provision about duration. First, we noted the provisions which currently apply in Scotland when it is necessary to detain a person in hospital because they have an infectious disease, another of the situations in which Article 5(1)(e) of the ECHR permits deprivation of liberty to be justified.

4.32 The current scheme for such detention is contained in Part 4 of the Public Health etc. (Scotland) Act 2008. Under this legislation, it is possible to obtain from the sheriff an order for the detention of a person in hospital, with the power to remove the person to hospital if necessary as well.[22] There must be, however, a significant risk to public health before an order can be granted.[23] The short-term detention provided for has a maximum duration of three weeks, and can only be authorised by the sheriff. If the three week period proves

[22] Sections 42 and 43 of the 2008 Act.
[23] Sections 42(2)(b) and 43(2)(b).

insufficient, there are additional provisions allowing the sheriff to grant an exceptional detention order, which can last for up to 12 months.[24]

4.33 The second model we examined was the set of provisions in chapter 3 of Part 17 of the 2003 Act, which pertain to detention in conditions of excessive security. These are provisions designed to achieve a change in the regime under which a person is detained, by means of transfer, either from the State hospital or another secure hospital, to another hospital in which the level of security is lower.

4.34 This set of provisions has a fairly complex structure, with an initial declaration by the Mental Health Tribunal that the person does not require the conditions of security under which they are detained, and a consequent requirement on the relevant Health Board to identify another hospital which is suitable for the person and where a place exists.[25] The initial period for compliance is specified and can be up to three months. There are then provisions enabling further orders to be sought in the event of non-compliance, with the second order possibly including a shorter period for compliance and a third order definitively requiring compliance within a shorter period. Recall of orders may be sought.[26] So too may an order for specific performance from the Court of Session, in limited circumstances, by any person with title and interest and also at the instance of the Mental Welfare Commission.[27]

4.35 We consider that neither of these models provides an exact template for the sort of provision required. On the other hand, however, both have features which are useful.

4.36 Detention on public health grounds under the 2008 Act is provided for entirely on the basis of the public interest. Whilst the idea of not seeing a regime as deprivation of liberty if its purpose is to benefit the person detained has been rejected,[28] the nature of the purpose is not irrelevant at the stage of justification. Thus, a purpose which is to benefit other people and can include disinfection, disinfestation and decontamination[29] may call for a particularly stringent process. The situations likely to lead to delayed discharge of people with impaired decision-making capacity are likely to be very different. The goal is to have an individual discharged as soon as possible, not to provide for potentially extensive further detention. The authorisation of the giving of treatment under section 47 is already in the hands of medical or other health personnel. It would be unnecessary and impracticable to provide for orders from the Court in every case where measures require to be taken to provide for the safety of a hospital inpatient who has been identified as needing treatment to safeguard or promote their health.

4.37 Turning to the excessive security provisions, it is noteworthy that they represent a process which could run for seven months. In a particularly difficult case, they might require court action after that before enforcement of a decision by the Mental Health Tribunal could occur. Interpretation of these provisions has proved challenging, and the relevance of

[24] Section 45(3)(b) of the Act.
[25] Section 264 (state hospital) and section 268 (other secure hospital).
[26] Sections 267 and 271.
[27] Section 272.
[28] *Austin v United Kingdom* (2012) 55 EHRR 14.
[29] Public Health etc. (Scotland) Act 2008, s 46(2).

resources has been controversial.[30] We consider that it would not be sensible to copy this process for people delayed in hospital awaiting a move to a care home.

4.38 The range of circumstances which may cause delayed discharge of a person in relation to whom Part 5 of the 2000 Act applies is wide. The main purpose of a provision about duration of measures to prevent a person leaving the hospital is to prevent indefinite *de facto* detention. We consider that it is not possible to prescribe a "one size fits all" solution involving, for example, fixed periods of time. It is our view that allowing the setting of an end date for the implementation of such measures should provide the necessary flexibility. The power to set an end date would be available to the sheriff; it is at least possible that the initiation of an application under such a provision would generate activity which might solve the problem without the need for an order to be granted. We recommend:

5. There should be provision for the setting of an end date for the exercise of authority to implement measures to prevent an adult from going out of a hospital.

(Section 50C of the draft Bill)

Community settings

4.39 The other area in which Scots law does not have a specific process for the authorisation of deprivation of liberty of people with cognitive impairment is in community settings. By "community settings", we mean care homes and certain other arrangements where people live in the community and in relation to which the State has some involvement and, therefore, potential responsibility under Article 5.

4.40 In proposing a different process for community settings we are conscious that questions may be posed concerning the boundary between the two schemes. It is therefore appropriate briefly to address this issue.

4.41 In practice, the boundary between health care and social care is not always clear. For some purposes, the distinction is being removed. We realise also that similar types of care are now found in hospitals and care homes. In broad outline, we have endeavoured to provide a scheme which will apply in hospitals as statutorily defined and a second scheme to apply in care homes and other similar forms of accommodation arrangement. In most cases, hospital care is temporary and relatively short-term. By contrast, the latter type of care is generally being provided in a place which is or becomes a person's home. Our scheme for community settings also includes provision for people who spend short periods in care homes for planned respite care or for other reasons.

Deprivation of Liberty Safeguards

4.42 In our Discussion Paper, we looked in some detail at the DoLS in operation in England and Wales.[31] We noted that the provisions had been subject to criticism for their length and complexity.[32]

---

[30] See the discussion by the Supreme Court in the appeal *G v Scottish Ministers and another* [2013] UKSC 79; 2014 SLT 247.

4.43 Recently, there has been further adverse comment on the operation of the safeguards. In their Report published in March 2014, the House of Lords Select Committee on the Mental Capacity Act 2005 recommended a comprehensive review of the DoLS legislation with a view to its replacement.[33] In the Supreme Court, Lady Hale described the safeguards as having the appearance of "bewildering complexity".[34] We do not therefore recommend framing similar legislation for Scotland.

4.44 It is readily apparent that the twin difficulties of definition and procedural complexity are the main explanation for the problems with the DoLS. We are acutely aware of the need to guard against the same problems with any Scottish scheme.

Definition

4.45 Essentially because of the difficulties pointed out to us in the responses to our Discussion Paper, as explained in chapter 3, we do not intend to try to fashion for Scotland a definition of deprivation of liberty in the context of incapacity.[35] But we do intend to recommend a new process to authorise arrangements which greatly reduce the liberty of individuals and for which the State has some responsibility. Any such process requires to define its area of operation, and in our view, it is better that it do so in terms which those working in the area are able to understand and apply.

4.46 At the time of publication of our Discussion Paper, the cases of *MIG and MEG* and *Cheshire West* had recently been decided in the Court of Appeal. There had been a number of critical comments about the principles emerging from such cases, however, to which we also referred.[36] Particular controversy had surrounded the idea that a régime the purpose of which is to benefit the person to whom it is applied cannot be a deprivation of liberty. The other test which was being referred to at that time was to compare the situation of the adult concerned with another person who had the same level of disability and, if the régime concerned was usual for persons in that situation, it would not represent deprivation of liberty. We made the following observation:

> Were Scots law to develop provisions concerning deprivation of liberty which relied directly on concepts such as the purpose of a measure and the effect of a comparison with another person with similar disabilities in distinguishing deprivation of liberty from the provision of care, there would be a risk that such measures might not accord with Strasbourg case-law on Article 5.[37]

4.47 Given the decision of the Supreme Court in the two conjoined appeals of *Cheshire West* and *MIG and MEG*, it is evident that developing a system which excludes from its ambit measures whose purpose is to benefit the person to whom they are applied, or measures which can be described as "normal" for persons with like disabilities, would be ill-advised.

---

[31] As set out in the Mental Capacity Act 2005, Sch A1.
[32] DP at paras 4.26-4.30.
[33] http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm (Recommendation 13).
[34] *Cheshire West* at para 9.
[35] Paras 3.22 to 3.38 above.
[36] See discussion in ch 6 of the Discussion Paper in general and the academic comments quoted in paras 6.33 and 6.34 in particular.
[37] Para 6.60 of the Discussion Paper.

4.48 We have decided therefore to take a different approach.

4.49 In the first place, we consider that it is important to distinguish between decisions as to where a person should live and decisions as to the conditions which should apply there. In paragraph 4.17 above, we observed that this is an important distinction. We share the view of Peter Jackson J, as expressed in the *Neary* case,[38] that

> "[B]y viewing the case primarily through the prism of Article 5 one risks repeating a central fallacy and conflating the secondary question of whether a person is lawfully deprived of his liberty with the primary question of where he should be living".[39]

4.50 Decisions as to where individuals should live are of great importance. They should not be subsumed in a process which is about authorisation of interference with physical liberty. It appears to us that this may be in effect what happens if a test of whether the person is "able to remove himself permanently in order to live where and with whom he chooses"[40] is used as one of the indicators of deprivation of liberty.

4.51 We have outlined above the different ways in which a decision about where someone should live may be taken.[41] This decision should be considered in its own right and, where consensus is absent, will probably have to be taken by a Court or a Court-appointed surrogate. Indeed, if it has not been taken by a Court, or a person appointed by a Court and vested with appropriate powers, it is difficult to see how an adult could, as a matter of law, be prevented from being able to live "where and with whom he chooses".

4.52 Turning to consider how measures which curtail a person's liberty in the place where they live should be authorised, we recommend utilising a concept of "significant restriction of liberty", and defining that. We do so because it has been observed repeatedly in case-law from the European Court of Human Rights that the difference between restriction of liberty and deprivation of liberty is a difference of degree or intensity, not of nature or substance.[42] Significant restriction of liberty is a concept which can be defined for Scotland; in so doing, we are aiming to develop a system which meets the needs and respects the rights of those with incapacity in this jurisdiction.[43]

4.53 Of course, the concept of significant restriction does not expressly match the concept of deprivation of liberty. We do not intend specifically to make it a wider concept than deprivation of liberty, but we do aim to capture the situations which the Strasbourg court would regard as deprivation of liberty, in order that Scots law can demonstrate that it has the "lawful process" required by Article 5. In addition, we hope that there may be a slight terminological advantage, especially as the House of Lords Select Committee heard

---

[38] *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (Fam); [2011] 4 All ER 584. See Discussion Paper at para 6.49.
[39] At para 152.
[40] See para 3.3 above.
[41] See paras 4.12- 4.29 above.
[42] *Guzzardi v Italy* (1980) 3 EHRR 333 at para 93; *HM v Switzerland* (2004) 38 EHRR 17 at para 42; *HL v United Kingdom* (2005) 40 EHRR 32 at para 89; *Storck v Germany* (2006) 43 EHRR 6 at para 71; *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 115; *Austin v United Kingdom* (2012) 55 EHRR 14 at para 57. See also DoLS Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice, which says this in terms at para 2.3, and Discussion Paper at para 4.5.
[43] As suggested at para 2.86 of the Discussion Paper.

evidence that the phrase 'deprivation of liberty' was itself a cause of under-use of the safeguards, and concluded that it is "unhelpful terminology".[44]

4.54 It is important, however, not to overstate any such linguistic advantage. There is an understandable desire to eliminate negative connotations, but exclusive use of language referring to empowerment or safeguards risks obscuring that, at least for some of those affected, the measures concerned are not welcome. Use of accurate language may be necessary in order to achieve conferment of the rights required for compliance with Article 5. As Baker J observed in *Cheshire West* at first instance:

> "61 …I make it clear that, in reaching [the finding of deprivation of liberty], I am not being critical of the local authority or the staff at Z House. In my judgment, it is almost inevitable that, even after he has been supplied with a bodysuit, P will on occasions gain access to his pads and seek to ingest pieces of padding and faeces in a manner that will call for urgent and firm intervention. Those actions will be in his best interests and therefore justifiable, but they will, as a matter of concrete fact and legal principle, involve a deprivation of his liberty. The reason for attaching that label to those actions is not to stigmatise either P or his hard-working and dedicated carers, but so that all involved with his care recognise the implications of what is happening."[45]

4.55 Given that the measures with which we are dealing affect the right to liberty, "the most precious right",[46] it appears to us that the definition and the authorisation process should be in legislation.

4.56 It will be appreciated that our approach draws on the idea of the move from restriction of liberty to deprivation being a cumulative shift. To enable the concept of significant restriction of liberty to be understood and applied will therefore involve an attempt to set a threshold beyond which the degree of restriction applied to an individual should be seen as "significant". We recommend:

6. The process for authorisation of a restrictive regime to which an individual in a community setting is subject should be constructed around the concept of "significant restriction of liberty".

(Sections 52B and 52C of the draft Bill, read with section 52A)

7. The process and the relevant definition should be in legislation.

(Sections 52A and 52D-I of the draft Bill)

8. The concept of significant restriction of liberty should be defined in a manner which, as far as possible, enables all those affected to measure the degree of restriction to which a person is subject in a straightforward manner.

(Section 52A(1) of the draft Bill)

---

[44] House of Lords Select Committee on the Mental Capacity Act 2005 http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf , paras 284 and 285.
[45] [2011] EWHC 1330 (Fam) at para 61.
[46] Quoting Viscount Stair in *Inst*.I, 2,5 (first edition, 1681). See Discussion Paper at para 3.93.

Process: grant of authorisation

4.57 As we explained in our Discussion Paper, and as referred to in paragraph 4.19 above, we have derived assistance from the Report of the Victorian Law Reform Commission in relation to guardianship. We noted that the Report mooted a mixed solution to the question of how substantial restraints on liberty in a person's living arrangements should be authorised:

- Authorisation by personally appointed enduring guardians (analogous to those acting under a welfare power of attorney in Scotland) or guardians appointed by the relevant administrative tribunal;

- For individuals who have no guardian (of either type), a new process of "collaborative authorisation", involving input from the manager of the relevant facilities, a medical professional and the individual's health decision maker (an automatic appointment);

- To assist those working in the area, specification of measures requiring to be authorised, possibly by legislation highlighting practices not amounting to deprivation of liberty and guidance identifying practices which are commonly used and should be authorised.

4.58 We consider that a mixed solution is likely to be suitable for Scotland also. In the first place, a guardian with welfare powers should be able to authorise significant restriction of liberty. This is likely to be an important source of authorisation where people who have never had capacity are concerned. For adults who have lost capacity, but who granted a welfare power of attorney before doing so, the question arises of the role, if any, which those acting under the power of attorney should have.

4.59 To omit those acting under powers of attorney from the decision-making process appears to us to be at odds with the recognition of the importance of autonomy in personal decision-making. This appears to be recognised in England and Wales, where provision is made for authorisation of restrictions by those acting under powers of attorney. Under the Mental Capacity Act 2005, an act intended to restrain an adult may be undertaken or authorised by the donee of a lasting power of attorney if the adult lacks capacity, the act is necessary to prevent harm to the adult and the act is proportionate to the likelihood and seriousness of any harm.[47]

4.60 There will unfortunately be occasions when an appointee misuses powers conferred on them. Appointment by the Court does not guarantee freedom from such abuse.[48] It is important that appointment processes are rigorous; insofar as guardianship is concerned, the provisions of the 2000 Act provide suitable safeguards. For appointment by adults themselves, the guidance issued by the Law Society of Scotland on powers of attorney and on assisting vulnerable clients will apply.[49] Importantly, as far as significant restriction of

[47] Section 11 of the Mental Capacity Act 2005.
[48] A recent English case involved court-appointed deputies incurring expenditure of around £200,000 from the adult's capital on luxury goods for themselves: http://www.bbc.co.uk/news/uk-england-derbyshire-27474872
[49] http://www.lawscot.org.uk/rules-and-guidance/section-f-guidance-relating-to-particular-types-of-work/division-h-guidance-on-continuing-and-welfare-powers-of-attorney/guidance/guidance-on-continuing-and-welfare-powers-of-attorney/ and https://www.lawscot.org.uk/rules-and-guidance/section-b/rule-b1-standards-of-conduct/guidance/b15-vulnerable-clients-guidance.

liberty is concerned, we do not propose that authorisation should be possible without additional process – additional elements will always be necessary in order to ensure compliance with the *Winterwerp* criteria, applicable under Article 5 of the ECHR. We recommend:

9. The authorisation process should make provision for guardians and those acting under welfare powers of attorney to authorise significant restriction of liberty.

(Section 52E(1)(a) and (3) to (7) of the draft Bill)

4.61 In recommending a process whereby guardians with welfare powers and those acting under power of attorney can authorise significant restriction of liberty, we appreciate that questions will arise concerning the necessary content of a guardianship order or power of attorney document. If our proposals are implemented then we recommend that, from the date of commencement of the provisions, welfare powers of attorney granted or guardianship orders made after that date should be taken to empower the person appointed to authorise significant restriction of liberty unless that power is expressly excluded. For pre-existing guardianship orders and power of attorney documents, the matter will require to depend on interpretation. Guardianship orders can be amended if necessary but, in relation to powers of attorney, we do not consider that it would be right for legislation to purport to innovate upon the existing terms of such contractual instruments. In our view, however, if significant restriction of an individual's liberty was taking place as part of necessary care, that context would be a relevant factor in the interpretation of a pre-existing power of attorney with welfare powers.

4.62 For individuals who do not have a welfare attorney or a guardian with welfare powers, or where such an attorney or guardian does not authorise significant restriction of liberty, authorisation by the court will be required.

4.63 It appears to us that a judicial process for the significant restriction of liberty of adults who lack capacity to consent to such measures should be integrated with the other provisions concerning decision-making for adults. We therefore propose that the process should be inserted into the 2000 Act by amendment, and the jurisdiction should be conferred on the sheriff. We recommend:

10. Where authorisation of significant restriction of liberty of an adult cannot be granted by an attorney or a guardian with welfare powers, application should be made to the sheriff, and the Adults with Incapacity (Scotland) Act 2000 should be amended to insert the necessary provisions.

(Section 52E(1)(b) of the draft Bill)

4.64 Under our scheme, some applications for authorisation of significant restriction of liberty will come before the sheriff because the adult who lacks capacity has no welfare guardian or attorney with welfare powers. It is possible that there may be an application for the appointment of a welfare guardian already underway. In such circumstances the sheriff may proceed to grant an authorisation but soon afterwards there will be an appointee to take any future decisions including, in due course, what should happen at the expiry of the period

authorised by the sheriff. There may, however, be cases where that is not so. It is likely that the adult in such a situation will be a vulnerable person. The sheriff can appoint a safeguarder under section 3(4) of the 2000 Act, in relation to significant restriction of liberty, but it may be a matter of concern that there is no appointee to take on an ongoing basis decisions which the adult does not have capacity to take him or herself. For that reason, we recommend:

11. In considering an application for authorisation of significant restriction of liberty for an adult who does not have a welfare guardian or an attorney with welfare powers, the sheriff should require the local authority to consider whether a guardian should be appointed.

(Section 52F(1) of the draft Bill)

12. If the local authority considers that a guardian is required, they should apply under the Act for an appointment unless there is another person who can be appointed.

(Section 52F(2) of the draft Bill)

Process: evidence

4.65 As we have already explained, we intend that the concept of significant restriction of liberty will cover the situations of those whom the European Court of Human Rights would regard as deprived of their liberty under Article 5 of the ECHR. The authorisation process should therefore comply with the requirements of Article 5(1). This means that it will be necessary to ensure that the *Winterwerp* criteria are met. Thus, the evidence gathered in order to justify authorisation will require to demonstrate, according to medical evidence, that the adult concerned has a mental disorder, which warrants the proposed restrictions and that the disorder is likely to persist throughout the period when the restrictions may be imposed. We recommend:

13. The process to authorise significant restriction of liberty should incorporate requirements designed to ensure that the *Winterwerp* criteria are met.

(Section 52D(1)(b) and 52D(2) of the draft Bill)

4.66 Scots law also has a framework of principles with which any intervention in the affairs of an adult must comply. Thus, according to section 1 of the 2000 Act:

> "(2) There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.
>
> (3) Where it is determined that an intervention as mentioned in subsection (1) is to be made, such intervention shall be the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention.

(4) In determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of–

(a) the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult;

(b) the views of the nearest relative, named person and the primary carer of the adult, in so far as it is reasonable and practicable to do so;

(c) the views of—

(i) any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention; and

(ii) any person whom the sheriff has directed to be consulted,

in so far as it is reasonable and practicable to do so; and

(d) the views of any other person appearing to the person responsible for authorising or effecting the intervention to have an interest in the welfare of the adult or in the proposed intervention, where these views have been made known to the person responsible, in so far as it is reasonable and practicable to do so."

4.67 Significant restriction of the liberty of an adult who cannot consent to the measures concerned is plainly a major intervention in the affairs of that person. The section 1 principles should therefore apply to it. We recommend:

14. The principles set out in section 1 of the Adults with Incapacity (Scotland) Act 2000 should apply to any proposed significant restriction of liberty.

15. The authorisation process should include ascertaining and taking account of the matters covered in subsections (2) to (4) of section 1.

(Section 52E(7)(b) of the draft Bill)

Duration

4.68 Section 58(4) of the 2000 Act sets the duration of the appointment of a guardian at three years, although on cause shown, an appointment may be made for any other period, including indefinitely. In our Discussion Paper, we observed that the use by a guardian of their powers to deprive an adult of his or her liberty for a period of three years without review would be likely to raise issues of compatibility with Article 5(4). We referred to the case of *Herczegfalvy v Austria*[50] where a period of 15 months without review was held to breach Article 5(4). It will be necessary for any process for authorisation of significant restriction of liberty to make provision for review of the authorisation, using the same or similar process as the initial grant.[51]

[50] (1993) 15 EHRR 437.
[51] This is different from review of the implementation, which will need to be constant – see para 6.16 below.

4.69 There does not appear to be a decision of the Strasbourg court in which a particular period has been identified as an appropriate interval between reviews of deprivation of liberty in the context of care of adults with some degree of learning difficulty. We have, however, been guided by the approach taken in the Court of Protection in England and Wales.

4.70 In 2008, Munby J, (now Munby LJ) held in *Re GJ, NJ and BJ (Incapacitated Adult*s),[52] that review of the arrangements applying under a residential placement should ordinarily take place at intervals of no more than 12 months, with the possibility of earlier reviews where this was thought necessary. The applicant in that case was the subject of an order covering a placement acknowledged to involve deprivation of liberty. Recently, the case of *Re X and others (Deprivation of liberty)*[53] addressed, amongst other questions, the issue of timescales for review of arrangements giving rise to a deprivation of liberty for the purposes of Article 5 ECHR. This was a preliminary judgement of the Court of Protection, issued by way of guidance in the wake of *Cheshire West*.

4.71 Question (11) in the case asked what frequency of review was required by Article 5(4) ECHR where a deprivation of liberty had been authorised by the Court of Protection? The answer given by the court was that review should typically take place approximately annually, unless circumstances require review within a shorter period. We recommend:

16. The process for authorising significant restriction of liberty should include provision for periodic review, at intervals of no more than a year, and renewal where appropriate.

(Section 52E(13) and 52G(1) of the draft Bill)

Other necessary features

4.72 While an authorisation is in force, it may be necessary to vary the measures specified in it. There will require to be certain procedural steps surrounding such a variation. We recommend:

17. Provision should be made within the authorisation process for variation of the specified restrictions while an authorisation is in force.

(Section 52H of the draft Bill)

4.73 It is also likely that individuals will move into accommodation before it has been possible to seek and obtain authorisation to implement restriction of liberty which is necessary in their own interests. Or it may not be until after they have been in the accommodation for a short time that the need for such measures emerges. Measures which are necessary in the interests of the person concerned should not be delayed while the authorisation process is pursued. Thus, there should be provisions applying to interim restriction of liberty.

[52] [2008] EWHC 1097 (Fam).
[53] [2014] EWHC 25 (COP).

4.74 Similarly, it is possible that individuals will reside in a care home or other facility on a temporary basis, either as respite for a carer at home or in an emergency. Provision for restriction of liberty in such situations will also be required. We recommend:

18. Provision should be made within the authorisation process for restriction of liberty on an interim basis, while the full assessment process operates.

(Section 52B(3)(b) as read with section 52B(4) and (5) of the draft Bill)

19. Provision should be made within the authorisation process for restriction of liberty on a short-term basis.

(Section 52C of the draft Bill)

Release provision

4.75 Finally, there is the question of creating a specific provision to allow unlawful detention to be terminated where it is occurring in circumstances which do not fit within section 291 of the 2003 Act. At present, because of the terms of the statutory provision, such a remedy could only be obtained for a person who is subject to *de facto* detention in a hospital[54] where they are receiving treatment primarily for mental disorder. Although it would be possible to seek release through judicial review, we consider that a provision similar to section 291 ought to exist for other premises in which individuals who may lack capacity are accommodated, such as care homes. We recommend:

20. There should be a provision, similar to section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to enable application to be made for the cessation of *de facto* detention in premises where people are accommodated in order to receive care but which are not covered by section 291.

(Section 52J of the draft Bill)

[54] As defined in s 329 of the 2003 Act.

Chapter 5 Hospitals

Introduction

5.1 As we have already observed, Scots law does not have a specific process for the authorisation of measures to prevent a patient from going out of a hospital, where this is required to keep them safe during treatment for physical health problems. People who require health care in general hospitals but do not have capacity to consent to it can receive treatment under Part 5 of the 2000 Act which provides a process whereby authority is conferred on a medical practitioner to provide medical treatment to an adult who lacks capacity to consent to it. An additional process is required to enable authorisation of any necessary measures to prevent an adult with incapacity from going out of a hospital unaccompanied. Such a process should be connected to the process of authorising medical treatment.

Scope of the process

5.2 The majority of patients lacking capacity who are admitted to hospital remain there on a relatively short term basis to receive treatment for an acute medical problem.[1] The new process is intended to cover authorisation of measures during these stays in hospital.

5.3 We are aware though that despite Government policy such as "people's homes should not be in hospitals",[2] some people may be in hospital for a protracted period, for example if they are receiving NHS continuing care in hospitals[3] or are "long stay patients."[4] Continuing and long-stay patients receive NHS care that is on-going but not acute, as inpatients over an extended period of time, sometimes several years. As at March 2014 there were 2,155 such patients in Scotland.[5] A large majority of those fall under "Geriatric Medicine" and are being cared for for less than a year or at most two years.[6] It is in our view appropriate that they are kept safe in hospital under this new authorisation process where it is necessary to restrain them; in many cases it may not be necessary because of the state of their health. We have taken soundings from consultants in medicine of the elderly and the alternative, namely covering these patients under the community process, appears

---

[1] In 2013 the average length of stay in a general hospital for routine admissions was 6.5 days and for emergency admissions 3.1 days, http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/ . According to a report published by the Mental Welfare Commission, focussing on visits to people with dementia in general hospitals in 2010, 25% of beds in acute wards in general hospitals were occupied by patients who had dementia. http://www.mwcscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf

[2] "The same as you", Scottish Executive, page 46 in relation to people with learning difficulty http://www.scotland.gov.uk/Resource/Doc/1095/0078271.pdf .

[3] A Scottish Government guidance note on responsibility of the NHS to provide continuing care services, issued to NHS Boards in 2008, provides information on eligibility for NHS continuing care. A copy can be found here: http://www.sehd.scot.nhs.uk/mels/CEL2008_06.pdf.

[4] By long stay is meant a patient who does not specifically meet the criteria for NHS continuing care but who has been in hospital for over one year, without an estimated discharge date having been set.

[5] Continuing Care Census 2014 https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2014-06-24/2014-06-24-NHSCC-Report.pdf?3504580260

Within the total of 2,155 patients, not all of those receiving NHS continuing care are accommodated in hospitals; a proportion of them are in care homes and hospices.

[6] See Continuing Care Census 2014, as above, p 7.

inappropriate because their life expectancy, whilst not known precisely, is likely to be limited. Against the background that their health is likely to be declining, subjecting them to the assessment processes attached to a procedure intended to be used primarily in connection with long-term stays in care homes seems both undesirable and unjustified.

5.4 For those patients who fall under the categories of General Psychiatry, Psychiatry of Old Age or have a learning difficulty[7] we have no exact figures of how many of those are needing to be kept safe in hospital by way of restraint. The 2003 Act may apply to some of the situations. Where it does not, and keeping in mind the general policy that nobody should have a hospital as their home, we think that the likelihood of measures of restraint needing to be authorised should be minimal and that the process we recommend will be suitable.

5.5 People who require compulsory treatment for mental illness can be detained in hospital under the 2003 Act. Where the patient is treated in a general hospital for both mental and physical health problems, it is conceivable that the new process of authorisation and powers of detention under the 2003 Act may overlap. We would anticipate that in practice the new authorisation process would be used where the medical treatment is authorised under Part 5 of the 2000 Act.

5.6 The authority to provide medical treatment under Part 5 of the 2000 Act includes not only treatment in hospital but also dental treatment or treatment by an ophthalmic optician. We have taken views from medical experts about whether measures to keep a patient safe require to be used in connection with treatment in for example a dental practice, these being measures which go beyond what is allowed under the principle of necessity and section 47(7)(a).[8] Having done so, and on the basis that even if measures were adopted for the purposes of other types of treatment, their duration would be very short, we have concluded that a hospital is the place where measures to prevent a patient from going out are most likely to be needed.

5.7 The authorisation process is to apply in hospitals as defined in section 108 of the National Health Service (Scotland) Act 1978 but with care homes explicitly excluded.[9] Applying that definition, both NHS hospitals[10] and private hospitals are covered by the process. We recommend:

21. The process to authorise measures to keep a patient safe should apply to hospitals.

(Section 50A(1)(a) and (11) of the draft Bill)

---

[7] A review of existing data on the Population with Learning Disability in Scotland was published by the Scottish Executive in 2008; see pp 15-19 for numbers of adults with learning difficulty occupying long stay hospital beds in Scotland.

[8] Section 47(7)(a) makes clear that the authority conferred by section 47(2) does not authorise the use of force or detention "unless it is immediately necessary and only for so long as is necessary in the circumstances."

[9] In terms of s 108 of the 1978 Act "hospital" includes any institution for the reception and treatment of persons suffering from illness.

[10] These would fall within the definition of a "health service hospital" in section 108 of the 1978 Act, namely "a hospital vested in the Secretary of State for the purposes of his functions under this Act or vested in an NHS trust".

Assessment or medical treatment

5.8 Measures to keep a patient in hospital may need to be applied not only for giving medical treatment but also for the prior assessment to establish if medical treatment is needed. The definition of "medical treatment" in section 47(4) of the 2000 Act may include diagnostic tests and procedures[11] but we want to make it explicit that the new authorisation process can be used to prevent the adult from going out of the hospital during any initial assessments. We want to ensure that there is no gap in time between the lapse of authority to detain a patient where it is "immediately necessary and only for so long as it is necessary in the circumstances" in accordance with section 47(7)(a) of the 2000 Act and the point from which the new authorisation process can be used. We recommend:

22. The authorisation process should apply to a patient who is receiving medical treatment or is being assessed as to whether they need it.

(Section 50A(1)(a) of the draft Bill)

Incapacity certified by medical practitioner primarily responsible for the treatment

5.9 The process should be used for an adult who is incapable of making a decision as to whether or not to go out of hospital or some part of the hospital. The definition of "incapable" in section 1(6) of the 2000 Act includes lack of capacity in a number of areas, on account of mental disorder or physical disability.[12] We think that any one or more of them could be relevant for an adult who is in hospital to be assessed or who is known to be in need of medical treatment.

5.10 We do not intend the process to be used for adults who are temporarily disorientated or unconscious for a short time, for example when arriving at the Accident and Emergency unit in a hospital after an accident. Such people are not caught by the definition of "incapable" unless they have a "mental disorder" or "inability to communicate because of physical disability". In a similar category to this are people arriving at hospital showing signs of delirium. Where symptoms persist and it becomes clear that the patient falls within the definition of "incapable" either because an underlying mental disorder is diagnosed or the patient is unable to communicate for reasons of physical illness, the process could be used to underpin any measures to keep the patient safely in (part of) the hospital for medical treatment.[13]

5.11 Responsibility for certifying that an adult lacks capacity to decide whether or not to stay in hospital should rest with the medical practitioner primarily responsible for the treatment or assessment of the patient. This mirrors the formulation in section 47 of the 2000 Act. In practice this could be the consultant to whom a patient is assigned but also any medical practitioner who is for the time being responsible for the treatment of the adult.

---

[11] See para 81 of the Policy Memorandum to the Adults with Incapacity (Scotland) Bill, http://www.scottish.parliament.uk/S1_Bills/Adults%20with%20Incapacity%20(Scotland)%20Bill/b5s1pm.pdf

[12] Subsection (6) provides that "incapable" means incapable of acting, making decisions, communicating decisions, understanding decisions or retaining the memory of decisions, as mentioned in any provision of the 2000 Act, by reason of mental disorder or inability to communicate because of physical disability. However, it makes clear that a person does not fall within the definition by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be addressed by use of a human or mechanical aid.

[13] The medical treatment itself should be covered by a s 47 certificate where the patient cannot give consent because of the delirium.

5.12 It is conceivable that there could be variation as to the timing of issue of a certificate of incapacity under section 50A. Some medical practitioners might issue a certificate in any situation where they concluded that a patient under their care was incapable in relation to deciding whether or not to go out of a hospital. Others would only do so where the patient had actively demonstrated a wish to go out of the hospital. Either approach would seem to be in accordance with Article 5 of the ECHR. We recommend:

23. It should be competent for the medical practitioner primarily responsible for the medical treatment or assessment of a patient to certify that the patient is incapable in relation to a decision as to whether or not to go out of the hospital.

(Section 50A(1)(b) of the draft Bill)

Measures to prevent an adult going out of a hospital

5.13 The medical practitioner primarily responsible for the treatment of the adult as well as any other person involved in the medical treatment of the patient, such as other consultants or nurses, can do what is reasonable to prevent the patient going out of a hospital.[14] The expression "to do what is reasonable" leaves a certain amount of flexibility as to what is needed. The principles expressed in section 1(3) of the 2000 Act apply to any measures to be authorised, because the measures would be an intervention in the affairs of the adult. That means the measures must be necessary for the treatment or assessment to be carried out and must be the least restrictive way of ensuring that it is undertaken.[15]

5.14 We have chosen the expression to "go out of a hospital" rather than "leave a hospital" because measures which are used merely for coming and going from wards or hospitals are to be covered as much as measures preventing someone from leaving a hospital permanently.[16]

5.15 The process is not intended to be used in relation to measures taken as part of general hospital care but which have the effect that a patient cannot leave the hospital, for example an anaesthetic being given before an operation. The same would apply to using bed cot sides where this is done to prevent a patient from falling.[17] Were cot sides to be used for other purposes, for example to keep patients in their beds when they do not need to be there for health reasons, then it is unlikely that the process could authorise such use. It would be difficult to reconcile with the above-mentioned principles, which ensure that interventions must be necessary and involve the least possible restriction.

5.16 We are aware that medication may be used to prevent a patient from going out of a hospital (in combination with other measures).[18] In a situation where the use of medication is necessary and the least restrictive option, it should be authorised.[19]

---

[14] Section 50A(2) of the draft Bill.
[15] See also ch 4 paras 4.66 and 4.67 for application of the principles in the community setting.
[16] Section 50A(2) of the draft Bill.
[17] See also ch 6 para 6.12.
[18] http://www.mwcscot.org.uk/media/125447/ms_ab_web_version.pdf.
[19] Section 50A(5) of the draft Bill.

5.17 We envisage that use of a certain degree of force might at times be necessary, for example if a patient has triggered an alarm by trying to leave the ward through a door and is being taken away from the door. Any use of force should be kept to the absolute minimum possible.[20] This mirrors the approach taken in relation to use of force being necessary for providing medical treatment to an adult without capacity.[21]

5.18 The certificate issued by the medical practitioner will follow a *pro forma;* a form may be prescribed in Regulations made under the 2000 Act.[22] We envisage that the certificate would also describe the measures, and in doing so would give sufficient detail to make clear to those implementing them the extent, or otherwise, of what has been authorised. Equally, though, there should be an inbuilt degree of flexibility, allowing a combination of measures to be used in the manner most appropriate to the circumstances of individual patients. We recommend:

24. The process should authorise any person involved in the medical treatment of a patient to do what is reasonable to prevent the patient from going out of a hospital.

(Section 50A(2) of the draft Bill)

25. If the use of medication is the only possible means of preventing an adult from going out of hospital, that use should be authorised.

(Section 50A(5) of the draft Bill)

26. The use of force is authorised only if it is immediately necessary and for so long as it is necessary.

(Section 50A(3)(b)(i) of the draft Bill)

27. Regulations may prescribe a form for the certificate of incapacity.

(Section 50A(10) of the draft Bill)

Duration

5.19 The authority conferred by a certificate of incapacity should last for as long as it is necessary throughout the period of assessment and treatment. The provision in the draft Bill provides that the authority lasts for as long as the need for the preventative measures is "manifest".[23] We believe that this expression gives a degree of flexibility which may be necessary in practice. It caters for the fact that a patient may remain in hospital after they have finished receiving medical treatment or undergoing assessment, at a time when the process of finding suitable accommodation or putting arrangements in place in their own home is ongoing but not yet complete. During that time they will still require to be subject to the measures, in the interests of their own safety. Where, however, this process is significantly delayed for reasons unrelated to the condition of the patient, the matter can be

[20] Section 50A(3)(b)(i) of the draft Bill.
[21] See s 47(7)(a) of the 2000 Act.
[22] Section 50A(10) of the draft Bill, together with s 87 of the 2000 Act.
[23] Section 50A(3)(a) of the draft Bill.

brought to the sheriff who can make an order bringing to an end the authority for use of the measures after a certain period of time.[24] This is discussed further below. We recommend:

28. The measures should be authorised for as long as the need for them is manifest.

(Section 50A(3)(a) of the draft Bill)

Setting an end date

5.20 A variety of reasons can lead to patients remaining in hospital beyond the time for which they receive medical treatment or require assessment, when they should be going "home".[25] That does not mean, however, that the patient does not need to be kept within (a part of) a hospital for his or her own safety. The measures to keep them there could even be in breach of Article 5, despite the existence of a section 50A certificate, if the measures were no longer the least restrictive option in catering for the situation of the patient.

5.21 In order to unblock whatever has been holding up a patient's discharge from hospital, the patient (or any other person claiming an interest in the personal welfare of the patient) may apply to the sheriff for an order setting an end date for use of the measures in question.[26]

5.22 In granting an application for an order the sheriff must be satisfied that the treatment or assessment has come to an end, and that the patient is ready to return home or that accommodation where suitable care can be provided is available for him or her elsewhere than at the hospital.

5.23 We considered the advantages and disadvantages of providing that alternative accommodation must actually be available. Without a provision to this effect, there would be doubt concerning the circumstances in which an end date could ever actually be set. On the other hand, including such a provision could result in the thwarting of attempts to achieve practical progress in arranging for an adult to leave hospital, in that it could be asserted that there is no suitable alternative to remaining there. We concluded on balance that the advantages of including the provision prevailed, but we envisage that in its application, local authorities will be expected to provide full information to the court regarding the availability of suitable alternative accommodation or provision of care in the person's own home and to account for the performance of their statutory duties regarding these matters.

5.24 Before deciding whether or not to grant an application the sheriff must give the medical practitioner who issued the certificate of incapacity, the chief social worker of the local authority in which the patient lives and (if it was not the patient him or herself who applied for the order) the patient, the opportunity to make representations about the proposal to set an end date.

---

[24] Section 50C of the draft Bill.

[25] In particular, elderly people end up staying in hospitals because even though their treatment has finished, all involved agree that care arrangements need to be put in place wherever they are going to live. The situation may at times be compounded by lack of agreement as to what those arrangements should be. For this and other categories of patients see paras 4.12 *et seq* of ch 4 above.

[26] Section 50C of the draft Bill.

5.25 Any order made by the sheriff will provide for the authority for use of measures to come to an end after what is thought to be a reasonable period, to enable families, local authorities and medical staff to ensure that the necessary care arrangements are put in place. In many cases the mere intimation of the application may be sufficient to produce progress. We recommend:

29. Where a patient no longer requires medical treatment or assessment, an application can be made to the sheriff by anyone claiming an interest in the personal welfare of the patient, including the patient, to set an end date after which there is no longer authority for imposition of measures of restriction.

(Section 50C of the draft Bill)

Duty to review and revocation

5.26 We are aware that in some cases the decision about capacity is not clear cut or the capacity in relation to decisions about staying in hospital may be fluctuating. To address this, the medical practitioner who issued the certificate should have a duty to review from time to time if the person is still incapable.[27] If the medical practitioner is no longer of the view that the patient lacks capacity he or she must revoke the certificate.[28]

5.27 We do not recommend provision for a person claiming an interest in the personal welfare of the patient to apply to the sheriff to review the decision on revocation. We envisage that if the revocation of the certificate and the resultant cessation of the use of measures were having any adverse consequences, in practice these would be likely to have arisen before the outcome of any application to the sheriff was known. We recommend:

30. There should be a duty on the medical practitioner to review and where appropriate to revoke the certificate of incapacity.

(Section 50B of the draft Bill)

Right to appeal

5.28 Anyone who can claim an interest in the personal welfare of the patient, or the patient him or herself, can apply to the sheriff to review any action which is taken in reliance on a certificate authorising measures to prevent a patient going out of a hospital.[29] This right of appeal to the sheriff is intended to be wide so that even a friend or neighbour who happens to be concerned about the measures can raise the issue.

5.29 Any challenge to administration of medication (for confining the patient to a hospital)[30] is to be brought by means of an appeal under section 52 of the 2000 Act, treating this as an appeal against a decision as to medical treatment.

---

[27] Section 50B(1) of the draft Bill.
[28] Section 50B(2) of the draft Bill.
[29] Section 50A(6) of the draft Bill.
[30] See para 5.16 above.

5.30 Any decision by the sheriff can be appealed to the appropriate sheriff principal and thereafter to the Court of Session in accordance with section 2(3) of the 2000 Act.

5.31 The role of any guardian or attorney in the hospital process is to be confined to exercising the right to apply to the sheriff, where they do not agree with the measures taken to prevent an adult from going out of a hospital, in the same way that the right would be exercisable by any other person with an interest in the personal welfare of the adult. Involving guardians and attorneys in the process of determining whether use of measures to prevent a person going out of a hospital should be authorised in the first place could undermine the very purpose of the detention, i.e. to allow the (relatively short-term) treatment to take place and to protect the adult from possible harm if they left the premises unaccompanied. We recommend:

31. The patient and any person claiming an interest in the personal welfare of the patient should be given a right to apply to the sheriff to review the exercise of authority under a section 50A certificate to prevent a patient from going out of a hospital.

(Section 50A(6) of the draft Bill).

Chapter 6 Community process

Introduction

6.1 This chapter sets out the detail of our proposals for a new process to authorise significant restriction of liberty in settings in the community for which the State has some responsibility. We explain the types of accommodation arrangement where the process will operate. We also set out our proposals for identifying when deprivation of liberty is occurring, by means of a concept, cumulative in nature, of significant restriction of liberty, which seeks to capture the elements of confinement, seclusion and control. The processes we envisage by which authorisation is granted are detailed, both in terms of the evidence required and the identity of the granter of the authorisation. Finally, we revert to the Convention, and explain how, in our view, our proposals fit with what we consider to be the requirements of Article 5.

Scope of process

6.2 As we have already observed, Scots law does not have a specific process for the authorisation of deprivation of liberty of people with cognitive impairment in community settings. By "community settings", we mean care homes and other arrangements where people live in the community and in relation to which the State has some involvement and, therefore, potential responsibility under Article 5. In devising a process, it is however necessary to specify the sorts of care arrangements in which such a process will operate.

6.3 We have already discussed arrangements which operate in hospitals. At present, people who require compulsory treatment for mental illness can be detained in hospital in accordance with the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003. People who require other forms of health care in hospital but who do not have the capacity to consent to the relative arrangements can receive treatment under Part 5 of the Adults with Incapacity (Scotland) Act 2000. If measures are required to keep them safe while they are undergoing such treatment, the amendments we have proposed to Part 5 are designed to ensure that such measures can be lawfully adopted. There are also individuals whose ordinary living arrangements involve significant restriction of their liberty. The degree of restriction may be such as would be characterised by the European Court of Human Rights as deprivation of liberty. If such arrangements are attributable to the State, the restriction needs to be authorised.

6.4 The largest category of premises in which significant restriction of liberty may occur is in care homes. But there are other arrangements made by the State for individuals who lack capacity to make their own accommodation decisions and, if deprivation of liberty were to occur in the context of such an arrangement but was unauthorised, this would be likely to be a breach of Article 5. These arrangements may be more diverse. The most straightforward way to identify places in which our proposed authorisation process ought to be available appears to us to be to link it to care services, as currently regulated by the Public Services Reform (Scotland) Act 2010, insofar as such services include provision of accommodation, with that accommodation being for adults.

6.5 By section 47 of the 2010 Act, a care service includes a care home service and an adult placement service.[1] These appear to us to be the categories of service which include accommodation and where a deprivation of liberty requires to be authorised. A care service must be registered.[2] A registered care service is subject to inspection by Social Care and Social Work Improvement Scotland (SCSWIS).[3] We recommend:

32. The process for authorisation of significant restriction of liberty should apply to care homes and arrangements made by adult placement services.

(Section 52A(3) of the draft Bill)

Definition

6.6 Integral to our proposed scheme is the concept of significant restriction of liberty. In order for the scheme to work, the definition of that concept must be as straightforward as possible. This is because many people will be affected: adults themselves, their families and their carers and all the many others whose jobs mean that they are involved, directly or indirectly, in the provision of care or representation for adults who lack capacity.

6.7 As we have explained, the concept is derived from the proposition that the difference between restriction of liberty and deprivation of liberty is a question of degree.[4] Our aim is therefore to specify the principal types of measure that operate and quantify the extent to which restriction is a feature of the life of a particular individual.

Types of restriction

6.8 We have included in our set of measures elements referred to in cases before the European Court of Human Rights where the court has had to determine if deprivation of liberty is occurring. Our starting point is whether or not the adult is able to come and go from the premises. For most premises, this will be a straightforward question to pose and answer: are the premises locked and, if so, does the adult have a key? But there are other ways of securing the entrance to premises, for example by electronic locking with an access code or password or even by having a member of staff stationed at the entrance.

6.9 As we observed in our Discussion Paper,[5] there is no touchstone for deprivation of liberty and even locked premises will not always lead to the conclusion that liberty has been removed. The locking of the main door of premises may be entirely for the protection of residents and there may be no restriction on the possibility of outings, provided the adult is accompanied by another person who can assist them in avoiding hazards to which they would be exposed if alone. Thus, there is a distinction from the paradigm case of

---

[1] These are services provided to people by reason of their vulnerability or need. A care home service provides accommodation, together with nursing, personal care or personal support. An adult placement service arranges for the provision of accommodation for an adult together with personal care or personal support or counselling; paragraphs 2 and 11 of sch 12 to the 2010 Act.

[2] Section 59 of the 2010 Act.

[3] SCSWIS was created by s 44 of the 2010 Act. It is known as the Care Inspectorate: http://www.scswis.com/index.php?option=com_content&view=article&id=7563&Itemid=363. Chapter 2 of Part 5 of the 2010 Act deals with inspections of care services.

[4] See above, para 4.52.

[5] Paras 2.73-2.74 of the Discussion Paper.

deprivation of liberty, confinement in a cell.[6] That appears to us to be a reason not to make the securing of the main door sufficient on its own to indicate that there is significant restriction of liberty, but the feature is plainly relevant.

6.10 Moreover, we appreciate that there will be individuals whose physical disability in effect confines them to premises. A small group home caring for people with such physical disability in addition to learning difficulty might not have a locked front door. We intend that people living in such conditions who do not enjoy an unrestricted right of egress from the accommodation should also be treated as confined, whether the main entrance is secured or not.

6.11 Within accommodation, it may be possible to confine individuals to particular areas. The most obvious example of this would be where people are locked in their rooms. We consider that this is also plainly relevant to an assessment of whether someone's liberty is significantly restricted.[7]

6.12 There are other ways in which the liberty of an individual can be restricted. Measures which are applied directly to someone can result in considerable restriction. We include here the range of the ways in which a person's actions can be controlled: by the use of physical force, restraints or medication. In our view, the presence of any of these features should be taken into account in deciding whether someone is subject to significant restriction of liberty. The only exception we have reflected is the use of simple safety measures such as bed rails or wheelchair lap belts, where these are used purely to prevent someone from falling. There is nothing to stop the use of such a measure being included in a person's care plan, and the need for it being reviewed from time to time, but it does not appear to us to be necessary to include such a factor in the list of what is relevant for the purposes of the formal authorisation process.

6.13 We have noted that the National Care Standards formulated by Scottish Ministers include several sets of standards that will be relevant here. There are standards applicable to different types of care homes, and to adult placement services. It is a feature of each that an individual user of such services can expect that their personal plan will set out any measures of restraint which staff may have to use for the user's own safety or for the safety of others.[8] The approach which we are recommending should, therefore, fit with the standards already operating in the care of individuals.

6.14 Accordingly, we recommend:

33. In identifying whether significant restriction of liberty is occurring, regard should be paid to the presence of the following elements:

- **Absence of unrestricted right of egress from the accommodation**
- **Confinement within the accommodation**

---

[6] *Austin v United Kingdom* (2012) 55 EHRR 14 at para 59.

[7] We considered following the same approach as in relation to confinement, namely regarding people with physical disability as, in effect, confined to a particular area if they cannot move around unassisted. We decided, however, that including such a level of detail risked generating confusion.

[8] http://www.nationalcarestandards.org/52.html.

- **The use of measures to control the actions of an individual.**

(Section 52A(1) of the draft Bill)

Measuring the extent

6.15 Given that we intend to rely on the idea of quantity of restriction, it is necessary to set a threshold. We have concluded that this can be achieved by tethering the concept of significant restriction to the use on a regular basis of more than one category of measure. In other words, a person living in a care home where the front door is ordinarily locked, who occasionally requires seclusion or restraint, would not be regarded as subject to significant restriction of liberty.

6.16 It is important, however, to negate any impression that such arrangements can operate without any form of scrutiny. The system we are recommending is in addition to, not a substitute for, good standards of care. As we have already observed, National Care Standards require that measures of restraint judged necessary are set out in the personal plan for an individual. We would not expect that because the plan for a particular individual fell below the threshold for qualifying as significant restriction of liberty, there would be less attention applied to whether any measures implemented are in fact necessary. In the same manner, we would not expect that, because a particular regime was above that threshold and significant restriction of an individual's liberty had been authorised, the measures concerned would be implemented on a specific occasion without any consideration of whether or not they were actually required.

Factors not included

6.17 In framing the list of factors to be taken into account in determining if a person's liberty will be significantly restricted by a proposed care regime, we contemplated other types of measure which are sometimes referred to in discussion about deprivation of liberty. In particular, we addressed the matter of communication, including face to face contact, with friends and relatives.

6.18 We noted that, for England and Wales, one of the features identified in the Supplementary Code of Practice on the Mental Capacity Act 2005 as a matter which may be relevant to identifying deprivation of liberty is:

> "(6) The person is unable to maintain social contacts because of restrictions placed on their access to other people."

6.19 Such a factor has also featured in several decisions of the European Court of Human Rights. For example, in *HL v UK*, in its decision that there had been deprivation of liberty, the Court noted that, for the person at the centre of the case, HL, "contact with his carers was directed and controlled by the hospital".[9] The Court contrasted the position in *HM v Switzerland*, where the appellant "was able to maintain social contact with the outside world".[10]

---

[9] *HL* v *United Kingdom* (2005) 40 EHRR 32 at para 91.
[10] *HM v Switzerland* (2004) 38 EHRR 17 at para 45; referred to in *HL*, at para 93.

6.20 We have concluded, however, that we should not recommend inclusion of a factor of this nature in the list of measures which will constitute significant restriction of liberty.

6.21 Our main reason for not including such a feature is that to include it is tantamount to creating a formal process for restriction of contact and communication. For several reasons, we do not favour such a course.

6.22 In the first place, it is integral to all the Care Standards applying to the sorts of regime we are addressing that contact with friends and family is encouraged. The standards for care homes for older people, care homes for people with learning difficulties and care homes for people with mental health problems all state:

> You can keep up relationships with friends, relatives and carers and links with your own community.[11]

6.23 Similar references are to be found in the standards for adult placement services and for care homes for people with drug and alcohol misuse problems. Maintenance of contact with friends and family is also in line with the importance placed on the views of the adult, their nearest relative, their named person and their primary carer in the principles set out in section 1 of the 2000 Act. We do not wish, even by implication, to compromise the primacy of the aim of maintaining social contact.

6.24 Secondly, a formal process which includes scope for restricting contact with other people will almost inevitably affect the rights of those others. If P is resident in a care home and staff purport to deny him contact with Q, his brother who wishes to visit him, Q's rights to respect for his private and family life under Article 8 will be adversely affected. For this to be an incidental effect of a process for the significant restriction of P appears to us to be undesirable, and it is not clear how full consideration of Q's Article 8 rights could occur in what requires to be a relatively straightforward process, focused on P.

6.25 Lastly, however, we also recognise that there may be situations where an adult's contact with specific individuals does need to be restricted, for their own protection. There is already legislation in place which is designed to operate in such a situation, in the shape of the Adult Support and Protection (Scotland) Act 2007. Under the 2007 Act, it is possible (for example) to obtain an order banning a named individual from the place where an adult at risk is living. There are detailed provisions governing the circumstances in which such an order may be obtained and implemented. It is better, in our view, for any measures which restrict contact between an adult and another person to be adopted under legislation specifically addressing the issues which will arise.

6.26 More generally, we also considered including a catch-all provision, so that there could be taken into account in the assessment of whether there is significant restriction of liberty any other factor which appears to those considering the question to restrict the liberty of a particular individual. The problem with that, however, is that it renders the concept of significant restriction less certain and more difficult to apply. All sorts of measures might be considered relevant in individual cases, but there would also be the potential for great

[11] http://www.nationalcarestandards.org/52.html.

variability around the country. We therefore concluded that a fourth factor, of a general nature, should not be included.

6.27 Related to our thinking on what should or should not be relevant to an assessment of whether a person's liberty is significantly restricted is the question of what we would term "house rules". In an institution, especially a care home, there are likely to be operational policies which could be seen as having a restrictive effect. For example, residents may not be allowed to access parts of the premises, such as the laundry or the maintenance workshop. Access to the kitchen may be restricted. The sending of e-mails may only be possible during certain times of day, when an office is open or staff are available to assist. We envisage that such policies will be reasoned, and that the reasons will relate to the smooth running of the institution. They will apply to all who live there. It would greatly increase the number of situations falling within the definition of significant restriction of liberty if the existence of policies of this nature were to be included in the assessment. We recognise also, however, that there is potential for measures to be used ostensibly as part of efficient organisation, but for these measures to have a serious effect on quality of life and even to be used to mask a failure to provide adequate staffing. In the end, this is an area where a balance has to be struck: rules which are reasonable, but only rules which are reasonable, should be left out of account.

6.28 Accordingly, we recommend:

34. It should be clear that measures which are designed to ensure the smooth running of a residential facility are not included in the assessment of whether a person's liberty is significantly restricted.

(Section 52A(2) of the draft Bill)

Process: evidential requirements

Short-term measures

6.29 It is our view that the implementation of significant restriction of liberty should not take place without detailed consideration of what is required, with careful attention paid to the section 1 principles. There will need to be planning on the part of the management of the residential facility where the person is cared for, medical assessment and mental health officer involvement. The views of the adult and of others who are important to him or her will need to be obtained. But a need to impose restrictions on an individual may be identified at the outset of their residence in a care home or other accommodation covered by this process. It may also be that a person moves into a care home or other accommodation on a temporary basis, perhaps to provide respite for their family or to cover absence or unavailability of their primary carer. There will therefore be a need for an authorisation process which can be effected within a short time scale, and in a shorter period than the full process will require.

6.30 If a potential need for restrictive measures in the short-term is identified, it will be necessary for the person's capacity to make decisions about those measures to be assessed. We consider that the likelihood of a degree of urgency means that it may not always be possible for that assessment of capacity to be made by a psychiatrist. In some

circumstances, a specialist in medicine of elderly people or a general practitioner may be better placed to provide an assessment of an individual's capacity. We recommend:

35. Before steps are taken to identify specific restrictive measures which may require to be taken for a short period in relation to an individual, that individual's capacity to make decisions about such restriction should be assessed by a medical practitioner.

(Sections 52B(2) and 52C(2) of the draft Bill)

6.31 If it is determined that the person concerned lacks capacity to make such decisions, but restriction is necessary in order to prevent harm to him or her, it should be possible for the relevant measures to be taken for an initial relatively short period. We recommend:

36. There should be provision for the adoption of significant restriction of liberty for a period of up to 28 days, renewable once only, in order to allow individuals to be safely cared for while assessment of their longer term needs is carried out, or during a short-term admission to residential care.

(Sections 52B(3)(b), (4) and (5) and 52C(3), (4) and (5) of the draft Bill)

Measures of longer duration

6.32 In all cases other than planned short-term care, it will be necessary to proceed to full assessment to identify and detail any restrictive measures which may be required in the longer term. It is likely that those who manage the accommodation or, if there is no manager, a social worker responsible for an individual's care, will be leading this process. We consider that it is appropriate for that person to take responsibility for preparing a statement in which the measures which appear to be required are specified. We recommend:

37. The person who manages the accommodation in which the adult is living or, if there is no such manager, the adult's social worker, should prepare a document specifying the measures which appear to be necessary in caring for the adult but which have restrictive effect, which document should be known as a Statement of Significant Restriction.

(Sections 52B(9) and 52D(1)(a) of the draft Bill)

6.33 It will also be necessary for there to be input to this process from other professionals. This should ensure compliance with the *Winterwerp* criteria: that the adult concerned has a mental disorder, which is likely to persist and which warrants the measures which are proposed. It should also address the principles in section 1 of the 2000 Act – measures should not be adopted unless they benefit the individual and, if there is more than one possible measure, that which is least restrictive of the adult's freedom should be chosen.

6.34 We envisage, firstly, that medical assessment will be required in order to achieve satisfaction of the *Winterwerp* criteria. Here, as no two adults will have the same history, symptoms and diagnosis, we consider that a degree of flexibility concerning specialism is essential. We therefore recommend:

38. In the assessment process, a medical report should be provided by an approved medical practitioner, as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003 or, where a physician specialising in medicine of elderly people or other medical practitioner has particular knowledge of the adult concerned, that practitioner.

(Section 52D(1)(b)(ii) and (2) of the draft Bill)

6.35 Secondly, as well as such medical input, there should be a report from a mental health officer. We recommend:

39. The assessment process should also be informed by a report from a mental health officer.

(Section 52D(1)(b)(i) of the draft Bill)

6.36 It is possible that one or both of the authors of the reports may disagree with the proposition that the suggested restrictions are warranted. In such circumstances, it appears to us to be preferable that differences of view are resolved, by discussion if necessary, and we therefore propose that revision of the draft Statement by the person who prepared it should be possible. We recommend:

40. There should be provision in the statutory scheme for the Statement to be revised after receipt of the reports from the medical practitioner and mental health officer.

(Section 52D(4) of the draft Bill)

41. The legislation should stipulate that the professionals involved should attempt to reach consensus on the measures which are required in relation to an individual.

(Section 52D(6) of the draft Bill)

6.37 It may be, however, that differences of view cannot be resolved. In such circumstances, we consider that judicial determination should take place. We recommend:

42. Where there are continuing differences of view among professionals as to the restrictive measures, if any, to which an individual should be subject, the author of the draft Statement of Significant Restriction should be able to apply to the sheriff to resolve the matter.

(Section 52D(7) of the draft Bill)

Process: Authorisation of implementation

Surrogate decision maker

6.38 It will be recalled that we have drawn upon the idea of collaborative authorisation, as developed by the Victorian Law Reform Commission.[12] Thus, where there is a surrogate decision-maker appointed either by the adult him or herself or by the court, that person should be able to authorise the implementation of measures set out in the Statement of Significant Restriction. It follows from our recommendation of application to the court where the professionals involved are in disagreement that authorisation by a surrogate decision-maker will be confined to those cases where there is consensus among professionals working with the adult involved. Moreover, the legislation will have to provide a mechanism for cases where the surrogate decision-maker does not agree with the measures in the Statement or simply does not wish to be involved in this process. We recommend:

43. Provision should be made for authorisation to implement the restrictions in the Statement to be granted by a person acting under a welfare power of attorney or a guardian with welfare powers.

(Section 52E(1)(a) of the draft Bill)

44. Where there is such a person, but he or she is not willing to grant authorisation, or where there is no such person, application for authority to implement the restrictions should be made to the sheriff.

(Section 52E(1)(b) of the draft Bill)

6.39 We have already alluded to the importance of all professionals involved in this process having regard to the principles in section 1 of the 2000 Act. If a surrogate decision-maker is supplying the necessary authority, or consent, for the implementation of measures generating significant restriction of liberty, they should also have regard to the section 1 principles. We note an analogous requirement under the Mental Capacity Act 2005: in the granting of powers of attorney in England and Wales, attorneys are required to indicate by their signature that they will act according to the principles of the Act.[13]

Authorisation by the Sheriff

6.40 Applications for authorisation will be made to the sheriff where there is no guardian or attorney with welfare powers, or where there is such a person but they do not wish to grant authorisation. We envisage that the application will be made in the same manner as already applies to other applications under the 2000 Act: by summary application, all as governed by the Summary Applications Rules.[14] The Rules already require service of an application on a wide range of individuals and bodies, and the sheriff has discretion to direct service on others not listed. There is also a requirement to fix a hearing, procedure at which is within the sheriff's discretion.[15]

---

[12] See above at ch 4, paras 4.57-4.60.
[13] Para 2(1)(d)(ii) of Sch 1 to the 2005 Act read with s 9(2)(b) and (4)(a).
[14] Act of Sederunt (Summary Applications, Statutory Applications and Appeals etc. Rules) 1999, SI 1999/929.
[15] Chapter 3, Part XVI, rule 3.16.4 and rules 3.16.2 and 3.16.6 respectively.

Rights of challenge or appeal

6.41 We have referred already to the requirements of Article 5(4), whereby anyone deprived of his or her liberty by detention is entitled to take proceedings whereby the lawfulness of the detention shall be decided by a court. In our Discussion Paper, we referred to dicta of the European Court of Human Rights in the case of *De Wilde, Ooms and Versyp v Belgium* concerning deprivation of liberty for vagrancy. The Court said:

> "Where the decision depriving a person of his liberty is one taken by an administrative body, there is no doubt that Article 5(4) obliges the Contracting States to make available to the person detained a right of recourse to a court."[16]

6.42 We have already recommended that, in cases where the adult who is subject to measures representing significant restriction of liberty has a guardian or attorney with welfare powers, the authorisation to implement such measures could emanate from that surrogate decision-maker. As we observed in our Discussion Paper, there is a passage in the reasoning of the European Court of Human Rights in *Stanev* which could be interpreted as meaning that the consent of a substitute decision maker may sometimes "validly replace" the wishes of the adult concerned.[17] Such valid replacement would presumably therefore mean that there is consent to the regime in question, which would prevent its being seen as deprivation of liberty.

6.43 In relation to Article 5(4) however, we consider that the reasoning referred to above is not sufficiently developed as to obviate the need to provide a right of recourse to a court in such a situation.

Duration and renewal

6.44 The standard position is that any significant restriction of liberty is authorised for a period of one year. On expiry of the one year period there must either be renewal of authorisation to implement significant restriction of liberty, or use of the measures of restriction must cease. Where renewal is sought, essentially the same procedure as for authorisation of the original Statement of Restriction is to be followed, subject to a change of focus to cover predominantly those areas where a modification of the statement is thought to be required. The first step in the process is production of a copy of the Statement of Significant Restriction highlighting any changes that are thought to be needed.

6.45 The one year period is intended to be the maximum amount of time for which authorisation may run. The existence of the variation process ensures that there is provision for review before the year comes to an end.

Variation

6.46 The only form of variation that is provided for is the addition of a further measure of restriction to a Statement of Significant Restriction. This may involve the addition of a new measure in its own right. Alternatively, it may mean that a measure of restriction is subject to modification of such a fundamental nature that a new measure is effectively imposed. We have given thought to including what would be more minor modification of measures, not

---

[16] *De Wilde, Ooms and Versyp v Belgium* (No.1) (1979-80) 1 EHRR 438 at para 76.
[17] DP No 156 at paras 6.72-6.74.

effectively amounting to new measures, but reached the view that this gave rise to an unwarranted level of detail and complexity. Similarly, we concluded that to capture the cessation of use of a measure as a variation would be overly detailed and, in any event, probably unnecessary.

6.47 The variation process is intended to be reasonably informal. It will be open to the relevant person to effect a variation of any of the measures contained in it where they consider it appropriate to do so. The variation is to be notified to a number of people, including any welfare attorney or welfare guardian of the adult. Such attorney or guardian does not, however, have the opportunity for input to the initial decision as to whether the variation takes place. This rests entirely with the care home manager or social worker who prepared and obtained authorisation of the statement.

Intimation and documentation

6.48 We consider that the Mental Welfare Commission, whose statutory role includes monitoring both respect for rights and provision of benefit in relation to persons with incapacity, should be informed of the significant restriction of liberty of particular individuals. A relevant person who has prepared a Statement of Significant Restriction (including a renewal document) which has been authorised in accordance with the statutory provisions should intimate that authorisation to the Mental Welfare Commission, together with a copy of the Statement of Significant Restriction.

Conclusion

6.49 It is now necessary to return to Article 5, and to examine how our proposed scheme fits with the jurisprudence on deprivation of liberty.

6.50 In our Discussion Paper we commented that sometimes the State is obliged by Articles 2 and 3 of the ECHR to take measures to protect individuals.[18] The range of disabilities people have means that in order to secure universal enjoyment of the right to life and freedom from ill-treatment, the State has to treat individuals differently, according to their situations. In some cases, allowing unrestricted freedom of action to an individual would pose unacceptable risks to their life and health.[19]

6.51 Turning to Article 5, it is also apparent that there are some regimes of care for people with disabilities which are unduly restrictive. If a regime is so restrictive that it can accurately be described as a deprivation of liberty, then it must be authorised, in order to comply with Article 5. It is necessary to try to ascertain what the European Court of Human Rights will take into account when it is analysing restrictive regimes and determining whether their extent is sufficient to be characterised as "deprivation" of liberty.

---

[18] Paras 2.64-2.69.

[19] This can be so where individuals in the care of the State might take action which would result in their death at a time when they are not making reasoned decisions. "In certain circumstances, the state's positive obligation to protect life ...entails an obligation to take positive steps to prevent a real and immediate risk to the life of a particular individual from materialising". *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2; [2012] 2 AC 72 at para 94.

6.52 In the first place, it will look at whether the person can come and go from the place where they live. This appears to us to be the sense in which the Court uses the term "free to leave".[20] It can be characterised as "confinement".

6.53 In the second place, the Court will look at measures adopted within the premises, such as medication or physical restraint.[21] Medication is a complex matter, however. Sometimes, medication is entirely about relief of unpleasant symptoms. We are attempting to cover situations where it is, to some extent, about controlling the person.

6.54 In the third place, it seems that the Court will look at "isolation".[22] As we explained, we have not included a factor of this nature in our scheme, as we could not envisage a need for authorisation of the banning of contact as part of a care regime, rather than using the provisions of the Adult Support and Protection (Scotland) Act 2007 to deal with contact which poses a threat of harm.

6.55 Additional factors may be relevant, but it is not possible to be clear as to their importance. This appears to be the case with purpose in general, or benevolent intention in particular. The case of *HM v Switzerland*[23] could be said to involve benevolent intention as a factor. The Court did refer to *HM* in *Chosta*, in 2014, albeit not specifically while discussing benevolence. It should also be noted that in *Creanga v Romania*,[24] the Court commented that the purpose of measures "no longer appears decisive" in determining whether there is a deprivation of liberty. In relation to purpose, the Court observed:

> "To date, the Court has taken this into account only at a later stage of its analysis, when examining the compatibility of the measure with Article 5 § 1 of the Convention."[25]

These dicta might be thought to suggest a degree of equivocation.

6.56 On the other hand, in *Austin v United Kingdom*[26], the Grand Chamber said:

> "Indeed, it is clear from the Court's case-law that an underlying public-interest motive, for example to protect the community against a perceived threat emanating from an individual, has no bearing on the question whether that person has been deprived of his liberty, although it might be relevant to the subsequent inquiry whether the deprivation of liberty was justified under one of the sub-paragraphs of Article 5 § 1. The same is true where the object is to protect, treat or care in some way for the person taken into confinement, unless that person has validly consented to what would otherwise be a deprivation of liberty (see *Storck*[27] and the cases cited therein and, most recently, *Stanev*[28]."

---

[20] See *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 128 ("not free to leave the home without permission whenever he wished"); *Kedzior v Poland* [2013] MHLR 115 at para 57 and *Mihailovs v Latvia* Application no. 35939/10, 22 January 2013 at para 132.

[21] For example, in *Storck v Germany* (2006) 43 EHRR 6, the applicant had been forced to take very strong medication. In *DD v Lithuania* [2012] MHLR 209, the applicant had been "given drugs and tied down".

[22] *Chosta v Ukraine* Application no. 35807/05,, 14 January 2014 at p 6. See also *Storck* at para 73; *Stanev* at paras 124-126; *Guzzardi v Italy* (1980) 3 EHRR 333 at para 95; *Mihailovs* at para 132.

[23] (2004) 38 EHRR 17.

[24] *Creanga v Romania* (2013) 56 EHRR 11.

[25] *Creanga* at para 93.

[26] *Austin v United Kingdom* (2012) 55 EHRR 14 at para 58.

[27] *Storck v Germany* (2006) 43 EHRR 6 at paras 74-78.

[28] *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 117.

6.57 Also on the list of potentially relevant factors is context. In *Austin* the Grand Chamber said:

> "However, the Court is of the view that the requirement to take account of the "type" and "manner of implementation" of the measure in question (see *Engel and Others*[29], and *Guzzardi*[30]) enables it to have regard to the specific context and circumstances surrounding types of restriction other than the paradigm of confinement in a cell (see, for example, *Engel and Others*[31], and *Amuur*[32]). Indeed, the context in which action is taken is an important factor to be taken into account, since situations commonly occur in modern society where the public may be called upon to endure restrictions on freedom of movement or liberty in the interests of the common good. As the judges in the Court of Appeal and House of Lords observed, members of the public generally accept that temporary restrictions may be placed on their freedom of movement in certain contexts, such as travel by public transport or on the motorway, or attendance at a football match. The Court does not consider that such commonly occurring restrictions on movement, so long as they are rendered unavoidable as a result of circumstances beyond the control of the authorities and are necessary to avert a real risk of serious injury or damage, and are kept to the minimum required for that purpose, can properly be described as "deprivations of liberty" within the meaning of Article 5 § 1."[33]

6.58 There are, therefore, interesting questions about how Strasbourg might assess the situation of those in social care placements unlike the ones it has examined to date, that is situations where the context is that people are "living happily in a domestic setting".[34] Such matters as whether a care home is run by the State or simply supervised by it could also be relevant.[35] There is no doubt that these are difficult issues, existing at the interface between, on the one hand, Articles 2 and 3 and, on the other, Article 5. Further clarification is likely, but Scots law may need to be reformed in advance of that occurring.

6.59 In our Discussion Paper we referred to devising a system which meets the needs and respects the rights of persons in this jurisdiction. In this Report, we are endeavouring to contribute to that exercise.

6.60 We have already said that we consider decisions as to where a person lives to be of great importance. This is true irrespective of the Convention, but clearly Article 8 is involved. In applications alleging breach of one or more Articles of the Convention, the European Court is likely to be influenced by decision-making which appears to attach insufficient importance to the idea of a person's home. For example, in *Stanev*, the decision to place S in what was described as "a social care home in a remote mountain location" was taken by his guardian in the following manner:

> "the duties of guardian were assigned to a State official (Ms R.P.), who negotiated and signed the placement agreement with the Pastra social care home without any contact with the applicant, whom she had in fact never met".[36]

---

[29] *Engel and Others v Netherlands* (1979-80) 1 EHRR 647 at para 59.
[30] *Guzzardi v Italy* (1980) 3 EHRR 333 at para 92.
[31] At para 59.
[32] *Amuur v France* (1996) 22 EHRR 533 at para 43.
[33] Para 59.
[34] *Cheshire West,* at paras 99 and 108.
[35] See para 121 of *Stanev.*
[36] *Stanev* at para 122.

These decisions need to be reached with great care and disputes need to be sensitively and carefully resolved.

6.61 Turning to consider the other ingredients of a system which meets the needs and respects the rights of people who are in social care, we have attempted to create a test to be used to identify a significantly restrictive regime in order that such a regime can then be scrutinised and authorisation to implement it can be sought. Our scheme is constructed around the elements of confinement to premises, seclusion and control, whether by physical restraint or medication. This combination appears to us to accord with the test referred to in the Supreme Court for deprivation of liberty: that a person is under continuous supervision and control and is not free to leave.[37] As previously explained, the scheme does not include something Strasbourg has now said it would also take into account, isolation, because we cannot think of circumstances where authorisation to implement that regularly in order to benefit a person might require to be sought.

6.62 Under our scheme, there will be some social care placements of individuals who lack capacity which do not constitute significant restriction of liberty. It appears to us that one of the issues which influenced the majority of the Supreme Court in its decision on the MIG and MEG appeal was the need for review, as set out in Article 5(4).[38] It is beyond dispute that decisions about where individuals live when they cannot make those decisions themselves need to be kept under review. It is also right that authorisation to implement restrictive regimes should be reviewed from time to time. It is less obvious that the best way to do all parts of the exercise required is through a court.

6.63 We very much hope that our scheme will come as close as possible to detecting those cases where the restriction of liberty for individuals who lack capacity is greater than it needs to be. We do not think our scheme infringes the principle that liberty means the same for all citizens. This is because of our belief that the principle does not mean that the State has a duty to permit a situation where individuals for whose care it has some responsibility are free to take action which will endanger their life or health, when they cannot take a reasoned decision about such action themselves. In those circumstances, the State may even have a duty to restrain them.

6.64 Authorisation of the deprivation of liberty of those in the most restrictive regimes is required, and it requires to take place within the justice system. But the continuous monitoring also required of the life and health of such vulnerable people is better carried out by professionals in other systems, who have a higher chance of demonstrating the constant vigilance required.

[37] *Cheshire West* at para 49.
[38] *Cheshire West at* para 32.

Chapter 7 Power to make an order for cessation of unlawful detention

Introduction

7.1 As noted in Chapter 3,[1] we asked in our Discussion Paper whether there should be a provision, along the lines of section 291 of 2003 Act, in relation to *de facto* detention in facilities other than hospitals. Of the 26 consultees who responded to the question, 22 expressed support for a provision along the lines proposed. Those consultees who did not support the provision tended to take the view that existing law already provided sufficient protection for people lacking capacity who were subject to unlawful detention. They referred to elements of criminal law, criminal procedure and also to the Adult Support and Protection (Scotland) Act 2007. Having considered existing provision in these areas, however, we are not persuaded that there currently exists sufficient protection which is applicable to the types of circumstances with which we are concerned.

Scope of the provision

7.2 Section 52J of the draft Bill makes provision for application to the sheriff to make an order to bring to an end detention in accommodation provided or arranged for by a care home service or adult placement service, but which is not authorised either by the 2000 Act or by the 2003 Act. We are concerned, therefore, with situations involving adults who lack, or may lack, capacity to consent to their own living arrangements who are living either in a care home or in accommodation arranged by an adult placement service. We have deliberately chosen to include adults who *may* lack capacity within the scope of the provision. We are concerned that nobody should be denied the protection of section 52J, owing to their lack of capacity having not yet been established.

7.3 The application to the sheriff may be made by the adult who is subject to the detention, or any other person who claims to have an interest in the personal welfare of the adult.[2] This could include the adult's guardian or a person to whom the adult has given power of attorney. Alternatively, it may be, for example, a carer or close friend or relative of the adult.

Operation of the provision

7.4 An order of the sheriff may require either the manager of the accommodation in which the adult is living, or any other person effecting the detention of the adult, to cease to detain the adult.[3] We would envisage that in most cases the application to the sheriff would be framed as a request to the sheriff to order that the manager of the accommodation cease to detain the adult. This is likely to be apt in the situation where a person is living in a care

[1] Paras 3.62–3.67 above.
[2] Section 52J(2).
[3] Section 52J(2) and (3).

home, in which there will be a manager who is in overall charge. In relation to an adult living in accommodation arranged by an adult placement service, however, the role of the manager is likely to be less clear-cut. The manager of the adult placement service is unlikely to have a direct role in the putting in place of the arrangements which are taken to amount to detention in the context of a particular placement. An order could, therefore, be made to direct a person with whom the adult is living, as part of an adult placement, to stop imposing certain measures upon them. If the manager or other person who was the subject of the order took the view that continued restriction of the adult's liberty was necessary, it would be open to them to follow through the community procedure. The aim of the provision is, in essence, to ensure that where arrangements giving rise to a significant restriction of liberty are in place in a setting to which the community procedure applies, that restriction is either authorised, or brought to an end.

7.5 The test to be applied by the sheriff in determining an application under section 52J is a clearly defined one. The sheriff is to make an order only if he or she is satisfied that the person is being detained unlawfully.[4] There are two situations in which apparent "detention" could be lawful. Either appropriate decisions governing place of residence and significant restriction of liberty under the 2000 Act are in place, or there is a compulsory treatment order under the 2003 Act which expressly authorises detention. The potential for reliance on compulsory treatment orders to authorise detention in social care settings in the community was brought into focus by the case of *AB v Bernarda Rodriguez and others,*[5] as discussed in chapter 2.[6]

Definitions

7.6 As discussed in Chapter 3 above[7], we do not make a recommendation that the 2000 Act be amended to define the terms "detention" and "deprivation of liberty." Several consultees suggested in their responses that a workable definition of those terms is likely to be extremely difficult to achieve. In addition, as the Faculty of Advocates pointed out, the application of Article 5 of the ECHR necessarily involves the balancing of a number of factors relevant to any given situation. It is questionable to what extent the inclusion of specific definitions would be consistent with that.

Interaction between the cessation of detention provision and section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003

7.7 In formulating our recommendation for the cessation of detention provision, we considered as our starting point section 291 of the 2003 Act. However, section 291 applies only where a person is in "hospital". The term "hospital" is defined in the Act to mean any health service hospital, independent health care service or state hospital.[8] It seems clear that this would not cover a person in the type of accommodation with which we are concerned in relation to the cessation of detention provision.

[4] Section 52J(3).
[5] 2012 GWD 34-702.
[6] Paras 2.36-2.38 above.
[7] Paras 3.22-3.38 above.
[8] Section 329 of the 2003 Act.

7.8 We are, though, conscious that applications under our proposed new provision would be similar in nature to those under section 291. Applications under section 291 are determined by the Mental Health Tribunal for Scotland. By contrast, the intention is that applications under the new provision for cessation of detention would be made to the appropriate sheriff court. It is possible that this could at times give rise to disputes between the Tribunal and the sheriff court as to jurisdiction. The matter of which is the appropriate body to deal with an application will, though, fall to be determined by reference to two concrete questions – whether the person is being treated in a hospital and, if so, whether the person is receiving treatment primarily for mental disorder, all within the meaning of the 2003 Act. Where the answer to both these questions is in the affirmative, use of section 291 will be appropriate.

7.9 Some concerns have been raised about the potential practical consequences of a power to require unlawful detention to be stopped. It could require the manager of a care home or a person offering accommodation under an adult placement to release a person, notwithstanding that the person is known to be in need of care as a result of their incapacity. However, we note that section 3(1) of the 2000 Act confers on the sheriff a power to make such consequential or ancillary order, provision or direction as he or she considers appropriate in any application or other proceedings under the Act. We consider that this could be used to put in place preliminary care arrangements thought necessary for an adult lacking capacity whose detention was ordered to cease under our proposed new provision. We further note that the same issue might arise where an order under section 291 of the 2003 Act is made by the Mental Health Tribunal. The 2003 Act does not contain an equivalent to section 3(1) of the 2000 Act.

7.10 We recommend:

45. There should be provision for an adult who may lack capacity to consent to his or her own living arrangements or any person claiming an interest in the personal welfare of such an adult to apply to the sheriff to make an order that the adult's unlawful detention in accommodation provided by a care home service or arranged by an adult placement service should cease.

(Section 52J of the draft Bill)

Chapter 8 Summary of recommendations

1. There should be a simple and straightforward process to authorise the use of measures to prevent an adult with incapacity who requires treatment for physical health from leaving a hospital unaccompanied.

(Paragraph 4.7)

2. The process should authorise the use of measures during inpatient assessment as well as actual treatment, and should include rights to challenge the decision to take such measures.

(Paragraph 4.8)

3. The Scottish Government should consider whether a single report from a medical practitioner should be sufficient for the granting of an intervention order under the Adults with Incapacity (Scotland) Act 2000.

(Paragraph 4.27)

4. Consideration should be given to widening the range of medical practitioners from whom a report can be obtained for the purposes of an application for an intervention order.

(Paragraph 4.27)

5. There should be provision for the setting of an end date for the exercise of authority to implement measures to prevent an adult from going out of a hospital.

(Paragraph 4.38)

6. The process for authorisation of a restrictive regime to which an individual in a community setting is subject should be constructed around the concept of “significant restriction of liberty”.

(Paragraph 4.56)

7. The process and the relevant definition should be in legislation.

(Paragraph 4.56)

8. The concept of significant restriction of liberty should be defined in a manner which, as far as possible, enables all those affected to measure the degree of restriction to which a person is subject in a straightforward manner.

(Paragraph 4.56)

9. The authorisation process should make provision for guardians and those acting under welfare powers of attorney to authorise significant restriction of liberty.

(Paragraph 4.60)

10. Where authorisation of significant restriction of liberty of an adult cannot be granted by an attorney or a guardian with welfare powers, application should be made to the sheriff, and the Adults with Incapacity (Scotland) Act 2000 should be amended to insert the necessary provisions.

(Paragraph 4.63)

11. In considering an application for authorisation of significant restriction of liberty for an adult who does not have a welfare guardian or an attorney with welfare powers, the sheriff should require the local authority to consider whether a guardian should be appointed.

(Paragraph 4.64)

12. If the local authority considers that a guardian is required, they should apply under the Act for an appointment unless there is another person who can be appointed.

(Paragraph 4.64)

13. The process to authorise significant restriction of liberty should incorporate requirements designed to ensure that the Winterwerp criteria are met.

(Paragraph 4.65)

14. The principles set out in section 1 of the Adults with Incapacity (Scotland) Act 2000 should apply to any proposed significant restriction of liberty.

(Paragraph 4.67)

15. The authorisation process should include ascertaining and taking account of the matters covered in subsections (2) to (4) of section 1.

(Paragraph 4.67)

16. The process for authorising significant restriction of liberty should include provision for periodic review, at intervals of no more than a year, and renewal where appropriate.

(Paragraph 4.71)

17. Provision should be made within the authorisation process for variation of the specified restrictions while an authorisation is in force.

(Paragraph 4.72)

18. Provision should be made within the authorisation process for restriction of liberty on an interim basis, while the full assessment process operates.

(Paragraph 4.74)

19. Provision should be made within the authorisation process for restriction of liberty on a short-term basis.

(Paragraph 4.74)

20. There should be a provision, similar to section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to enable application to be made for the cessation of de facto detention in premises where people are accommodated in order to receive care but which are not covered by section 291.

(Paragraph 4.75)

21. The process to authorise measures to keep a patient safe should apply to hospitals.

(Paragraph 5.7)

22. The authorisation process should apply to a patient who is receiving medical treatment or is being assessed as to whether they need it.

(Paragraph 5.8)

23. It should be competent for the medical practitioner primarily responsible for the medical treatment or assessment of a patient to certify that the patient is incapable in relation to a decision as to whether or not to go out of the hospital.

(Paragraph 5.12)

24. The process should authorise any person involved in the medical treatment of a patient to do what is reasonable to prevent the patient from going out of a hospital.

(Paragraph 5.18)

25. If the use of medication is the only possible means of preventing an adult from going out of hospital, that use should be authorised.

(Paragraph 5.18)

26. The use of force is authorised only if it is immediately necessary and for so long as it is necessary.

(Paragraph 5.18)

27. Regulations may prescribe a form for the certificate of incapacity.

(Paragraph 5.18)

28. The measures should be authorised for as long as the need for them is manifest.

(Paragraph 5.19)

29. Where a patient no longer requires medical treatment or assessment, an application can be made to the sheriff by anyone claiming an interest in the personal welfare of the patient, including the patient, to set an end date after which there is no longer authority for imposition of measures of restriction.

(Paragraph 5.25)

30. There should be a duty on the medical practitioner to review and where appropriate to revoke the certificate of incapacity.

(Paragraph 5.27)

31. The patient and any person claiming an interest in the personal welfare of the patient should be given a right to apply to the sheriff to review the exercise of authority under a section 50A certificate to prevent a patient from going out of a hospital.

(Paragraph 5.31)

32. The process for authorisation of significant restriction of liberty should apply to care homes and arrangements made by adult placement services.

(Paragraph 6.4)

33. In identifying whether significant restriction of liberty is occurring, regard should be paid to the presence of the following elements:

- Absence of unrestricted right of egress from the accommodation
- Confinement within the accommodation
- The use of measures to control the actions of an individual.

(Paragraph 6.13)

34. It should be clear that measures which are designed to ensure the smooth running of a residential facility are not included in the assessment of whether a person's liberty is significantly restricted.

(Paragraph 6.27)

35. Before steps are taken to identify specific restrictive measures which may require to be taken for a short period in relation to an individual, that individual's capacity to make decisions about such restriction should be assessed by a medical practitioner.

(Paragraph 6.29)

36. There should be provision for the adoption of significant restriction of liberty for a period of up to 28 days, renewable once only, in order to allow individuals to be safely cared for while assessment of their longer term needs is carried out, or during a short-term admission to residential care.

(Paragraph 6.30)

37. The person who manages the accommodation in which the adult is living or, if there is no such manager, the adult's social worker, should prepare a document specifying the measures which appear to be necessary in caring for the adult but which have restrictive effect, which document should be known as a Statement of Significant Restriction.

(Paragraph 6.31)

38. In the assessment process, a medical report should be provided by an approved medical practitioner, as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003 or, where a physician specialising in medicine of elderly people or other medical practitioner has particular knowledge of the adult concerned, that practitioner.

(Paragraph 6.33)

39. The assessment process should also be informed by a report from a mental health officer.

(Paragraph 6.34)

40. There should be provision in the statutory scheme for the Statement to be revised after receipt of the reports from the medical practitioner and mental health officer.

(Paragraph 6.35)

41. The legislation should stipulate that the professionals involved should attempt to reach consensus on the measures which are required in relation to an individual.

(Paragraph 6.35)

42. Where there are continuing differences of view among professionals as to the restrictive measures, if any, to which an individual should be subject, the author of the draft Statement of Significant Restriction should be able to apply to the sheriff to resolve the matter.

(Paragraph 6.36)

43. Provision should be made for authorisation to implement the restrictions in the Statement to be granted by a person acting under a welfare power of attorney or a guardian with welfare powers.

(Paragraph 6.37)

44. Where there is such a person, but he or she is not willing to grant authorisation, or where there is no such person, application for authority to implement the restrictions should be made to the sheriff.

(Paragraph 6.37)

45. There should be provision for an adult who may lack capacity to consent to his or her own living arrangements or any person claiming an interest in the personal welfare of such an adult to apply to the sheriff to make an order that the adult's unlawful detention in accommodation provided by a care home service or arranged by an adult placement service should cease.

(Paragraph 7.10)

Appendix A

Adults with Incapacity (Scotland) Bill
[DRAFT]

An Act of the Scottish Parliament to make further provision as regards the safety and liberty of adults with incapacity; and for connected purposes

1 Amendment of Adults with Incapacity (Scotland) Act 2000

(1) The Adults with Incapacity (Scotland) Act 2000 is amended as follows.

(2) After section 50 insert the following sections—

"**50A Measures to prevent adult patient from going out of a hospital**

(1) This section applies—

(a) where an adult ("the patient") either—

(i) is receiving medical treatment in a hospital, or

(ii) is being assessed in a hospital for the purpose of ascertaining whether the patient requires such treatment, and

(b) the medical practitioner primarily responsible for that medical treatment or as the case may be for that assessment—

(i) is of the opinion that the patient is incapable in relation to a decision as to whether or not to go out of the hospital (or whether or not to go out of some part of the hospital), and

(ii) has so certified in accordance with subsection (10).

(2) The medical practitioner who by virtue of subsection (1) has issued the certificate shall have authority to do what is reasonable to prevent the patient's going out of the hospital (or as the case may be going out of some part of the hospital) as shall any person acting—

(a) on behalf of, and under the instructions of, the medical practitioner, or

(b) with the medical practitioner's approval or agreement.

(3) The authority conferred by subsection (2)—

(a) shall subsist for so long as the need for such preventative measures is manifest, and

(b) shall not authorise—

(i) the use of force unless immediately necessary and then only for so long as is necessary in the circumstances, or

(ii) action which would be inconsistent with any decision by a competent court.

(4) Subsections (2) and (3) do not affect any authority conferred by any other enactment or rule of law.

(5) Without prejudice to the generality of subsection (2), what is done under that subsection may include the administering of medication for the purpose of confining the patient to the hospital (or some part of the hospital).

(6) Any exercise of the authority conferred by subsection (2) (other than the administering of medication by virtue of subsection (5)) may be appealed against by application to the sheriff—

(a) by the patient, or

(b) by any person claiming an interest in the personal welfare of the patient.

(7) A decision to administer medication to a patient by virtue of subsection (5) is, for the purposes of section 52, a decision as to the medical treatment of the patient.

(8) Where—

(a) an appeal has been made under subsection (3) of section 50 in relation to the medical treatment of the patient and has not been determined,

(b) an application has been made under subsection (6) of that section in relation to that treatment and has not been determined, or

(c) an appeal has been made under section 52 in relation to that treatment and has not been determined,

any appeal under subsection (6) shall be sisted pending such determination.

(9) Where a nomination has been requested under section 50(4) in relation to the medical treatment of the patient and the opinion to be given has not been obtained, any appeal under subsection (6) shall be sisted pending the opinion being obtained and the determination of any resultant appeal under section 50(6).

(10) A certificate for the purposes of subsection (1) shall be in the prescribed form.

(11) In this section and in sections 50B and 50C, "hospital"—

(a) is to be construed in accordance with section 108(1) of the National Health Service (Scotland) Act 1978 (c.29), but

(b) does not include a care home service (as defined in schedule 12 to the Public Services Reform (Scotland) Act 2010 (asp 8)).

NOTE

Section 50A implements recommendations 21-28 and 31. It provides for authorisation of use of measures to prevent a patient going out of a hospital (or a part of a hospital) unaccompanied whilst in the course of receiving medical treatment or undergoing medical assessment to establish if they need medical treatment. It covers short-term absences, as well as attempts to leave a hospital on a permanent basis. Its aim is to capture measures that restrict an adult's liberty to such an extent that the European Court of Human Rights would regard Article 5 ECHR as being engaged.

By subsection (1), authorisation is to be granted by means of the issuing of a certificate by the medical practitioner primarily responsible for the treatment of the adult. The certificate is to the effect that the medical practitioner takes the view that the adult is incapable in relation to a decision as to whether or not to go out of the hospital, or some part of the hospital. This distinction is made to reflect the differing layouts of hospitals; whether measures are taken at ward exits or main entrances will vary.

Subsection (2) is intentionally framed in a general way, enabling the medical practitioner and any person acting on behalf of that medical practitioner or with their agreement to do what is reasonable to prevent a patient from going out of a hospital or any part of a hospital. The provision is not, though, intended to capture measures taken purely as part of general hospital care, but which have the effect of preventing someone from leaving a hospital. Such general measures would include use of bed rails, and, indeed, anaesthetics.

Subsection (3) deals with the duration of the authorisation of use of restrictive measures and imposes certain constraints as to what measures can be used. As regards duration, subsection (3)(a) makes clear that the certificate should remain in place for so long as the medical practitioner who issued the certificate considers that the need for the measures is manifest. This is intended to be a flexible test, catering in particular for a possible period when treatment or assessment is complete but the adult requires to remain in hospital, pending the putting in place of suitable arrangements for the future. As regards the nature of the measures, subsection (3)(b) provides that use of force is to be taken to be authorised only where this is immediately necessary, and where it is to be used for the minimum amount of time possible in the circumstances. Moreover, no action is to be taken to be authorised which would be inconsistent with a competent court decision.

Subsection (4) is intended to ensure that where keeping a person in hospital has already been authorised via other statutory or common law authority, for example the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), such authorisation is not affected by any certificate issued under section 50A(1).

Subsection (5) explicitly provides that notwithstanding the general approach provided for in subsection (2), use of medication is one measure that might be invoked for the purposes of confining a patient to a hospital where it is appropriate to do so.

Subsections (6) and (7) deal with rights of appeal. Subsection (6) establishes that any exercise of authority in terms of a section 50A(1) certificate can be appealed to the sheriff and thereafter the relevant Sheriff Principal and ultimately the Court of Session. The right to go to court is intentionally widely framed, allowing it to be exercised by a concerned friend or neighbour in appropriate circumstances. Subsection (7) provides that where an appeal is brought in connection with use of medication under subsection (5), this is to be treated as an appeal against a decision as to medical treatment.

Subsection (8) deals with timing and sisting of appeals. Where an appeal or application under section 50(3) or (6) or section 52 of the 2000 Act has been brought but has not yet been determined, the determination of the appeal under section 50A(6) is to be sisted pending completion of the other proceedings.

Similarly, subsection (9) provides for sisting of an appeal under subsection (6) where there has been a request to the Mental Welfare Commission to nominate a person to deal with a dispute between the person who issued a certificate under section 47(1) and a welfare attorney, welfare guardian or person authorised by an intervention order in relation to the adult, as to medical treatment authorised in terms of section 47(1). The appeal is to be sisted pending the provision of an opinion by the nominated person. In any situation where an appeal is brought, it is intended that measures authorised by a certificate issued under section 50C should continue to be implemented pending the determination of the appeal. This is to apply also where an appeal under subsection (6) has been sisted until the outcome of another appeal is determined.

Subsection (10) makes clear that a certificate of incapacity issued in terms of subsection (1) must follow the prescribed form. Applying the definition of "prescribed" in section 87(1) of the 2000 Act, this will be by means of regulations.

Subsection (11) makes provision in relation to the definition of "hospital". The definition in section 108 of the National Health Service (Scotland) Act 1978 is applied, subject to the express exclusion of care home services. Both NHS and independent hospitals are caught by this definition.

50B Review and revocation of certificate issued by virtue of section 50A(1)

(1) A medical practitioner who by virtue of subsection (1) of section 50A has issued a certificate in respect of a patient admitted to a hospital shall, from time to time while the patient continues to receive medical treatment or continues to be assessed there, consider whether the patient remains incapable in relation to a decision mentioned in paragraph (b)(i) of that subsection.

(2) If, having conducted such a review, the medical practitioner is no longer of the opinion that the patient is incapable in relation to such a decision, the medical practitioner shall revoke the certificate.

NOTE

Section 50B implements recommendation 30. It seeks to ensure that certificates under section 50A remain in place only for so long as there is a need for them.

Subsection (1) imposes a requirement that any patient in respect of whom a section 50A certificate has been issued be kept under review by the medical practitioner who issued the certificate, to determine if they continue to lack capacity in relation to deciding whether to go out of a hospital. Where it is thought that they no longer lack such capacity, the certificate is to be revoked in terms of subsection (2).

50C Setting end date for exercise of authority conferred by section 50A(2)

(1) This section applies where a certificate—

(a) has been issued under section 50A(1)(b)(ii) in respect of a patient, and

(b) has not been revoked under section 50B(2).

(2) The patient, or any person having an interest in the personal welfare of the patient, may apply to the sheriff for an order setting a date beyond which measures in respect of the patient are not to be treated as authorised under section 50A(2).

(3) The sheriff may grant the application if satisfied, after giving the applicant, the medical practitioner who issued the certificate, the chief social work officer of the local authority and (where the applicant is a person having an interest in the personal welfare of the patient) the patient an opportunity to be heard—

(a) that the patient—

(i) no longer requires the medical treatment for which admitted to hospital, or

(ii) does not require continuing assessment there, and

(b) that—

(i) it is appropriate and practicable for the patient to return home, or

(ii) accommodation, where appropriate long term care can be provided, is available for the patient elsewhere than at the hospital.".

NOTE

Section 50C implements recommendations 5 and 29. It caters for the scenario in which, for a variety of possible (and non-clinical) reasons a patient remains in a hospital beyond the point at which they are receiving medical treatment or undergoing assessment.

Subsection (1) makes clear that the application of the section is confined to circumstances where a certificate under section 50A(1)(b)(ii) has been issued in respect of a patient and has not been revoked.

Subsection (2) provides for the patient or any person having an interest in the personal welfare of the patient to apply to the sheriff for an order, the effect of which would be that use of measures of restriction would no longer be authorised as from the date specified in the order.

Subsection (3) sets out certain requirements which the sheriff must consider are met before an order under section 50C can be made. Firstly, the sheriff must be satisfied that the need for the medical treatment or assessment which initially gave rise to the patient's admission to hospital has come to an end. Secondly, the sheriff must take the view that the patient is ready to return home (this being practicable) or to move to other accommodation where appropriate long-term care can be provided. The reference to accommodation providing "long term care" is intended to cover any residential accommodation. Suitable accommodation or arrangements must already be available or in place before the order can be made. By "home" may be meant the care home or facility in which the patient lived prior to admission to hospital.

(3) After Part 5, insert the following Part—

"PART 5A

LIBERTY OF ADULTS

52A Interpretation of Part 5A: the expression "significant restriction" etc.

(1) For the purposes of this Part, an adult's liberty is subject to "significant restriction" if (and only if) measures mentioned in more than one of paragraphs (a) to (c) apply on a regular basis as respects the adult—

(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,

(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.

(2) But measures applicable to all residents at those premises (other than such staff as reside there) and intended to facilitate the proper management of the premises without disadvantaging residents excessively or unreasonably are not to be regarded as giving rise to significant restriction.

(3) In this Part, "placed" means placed, by reason of the adult's vulnerability or need, in accommodation provided by (or as the case may be arranged for by) a care home service or an adult placement service.

(4) In subsection (1)(c), "restraint"—

(a) includes specially designed clothing, but

(b) does not include a device the sole purpose of which is to act as a safeguard against falling.

(5) In subsection (3), "vulnerability or need" means vulnerability or need arising as mentioned in any of paragraphs (a) to (c) of the definition of that expression in paragraph 20 of schedule 12 to the Public Services Reform (Scotland) Act 2010 (asp 8).

(6) In this Part, "care home service" and "adult placement service" have the meanings assigned to those expressions by section 47(2) of, and paragraphs 2 and 11 of that schedule to, that Act.

NOTE

Section 52A implements recommendations 32-34. It provides for the interpretation of key terms in relation to restriction of liberty in certain care settings within the community, namely in care homes and in accommodation arranged by adult placement services. We refer to this as the community process. In connection with the community process the term "relevant person" is used in a number of places in the Bill. In essence it is a shorthand reference to the manager of the premises in which accommodation is, or is to be, provided or, absent such a manager, the social worker assigned to the adult.

Subsection (1) sets out three categories of measures of restriction. When two or more are in use on a regular basis, this will give rise to what is referred to as "a significant restriction of liberty." The key consideration is that their cumulative effect produces elements of confinement, seclusion and control, to such a degree that the European Court of Human Rights in Strasbourg would be likely to regard Article 5 of the ECHR as being engaged. The requirement effectively operates as a screening test to help keep the application of the process within suitable limits. Subparagraph (a) is intended to cater for any situation where a person would be prevented from leaving premises unaccompanied. This might be by means of a physical barrier – such as the presence of a locked door for which they do not have a key or keypad code – or by staff whose duty it is to supervise the entrance and exit points or monitor CCTV footage of them. It also ensures that the protection of the scheme extends to those who would not be affected by the presence of a locked door or any other physical means of preventing unaccompanied departure, given that they are not physically able to leave alone. This could be of relevance to people who have both physical and learning disability, living in small group homes.

Subsection (2) is intended to exclude from the process what may be regarded as house rules. In other words, it is concerned with rules which are intended to ensure the calm and efficient running of the premises, but without impinging to an unreasonable extent on the life of any particular resident. Examples may include that there should be no visitors after a certain time in the evening, and that residents can only gain access to a computer to send e-mails during normal business hours. An overarching consideration is that the rules are applicable to all residents. Importantly, the provision is not intended to exempt practices that are used to deal primarily with staff shortages and other similar organisational factors, without any tangible benefit to residents.

Subsection (3) provides a definition of the word "placed." The use of that particular term is designed to capture the intention that the procedure provided for in section 52B should operate where it is envisaged that a person will remain in a given care setting on a permanent or at least long-term basis.

Subsection (4) makes express provision as to what is, and is not, intended to be covered by the term "restraint". Paragraph (b) is intended to ensure that where a device such as a bed rail or wheelchair lap belt is used solely for protective purposes, this should not be taken to constitute a restraint and, therefore, to contribute towards a significant restriction of liberty.

Subsection (5) defines the term "vulnerability or need" with reference to certain paragraphs of schedule 12 to the Public Services Reform (Scotland) Act 2010. The result is that the vulnerability or need may stem from the effects of infirmity or ageing, or the effects of illness, disability or mental disorder, or from drug or alcohol dependency.

Subsection (6) defines the terms "care home service" and "adult placement service."

52B Significant restriction of adult's liberty: placement

(1) This section applies where an adult has been placed, or is to be placed, in accommodation and a relevant person forms the view—

(a) that the adult's needs may call for the adult's liberty to be subject to significant restriction, but

(b) that the adult is incapable in relation to decisions about such restriction.

(2) The relevant person must without delay refer the matter to a medical practitioner.

(3) If a medical practitioner, on a reference under subsection (2), is satisfied that the adult is incapable as mentioned in subsection (1)(b) and so certifies, the relevant person—

(a) must initiate an assessment of what measures are called for, and

(b) if the adult has been placed in the accommodation, may introduce during the period of the assessment (being a period which, subject to subsections (4) and (5), is not to exceed 28 days from the date of certification under this subsection) such significant restriction of the adult's liberty as is immediately necessary to ensure that the adult does not come to harm.

(4) On one occasion only, the relevant person may, if that person considers it necessary to do so for the purposes of the assessment, again refer the matter to a medical practitioner.

(5) If a medical practitioner, on a reference under subsection (4), is satisfied that the adult continues to be incapable as mentioned in subsection (1)(b) and so certifies, the relevant person may, for a period not exceeding 28 days from the date of certification under this subsection, continue to impose the significant restriction introduced by virtue of subsection (3)(b).

(6) The relevant person must intimate without delay—

(a) the issuing of a certificate under subsection (3) and the imposition, by virtue of paragraph (b) of that subsection, of significant restriction of liberty, or

(b) the issuing of a certificate under subsection (5) and the continuation, by virtue of that subsection, of such restriction,

to each person mentioned in subsection (10).

(7) The relevant person's concluding that there is an immediate necessity to impose significant restriction by virtue of subsection (3)(b) may be appealed against by application to the sheriff by any person mentioned in subsection (10); but the relevant person may, pending the determination of that appeal, impose the restriction in question.

(8) A certificate for the purposes of subsection (3) or (5) shall be in the prescribed form.

(9) In this section and in sections 52C to 52I, any reference to a "relevant person" is to—

(a) the manager of the premises within which the accommodation is, or as the case may be is to be, provided, or

(b) if there is no such manager, a social worker (as defined in section 77(1) of the Regulation of Care (Scotland) Act 2001 (asp 8)) who has been assigned responsibilities in relation to the care and supervision of the adult.

(10) The persons are—

(a) the adult,

(b) if the adult has a guardian with welfare powers, that guardian,

(c) any welfare attorney of the adult,

(d) any person who is the adult's named person,

(e) the adult's primary carer, and

(f) the adult's nearest relative (in the case of intimation, unless unknown).

NOTE

Section 52B implements recommendations 35 and 36. It provides for the process for authorisation of a significant restriction of liberty where an adult who lacks capacity is to live on a long-term basis in a care home or in accommodation arranged by an adult placement service.

Subsection (1) sets out the "trigger" for use of the community process in relation to placing of adults who lack capacity. The test to be met is two-fold. Firstly, the adult has been or is to be placed in accommodation to which the community process potentially applies. Secondly, the relevant person (see Note on section 52A) has come to the view that the adult may require to be subject to significant restriction of liberty, on account or his or her needs, but that the adult is incapable in relation to decisions about such restriction.

Subsection (2) sets out the first practical step in the process, namely that the relevant person is to refer the matter to a medical practitioner as quickly as possible.

Subsection (3) details the procedure to be followed in the event that the medical practitioner issues a certificate to the effect that the adult is incapable in relation to decisions about restriction of liberty. The relevant person comes under a duty to initiate an assessment of what measures should be put in place. There is also provision for measures giving rise to a significant restriction of liberty to be put in place on an interim basis, pending the completion of such an assessment, where the adult has already been placed in the accommodation. This is to be done only where it is thought immediately necessary to ensure that the adult does not come to harm. Interim use of measures is for an initial maximum period of 28 days. In terms of subsection (5) an extension of a further 28 day period may be granted on one occasion only. This is dependent on the re-referral of the adult's case to a medical practitioner under subsection (4), and certification by the medical practitioner in terms of subsection (5) that the adult continues to lack capacity in relation to decisions about significant restriction of liberty.

Subsection (6) places the relevant person under a duty to notify a number of individuals, as subsequently listed in subsection (10), of the issuing of a certificate of incapacity and of any interim use of measures giving rise to a significant restriction of liberty. An identical duty arises where a further certificate is issued under subsection (5).

Subsection (7) makes provision for an appeal against a decision that there is a need to impose measures amounting to a significant restriction of liberty on an interim basis, pending completion of assessment. The right of appeal is exercisable by each of the persons listed in subsection (10). Subsection (7) also makes clear that the fact an appeal has been brought does not prevent measures of restriction validly being imposed during the period when the outcome of the appeal is yet to be determined. This might include putting the measures in place during that time, as opposed to mere continuation of their usage.

Subsection (8) requires that any certificate of incapacity that is issued should be in the form prescribed by regulations.

Subsection (9) provides for a definition of the term "relevant person" as set out above in relation to section 52A.

Subsection (10) lists those who are entitled to be advised of the matters and to exercise the rights of appeal set out in section 52B. These include the adult and any welfare attorney or guardian of the adult, where the guardian has welfare powers.

52C Significant restriction of adult's liberty: short term care

(1) This section applies where an adult is receiving short term care in accommodation provided by (or as the case may be arranged for by) a care home service or an adult placement service.

(2) If a relevant person forms the view—

(a) that the adult's needs may call for the adult's liberty to be subject to significant restriction, but

(b) that the adult is incapable in relation to decisions about such restriction,

the relevant person must without delay refer the matter to a medical practitioner.

(3) If a medical practitioner, on a reference under subsection (2), is satisfied that the adult is incapable as mentioned in subsection (2)(b) and so certifies, the relevant person may introduce, for a period which, subject to subsections (4) and (5), is not to exceed 28 days from the date of certification under this subsection, such significant restriction of the adult's liberty as is immediately necessary to ensure that the adult does not come to harm.

(4) On one occasion only, the relevant person may, if that person considers it necessary to do so for the purposes of the short term care, again refer the matter to a medical practitioner.

(5) If a medical practitioner, on a reference under subsection (4), is satisfied that the adult continues to be incapable as mentioned in subsection (2)(b) and so certifies, the relevant person may, for a period not exceeding 28 days from the date of certification under this subsection, continue to impose the significant restriction introduced by virtue of subsection (3).

(6) The relevant person must intimate without delay—

(a) the issuing of a certificate under subsection (3) and the imposition, by virtue of that subsection, of significant restriction of liberty, or

(b) the issuing of a certificate under subsection (5) and the continuation, by virtue of that subsection, of such restriction,

to each person mentioned in section 52B(10).

(7) The relevant person's concluding that there is an immediate necessity to impose significant restriction by virtue of subsection (3) may be appealed against by application to the sheriff by any person mentioned in section 52B(10); but the relevant person may, pending the determination of that appeal, impose the restriction in question.

(8) A certificate for the purposes of subsection (3) or (5) shall be in the prescribed form.

NOTE

Section 52C implements recommendations 35 and 36. It makes provision for authorisation of significant restriction of liberty on a short-term basis. It is designed to cater for the situation in which an adult who is incapable in relation to decisions about restriction of liberty moves temporarily into accommodation to which the community process applies. A typical scenario may arise where an adult's carer is unavailable on a temporary basis, for example during a hospital stay.

Subsection (1) sets out the types of setting in which significant restriction of liberty might be authorised on a short-term basis. This mirrors precisely the types of accommodation in which significant restriction might be authorised in connection with a placement, namely in care homes and in accommodation arranged by adult placement services.

Subsection (2) makes provision as to the initiation of the process for authorisation of significant restriction of liberty on a short-term basis. A duty is placed on the relevant person to refer the matter to a medical practitioner without delay where they come to the view that the adult's needs may require them to be subject to significant restriction, but that the adult does not have capacity to make a decision about such restriction.

Where the medical practitioner is satisfied that the adult lacks capacity as regards decisions relating to restriction of liberty, and issues a certificate to that effect, subsection (3) functions as authority for the use of measures amounting to a significant restriction of liberty. These may be put in place initially for a maximum period of 28 days. The degree of restriction must be no greater than is thought immediately necessary to ensure that the adult does not come to harm.

Subsection (4) provides for re-referral of an adult's case to a medical practitioner, on one occasion only, in connection with possible renewal of short-term authorisation of a significant restriction of liberty.

Subsection (5) provides for a one-off renewal of authority to impose measures on a short-term basis, allowing them to be imposed for a further period of 28 days. This is conditional on the issuing of a further certificate by a medical practitioner to the effect that the adult continues to lack capacity in relation to decisions about restriction of liberty.

Subsection (6) requires the relevant person to notify each of the persons listed in section 52B(10) of the issuing of a certificate under subsection (3) and the imposition of any measures of restriction on the basis of that. An equivalent duty arises where a further certificate is issued, covering a subsequent period of 28 days.

Subsection (7) makes provision for challenge of a decision of the relevant person that there is an immediate necessity to impose a significant restriction of liberty on a short-term basis. The challenge is by means of appeal to the sheriff. It also covers any decision to authorise continued use of the measures for a further period of 28 days. The right of appeal is exercisable by each of the persons listed in section 52B(10). It is also made clear that measures may validly be imposed pending the determination of an appeal.

Subsection (8) requires that any certificate of incapacity that is issued should be in the prescribed form.

52D Assessment initiated under section 52B(3)(a)

(1) For the purposes of an assessment initiated under section 52B(3)(a)—

(a) the relevant person is to prepare a statement (to be known as a "Statement of Significant Restriction")—

(i) specifying the measures to which that person considers the adult's liberty should be subject, and

(ii) explaining why those measures are called for, and

(b) there is to be obtained by the relevant person, as regards the statement—

(i) a report from a mental health officer (as defined in section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)), and

(ii) a report from a medical practitioner described in subsection (2).

(2) The descriptions of medical practitioner are—

(a) an approved medical practitioner (within the meaning assigned by section 22(4) of that Act of 2003),

(b) a medical practitioner with expertise in medical care of the elderly (but only if that practitioner is primarily responsible for the medical treatment of the adult), and

(c) any other medical practitioner if, by reason of—

(i) possessing skills, qualifications and experience of particular relevance to the medical treatment of the adult, and

(ii) having personal knowledge of the adult's circumstances,

that practitioner may be regarded as the most appropriate person to produce the report in question.

(3) For the purposes of subsection (1)(b), the persons from whom the reports are to be obtained are each to be sent a copy of the Statement of Significant Restriction.

(4) After considering those reports the relevant person may (but need not) revise the Statement of Significant Restriction.

(5) Subsections (6) to (8) apply where, because the reports disagree with, or about, measures specified, under subsection (1)(a)(i), in the Statement of Significant Restriction, the relevant person does not consider revision under subsection (4) to be feasible.

(6) The relevant person and the authors of the reports shall attempt, whether by meeting or otherwise, to reconcile their views as respects the Statement of Significant Restriction and to reach agreement as to what revision (if any) of that statement is appropriate.

(7) But where, after such an attempt, it becomes apparent to the relevant person that such agreement cannot be arrived at, the relevant person shall apply to the sheriff—

(a) for a determination as to whether (and if so how) to revise the Statement of Significant Restriction, and

(b) seeking authorisation to implement the measures specified in the statement (if revised by virtue of paragraph (a), as so revised).

(8) The sheriff is not to make such a determination, or to grant such authority, without affording an opportunity to be heard to—

(a) the relevant person,

(b) the authors of the reports,

(c) the adult to whom the statement relates, and

(d) if that adult has a welfare attorney or a guardian with welfare powers, that attorney or guardian.

(9) A report for the purposes of subsection (1)(b) shall be in the prescribed form.

(10) Different forms may be prescribed according to whether the report is from a mental health officer or a medical practitioner.

NOTE

Section 52D implements recommendations 37- 42. It sets out in detail how the assessment required by section 52B(3)(a) is to be carried out. The assessment is founded on preparation of a document to be known as a "Statement of Significant Restriction."

Subsection (1) introduces the concept of a Statement of Significant Restriction.

Subsection (1)(a) lays down the main components of a Statement of Significant Restriction, namely specification of the measures to which the relevant person considers the adult's liberty should be subject, and an explanation of why those measures are needed.

Subsection (3) makes clear that the statement as originally drafted should be sent to a mental health officer and a medical practitioner falling within the description in subsection (2). A report should be prepared by both, offering their assessment on the measures set out in the statement (subsection (1)(b)). This requirement of input from other professionals –without a direct connection to the accommodation in which the adult lives or is to live – is intended to contribute to the satisfaction of the criteria laid down by the *Winterwerp* judgement, as also the principles set out in section 1 of the 2000 Act.

Subsection (2) specifies various categories within which a medical practitioner who provides comments on a Statement of Significant Restriction might fall. The approach is such that the medical practitioner *may* be an approved medical practitioner, but this will not automatically be the case. The aim is to ensure that the medical practitioner who is invited to comment on a draft Statement of Significant Restriction is the one who is most suited to that task, both in terms of their skills and experience and their knowledge of the adult's particular circumstances.

Subsection (4) deals with the handling of reports on draft Statements of Significant Restriction. Whilst it is open to the relevant person to modify a draft statement in light of such reports, where it is feasible for them to do so, they do not fall under any obligation so to modify it.

As subsection (5) makes clear, subsections (6) to (8) deal with certain circumstances where the reports produced are at variance with each other or with the content of the draft Statement of Significant Restriction. The situation envisaged is one where the nature of the reports is such that it is not feasible for the relevant person simply to effect a revision under subsection (4) to take account of comments received, or to decide not to make any revision. The typical scenario might be where either or both of the authors of the reports takes the view that imposition of measures of the nature set out in the draft statement is not warranted. Subsection (6) places an express duty on the relevant person and the report authors to seek to reach an agreed view on the content of a draft Statement of Significant Restriction, incorporating any revision that is thought to be needed. They are to resolve any matters of dispute by any means open to them. The holding of a meeting is given as an example of a possible route to agreement.

Where agreement cannot be reached, subsection (7) applies. The relevant person is required to refer the case to the sheriff. It is then for the sheriff to determine how, if at all, the statement should be revised. On the basis of any such revision, the sheriff is also required to reach the decision as to whether or not authorisation for implementation of the measures giving rise to a significant restriction of liberty should be granted. In terms of subsection (8), both of these determinations are to be made taking account of the views of any welfare attorney or welfare guardian of the adult. Importantly, however, neither decision will rest with the guardian or attorney. Other parties whose views must be taken into account include the adult him or herself and the authors of the reports on the draft statement.

Subsections (9) and (10) deal with the form of reports to be produced on draft Statements of Significant Restriction. These must follow the form prescribed. There is provision for different forms to be prescribed as between reports by mental health officers and medical practitioners.

52E Authorisation of implementation of restrictions

(1) A relevant person who has received the reports required by subsection (1)(b) of section 52D as regards a Statement of Significant Restriction (the reports so required being referred to in this section as "the reports") shall without delay, though after revising, under subsection (4) of that section, the Statement of Significant Restriction if the person considers it appropriate to do so, seek authorisation to implement the measures specified in the statement—

(a) in a case where the adult to whom the statement relates has a welfare attorney or a guardian with welfare powers, from the attorney or guardian, and

(b) in any other case, or if the attorney or guardian declines to grant authorisation, by application to the sheriff.

(2) But subsection (1) does not apply in relation to a Statement of Significant Restriction as regards which an application has been made under section 52D(7).

(3) A welfare attorney, or a guardian with welfare powers, is by virtue of this subsection entitled to grant an authorisation sought from that person under subsection (1)(a) unless the power of attorney or guardianship order expressly provides otherwise.

(4) Subsection (3) is without prejudice to any entitlement which a welfare attorney or a guardian with welfare powers may have, other than by virtue of that subsection, to grant an authorisation sought under subsection (1)(a).

(5) In relation to a power of attorney made, or a guardianship order granted, before the coming into force of section 1(3) of the Adults with Incapacity (Scotland) Act 2014, any question as to whether a welfare attorney, or a guardian with welfare powers, has such entitlement as is mentioned in subsection (4) must be determined by reference only to the terms of that power of attorney or guardianship order.

(6) Where authorisation is sought under subsection (1)(a), the attorney or guardian in question must be sent—

(a) a copy of the Statement of Significant Restriction (as revised under section 52D(4) if it has been so revised), and

(b) a copy of each of the reports.

(7) If a welfare attorney, or a guardian with welfare powers, grants authorisation by virtue of subsection (1)(a), that person must give it in writing and must include a declaration—

(a) of having given it after reading the reports, and

(b) of being satisfied that—

(i) the significant restriction will benefit the adult,

(ii) that such benefit cannot reasonably be achieved without such restriction, and

(iv) that the measures specified in the Statement of Significant Restriction are the least restrictive option in relation to the freedom of the adult which is consistent with their purpose.

(8) On being granted authorisation by virtue of subsection (1)(a), the relevant person is to intimate that occurrence to each person mentioned in section 52B(10).

(9) An authorisation granted by virtue of subsection (1)(a) may be appealed against by application to the sheriff—

(a) by the adult, or

(b) by any person having an interest in the personal welfare of the adult.

(10) The relevant person may, pending the determination of the appeal, implement the measures specified in the Statement of Significant Restriction.

(11) The reports and the Statement of Significant Restriction shall be lodged in court along with any application—

(a) under subsection (1)(b),

(b) by virtue of subsection (9), or

(c) under section 52D(7).

(12) On—

(a) an application under subsection (1)(b) or 52D(7)(b), the sheriff may—

(i) grant the authorisation if satisfied as mentioned in subsection (7)(b), or

(ii) authorise implementation of the restrictions subject to such modifications to them as the sheriff may specify (being modifications necessary for the sheriff to be satisfied as mentioned in subsection (7)(b)), or

(b) an application under subsection (9), the sheriff may—

(i) uphold the authorisation if satisfied as mentioned in subsection (7)(b),

(ii) authorise implementation of the measures subject to such modifications to them as the sheriff may specify (being modifications necessary for the sheriff to be satisfied as mentioned in subsection (7)(b)), or

(iii) nullify the authorisation.

(13) A relevant person receiving authorisation by virtue of this section may implement the measures specified in the Statement of Significant Restriction (or as the case may be those measures as modified by virtue of subsection (12)(a)(ii) or (b)(ii)) for a period of one year after the date on which authorisation is obtained.

(14) In subsection (13), "authorisation" does not include an authorisation appealed against under subsection (9) unless it is upheld under subsection (12)(b)(i).

NOTE

Section 52E implements recommendations 9, 10, 43 and 44. It makes provision in relation to authorisation of implementation of measures of restriction set out in a Statement of Significant Restriction.

Subsection (1) places a duty on the relevant person to seek authorisation of implementation of the measures in the Statement of Significant Restriction following receipt of the relevant reports. Authorisation should ordinarily be sought from the welfare attorney of the adult or the welfare guardian, where either such person has been appointed. Where, however, there is no such attorney or guardian, or where they decline to authorise implementation of the restrictions, recourse must be had to the sheriff.

Subsection (2) excludes the application of subsection (1) where application to the sheriff under section 52D(7) has been required. In other words, it makes clear that the default procedure under subsection (1) applies only where consensus has been reached between the relevant person and authors of the reports as to the measures set out in a Statement of Significant Restriction.

Subsection (3) makes clear that as from commencement of the provision, any guardianship order or power of attorney made or granted will be assumed to confer power to authorise significant restriction of liberty, unless the order or instrument expressly provides otherwise.

Subsection (4) clarifies that the general provision in subsection (3) does not displace any specific power in a power of attorney or guardianship order to authorise significant restriction of liberty.

Subsection (5) makes clear that, in relation to powers of attorney and guardianship orders made or granted prior to the commencement of Part 5A, whether authorisation of significant restriction of liberty can be

authorised will depend on the terms of the order or instrument. Given that the context of the restriction is care, however, we would anticipate that general powers to safeguard a person's welfare would suffice.

Subsection (6) lays down a requirement that where authorisation by a welfare attorney or welfare guardian is sought, the guardian or attorney must be sent a copy of the Statement of Significant Restriction and each of the reports prepared in relation to it.

Subsection (7) lays down requirements on the basis of which authorisation by a guardian or attorney is to be given. The attorney or guardian must make a written declaration to the effect that authorisation is given having taken account of the content of the reports produced on the statement. Moreover, the declaration must set out the basis on which the attorney or guardian is satisfied that the significant restriction will benefit the adult, that such benefit cannot be achieved without the restriction and that the restriction will have the minimum possible effect on the freedom of the adult.

Subsection (8) requires the relevant person to notify any grant of authorisation by an attorney or guardian to each of the persons listed in section 52B(10).

Subsection (9) entitles the adult and any person claiming an interest in the personal welfare of the adult to challenge the granting of any authorisation by a welfare attorney or welfare guardian by means of appeal to the sheriff. This seeks to give effect to the Article 5(4) ECHR requirement for access to a court.

Subsection (10) confirms that, where there is authorisation by a guardian or attorney of implementation of measures set out in a Statement of Significant Restriction, these measures may continue to be imposed, notwithstanding that an appeal against the authorisation has been brought.

Subsection (11) lays down the procedural requirement that the reports and the Statement of Significant Restriction to which they relate be lodged in court along with any application to the sheriff in connection with authorisation of significant restriction of liberty. This covers an application because there is no welfare attorney or welfare guardian (or the attorney or guardian declines to grant authorisation), an application for review of authorisation by a guardian or attorney, or an application because of ongoing disagreement between the relevant person and authors of reports as to the measures set out in a draft Statement of Significant Restriction.

Subsection (12)(a) makes clear that where there is an application to the sheriff as a result of absence of a welfare attorney or welfare guardian, or an unwillingness of the guardian or attorney to grant authorisation, or as a result of an ongoing dispute, the sheriff has two available options for disposal of the application. The sheriff may simply grant the authorisation, without modification, if satisfied that the criteria set out in subsection (7)(b) are met. Where the sheriff is not so satisfied, authorisation may be granted subject to such modification as the sheriff thinks necessary to ensure that the subsection (7)(b) criteria are fulfilled.

Subsection (12)(b) deals with disposal by the sheriff of appeals against authorisation granted by a welfare attorney or welfare guardian. The sheriff has three available options: upholding of the authorisation, modification of its terms such as to ensure that the requirements of subsection (7)(b) are met or nullification of the authorisation.

Subsection (13) sets a period of one year as the duration for which measures authorised in terms of a Statement of Significant Restriction can be implemented. The period runs from the date on which authorisation is obtained. Subsection (14) makes clear that, for the purposes of the running of the one year period referred to in subsection (13), authorisation does not include an authorisation that is subject to review by the sheriff, unless that authorisation is upheld. The result is that where the sheriff authorises implementation of measures originally authorised by a welfare attorney or welfare guardian, but with modification, the one year period effectively re-starts. It runs from the date on which authorisation is obtained from the sheriff.

52F Application under section 52E to sheriff: consideration of need for guardianship order

(1) Without prejudice to section 3(4), in an application under section 52E(1)(b) in relation to an adult who does not have a guardian the sheriff shall require the local authority within whose area the accommodation in which the adult has been, or is to be, placed is situated—

(a) to consider whether a guardianship order is necessary for the protection of the personal welfare of the adult, and

(b) if it appears to the local authority that there is such a necessity, to apply under section 57 for such an order.

(2) Where an application is made by virtue of subsection (1)(b), the sheriff is not to appoint the chief social work officer of the local authority as guardian if there is an individual mentioned in section 59(1)(a) who may instead be appointed.

NOTE

Section 52F implements recommendations 11 and 12. Subsection (1) makes further provision in relation to the specific scenario where an application for authorisation falls to be considered by a sheriff because the adult to whom it relates does not have a welfare guardian. A duty is placed on the local authority within whose area the accommodation is situated to consider whether a guardianship order is necessary for the protection of the personal welfare of the adult. Where it appears to the local authority that it is necessary, the authority is required to apply for an order under section 57 of the 2000 Act.

Where an application is made under section 57, the sheriff is not to appoint the chief social worker of the local authority as guardian if there is an individual who, in terms of section 59(1)(a), is suitable for such appointment and has consented to being guardian. That individual should be appointed instead. This is in terms of subsection (2).

52G Renewal

(1) Where, during a period in which the measures specified in a Statement of Significant Restriction may be implemented (that period being in this section referred to as the "current period"), the relevant person forms the view that, in the interest of the adult to whom that statement relates, those measures ought to continue to be implemented (whether or not with modifications) after the current period ends, the relevant person may seek authorisation for such continuance.

(2) For the purposes of seeking authorisation under subsection (1), the relevant person is to prepare a copy of the Statement of Significant Restriction (whether or not with modifications).

(3) Sections 52D(1)(b) to (10), 52E and 52F apply for the purposes of seeking authorisation under subsection (1) and in relation to a copy prepared under subsection (2) as they apply for the purposes of an assessment initiated under section 52B(3)(a) and in relation to a statement prepared under section 52D(1)(a).

(4) The reference in subsection (1) to "a period in which the measures specified in a Statement of Significant Restriction may be implemented" includes a reference to a period in which such measures may be implemented (whether or not with modifications) by virtue of this section.

NOTE

Section 52G implements recommendation 16. It caters for the situation where there is thought to be a need to seek authority for the continued use of measures amounting to a significant restriction of liberty beyond the expiry of the period of one year for which they are originally authorised.

Subsection (1) confers power on the relevant person to seek renewal of authorisation for use of measures giving rise to significant restriction of liberty where this is thought to be necessary for the benefit of the adult who is currently subject to them.

Subsection (2) sets out the first practical step towards renewal of authorisation, namely that the relevant person produce a copy of the Statement of Significant Restriction as it currently stands, showing any modification that is thought to be required.

Subsection (3) makes clear that a copy of a Statement of Significant Restriction produced in connection with a possible renewal is to be subject to the same procedure as regards reports by professionals and authorisation as an initial draft statement that is drawn up. In practice, though, it is envisaged that the statement submitted for renewal might in many cases be very similar to the original statement.

Subsection (4) makes clear that a decision to seek renewal of authorisation to implement measures amounting to a significant restriction of liberty may be taken during a period when the authorisation is already subsisting on the basis of a renewal. The result is that there is no limit to the number of occasions on which authority to implement measures may be renewed for a further 12 month period.

52H Variation to implement a further measure

(1) Where, during a period in which the measures specified in a Statement of Significant Restriction may be implemented, the relevant person forms the view that, in the interest of the adult to whom that statement relates a further measure ought to be implemented, the relevant person may implement that measure.

(2) If a measure is implemented by virtue of subsection (1), the relevant person must without delay—

(a) vary the Statement of Significant Restriction accordingly, and

(b) intimate to each person mentioned in section 52B(10) that the measure is being implemented and why.

(3) Any variation occurring by virtue of paragraph (a) of subsection (2) may be reviewed by the sheriff on application by a person receiving intimation by virtue of paragraph (b) of that subsection.

(4) The relevant person may, pending the determination of the review, continue to implement the further measure.

(5) References in this section to a Statement of Significant Restriction include references to a copy of such a statement prepared under section 52G(2).

NOTE

Section 52H implements recommendation 17. It caters for the possibility that the view of the relevant person as to what measures of restriction are necessary in the interests of an adult may change during the currency of an authorisation.

Subsection (1) provides that a variation takes place where a further measure of restriction is to be added to those set out in a Statement of Significant Restriction. This is intended to include the scenario where a measure of restriction is to be subject to modification of such a fundamental nature that a new measure is effectively imposed instead of the existing measure. It is open to the relevant person simply to implement

the new measure, where they consider that it is to the benefit of the adult to do so. The decision in this scenario lies entirely with the relevant person – it is not a matter for the welfare attorney or welfare guardian of the adult, if such a person has been appointed. This gives effect to the intention that variation during the course of the year should be readily available and reasonably informal.

In the event that a variation is effected, subsection (2) places on the relevant person a duty that is two-fold. Firstly, the relevant person is required to amend the Statement of Significant Restriction, in physical terms, to reflect the variation. Secondly, they are required to intimate the variation to each of the persons listed in section 52B(10), including providing reasons for it. Subsection (3) confers on any person who receives intimation of a variation the opportunity to challenge it. These provisions are intended to ensure that sufficient safeguards are in place, notwithstanding the intentionally informal nature of the process of variation.

Subsection (4) puts beyond doubt that where there has been a variation in measures of restriction imposed, the additional measure may continue to be effected, notwithstanding that an appeal against the addition has been brought.

Subsection (5) provides confirmation that the variation process applies also to any copy of a Statement of Significant Restriction, where renewal has been granted.

52I Further duties of relevant person

It is the duty of a relevant person who has prepared a Statement of Significant Restriction under section 52D(1) (or, under section 52G(2), a copy of such a statement)—

(a) to intimate to the Mental Welfare Commission, without delay, any authorisation granted by virtue of section 52E(1) to implement, as regards the adult to whom the statement relates, the measures specified in the statement (or as the case may be in the copy), and

(b) to deliver to the Mental Welfare Commission with that intimation a copy of the statement prepared under section 52D(1) (or as the case may be a copy prepared under section 52G(2)).

NOTE

Section 52I imposes on the relevant person a duty of intimation to the Mental Welfare Commission for Scotland of any authorisation of a significant restriction of liberty. It encompasses any authorisation of continued use of measures of restriction, in terms of the provision for renewal. In addition, a duty is imposed to provide a copy of the Statement of Significant Restriction as authorised or, as the case may be, renewed. This is intended to strike a balance between ensuring that the Mental Welfare Commission is aware of any authorisation that takes place, and avoiding an unnecessary burden in terms of retention of documents.

52J Application to sheriff in relation to unlawful detention of adult

(1) This section applies where 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.

(2) The adult, or any person claiming an interest in the personal welfare of the adult, may apply to the sheriff for an order requiring the manager of the accommodation, or any person effecting the detention of the adult in the accommodation, to cease to detain the adult.

(3) On an application under subsection (2) the sheriff—

(a) if satisfied that the adult is being detained unlawfully in the accommodation, shall grant the order mentioned in that subsection, or

(b) if not so satisfied, shall refuse the application.

(4) This section is without prejudice—

(a) to any other provision of this Act, or

(b) to any provision of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp13).".

NOTE

Section 52J implements recommendation 45. It provides for application to the sheriff for an order to bring to an end detention which is unlawful. In effect it offers an equivalent to section 291 of the 2003 Act, applicable in certain non-hospital settings within the community, and with applications being determined by the appropriate sheriff rather than the Mental Health Tribunal for Scotland.

Subsection (1) sets out the circumstances where section 52J applies. This is the case in any situation where a person who lacks capacity to make decisions as to their own living arrangements is being detained in a care home or in accommodation arranged by an adult placement service. The detention may be argued to be unlawful because the nature of the restrictions is such as to require authorisation but no authorisation has been sought. Such authorisation may be via the community process or, alternatively, via the 2003 Act or other provisions of the 2000 Act. Alternatively, the detention may be unlawful because it falls outwith the scope of an authorisation that has been granted for significant restriction of liberty.

Subsection (2) provides that application to the sheriff for an order may be submitted by the adult or any person claiming an interest in the personal welfare of the adult. The order is to require a particular person – namely the manager of the accommodation in which the adult is living, or any other person who is directly involved in effecting the detention of the adult – to cease to detain the adult.

Subsection (3) lays down the test to be applied by the sheriff in determining an application. An order should be made only if the sheriff is satisfied in all the circumstances that the adult is being subject to detention which is unlawful. The power will operate in tandem with the existence of section 3(1) of the 2000 Act. This could serve to bridge a gap in the event that the release is ordered of a person who has care needs as a result of their incapacity, meaning that they cannot live independently in the community.

Subsection (4) confirms that any measures of restriction imposed either in terms of the 2003 Act, or other provisions of the 2000 Act, cannot be set aside by a decision under section 52J.

2 Amendment of Mental Health (Care and Treatment) (Scotland) Act 2003

In section 291(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) (which provides for applications to the Mental Health Tribunal for Scotland as regards the detention in hospital of certain patients), for the words "or the 1995 Act" there is substituted ", the 1995 Act or the Adults with Incapacity (Scotland) Act 2000 (asp 4)".

NOTE

Section 2 provides for amendment of section 291 of the 2003 Act to insert reference to the 2000 Act. This serves to update section 291 to reflect the existence of the new provisions introduced in section 1.

3 Commencement

(1) This section and section 4 come into force on the day after Royal Assent.

(2) Sections 1 and 2 come into force on such day as the Scottish Ministers may by regulations appoint.

NOTE

Section 3 makes provision in relation to commencement of the legislation. With the exception of those provisions which come into force on the day after Royal Assent, the provisions will come into force on a date appointed by the Scottish Ministers in making an order.

4 Short title

The short title of this Act is the Adults with Incapacity (Scotland) Act 2014.

Appendix B

List of respondents to the Discussion Paper

Aberdeen City Council, Anneliese Stellmach

Association of Directors of Social Work

David W Cobb, Faculty of Advocates

Care Inspectorate, Willie Paxton

Connecting Carers, Dwynwen Hopcroft

Equality and Human Rights Commission, Irene Henery

Faculty of Advocates

Glasgow City Council, Raymond Bell, Social Work Services

Professor Tom Guthrie, University of Glasgow School of Law (his response was, however, submitted in a personal capacity)

The Legal Services Agency

The Mental Health and Disability Sub-committee of the Law Society of Scotland

The Mental Health Tribunal for Scotland

The Mental Welfare Commission for Scotland, George Kappler (Executive Director, Social Work)

John A L Miller (legal member of the Mental Health Tribunal for Scotland)

NHS Greater Glasgow and Clyde Health Board, Mental Health Clinical Governance Legislation Sub-group

North Ayrshire Council, John McCaig /Mary Francey, Social Services

North Lanarkshire Council, Mike Baxter, Senior Mental Health Officer

Patients' Advocacy Service, Anne Morton

Hilary Patrick, University of Edinburgh, School of Law (Honorary Fellow)

People First (Scotland), Monica Hunter, Edinburgh Director

Anton Randle, Community Psychiatric Nurse

Royal College of Psychiatrists in Scotland: Faculty of Old Age Psychiatry

Royal College of Psychiatrists in Scotland: Faculty of Psychiatry of Intellectual Disabilities and Faculty of Child and Adolescent Mental Health

Scottish Consortium for Learning Disability, Chloe Trew

Scottish Court Service and Office of the Public Guardian, Sandra McDonald

Scottish Independent Advocacy Alliance, Shaben Begum

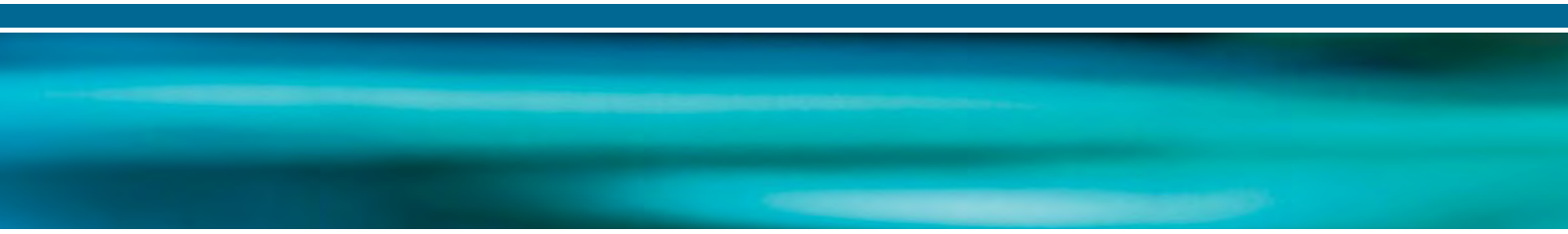
Senators of the College of Justice

Dr Lucy Series, postgraduate researcher at Department of Law at the University of Exeter at time of submitting a response; now Research Associate at Cardiff Law School, Cardiff University

Sheriffs' Association, Sheriff Gordon Liddle, Secretary to the Sheriffs' Association

Dr Jill Stavert, Reader in Law, Edinburgh Napier University, School of Accounting, Financial Services and Law

West Dunbartonshire Community Health & Care Partnership (Drew Lyall, Senior Mental Health Officer, on behalf of Jackie Irvine, Chief Social Work Officer)



Published by TSO (The Stationery Office) and available from:
Online
www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone 0870 240 3701

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-888277-7
9 780108 882777