PE1667/E
Mental Welfare Commission for Scotland submission of 5 December 2017

Thank you for the invitation to comment on the above petition.

Introduction

We do not share the views of Mr Watson and other correspondents on all the alleged deficiencies of the current Mental Health (Care and Treatment) (Scotland) Act 2003 ('the 2003 Act') and Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). However, we agree that, in the next 3-5 years, there should be a coherent, systematic and thorough process to review the legal framework in Scotland for non-consensual care and treatment, to ensure it remains effective and in line with developing human rights standards. This process of review should encompass both of the above Acts and the Adult Support and Protection (Scotland) Act 2007.

We called for such a process in our submissions to Government and the Health and Sport Committee on the draft Mental Health Strategy and in our response to the Scottish Government consultation on reforms to the Adults with Incapacity Act. Other agencies made similar calls, including the Scottish Human Rights Commission, the Law Society of Scotland, and the Rights to Life campaign. If required, we would be happy to provide links to these.

The case for reform

In 2016 the Commission and the Centre for Mental Health and Capacity Law at Edinburgh Napier University led discussion of the case for law reform with key stakeholders including lawyers, psychiatrists, social workers, the voluntary sector, the Public Guardian and the Mental Health Tribunal for Scotland. We also engaged with people with lived experience of mental ill-health. The conclusions of that work were published in May 2017[1], and the first recommendation was that there should be a long term programme of law reform, covering all forms of non-consensual decision making affecting people with mental disorders.

The reasons for this, and the priority areas for attention, are set out in the report. We stand by the report's conclusions.

Some law reform is underway. The Mental Health (Care and Treatment) (Scotland) Act 2003 was recently amended by the Mental Health (Scotland) Act 2015. However, these were minor technical amendments, based on a report from 2009.

A review of the place of learning disability and autism in the 2003 Act was recently announced, chaired by Andrew Rose, and the Government is committed to consulting in January 2018 on reforms to the Adults with Incapacity Act. We welcome these reviews. However, it is vital that law reform does not proceed by piecemeal amendments of individual Acts, but is done in a long term and joined up manner.

[1] http://www.mwcscot.org.uk/media/371023/scotland_s_mental_health_and_capacity_law.pdf

We also note that a review has been established of the English Mental Health Act[2]. Although the 2003 Act is superior in many respects to the English Act, some of the same concerns apply here, including rising rates of detention and stakeholder concerns that some processes relating to the act are out of step with a modern mental health system.

Our principal concerns about the current law can be summarised as follows.

The law is not compatible with the Convention on the Rights of Persons with Disabilities

The Scottish Government has committed to full implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD). The UN Committee responsible for the CRPD has criticised the UK's current legislative framework, as still allowing substitute decision making and forcible treatment on the grounds of mental disability, which the Committee regards as a breach of the Convention.

We accept that the approach of the Committee is a radical one, and no country in the world currently meets the standards it sets. However, even on a more conservative reading of the UN Convention, there is little doubt that the current law does not fully comply. A detailed analysis of the AWI Act by the Essex Autonomy Project[3] set out a number of reforms that would need to be made to make the AWI Act compliant. These are generally about ensuring greater respect for the will and preference of people who are made subject to the AWI Act.

There has not been a similarly thorough review of the 2003 Act, but there is good reason to suppose that it is not fully compliant with the CRPD. The whole basis of the Act is that the liberty and autonomy of people with a mental disability can be removed in a way which cannot be done for people without a mental disability. From the perspective of the CRPD, this is discriminatory.

The issues we set out below regarding the ECHR and the balance between the rights of the state and of the individual are also relevant in considering whether the 2003 Act complies with the CRPD.

There is also increasing pressure from other human rights bodies for action on mental health law. Examples include the recent report of the UN Special Rapporteur[4] and a report of the UN sub-committee on the prevention of torture regarding treatment without informed consent[5]. Both of these reports set out expectations for modern human rights based practice which the 2003 Act may not meet.

The law may not comply with the European Convention on Human Rights

There has not yet been a successful ECHR challenge to the 2003 Act or the AWI Act, but developing case law means that a future challenge is more likely.

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[2] The terms of reference are at https://www.gov.uk/government/publications/mental-health-act-independent-review/terms-of-reference-independent-review-of-the-mental-health-act-1983

[3] https://autonomy.essex.ac.uk/resources/eap-three-jurisdictions-report/

[4] https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement

[5] https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement

We already know that the processes of guardianship and powers of attorney under the AWI Act may not meet the requirements of article 5 of the ECHR in respect of deprivation of liberty. We hope that this will be addressed in the forthcoming consultation.

The 2003 Act allows in some circumstances for forcible treatment to be given as a consequence of detention, and without prior judicial authorisation. This particularly applies to short term detention for up to 28 days. This may be difficult to justify following the decision of the European Court in X v Finland.[6]

The Act also allows for forcible treatment to be given to detained patients, even where they are judged capable of making a treatment decision. There is a risk that this would be found to be discriminatory and in breach of Article 8 of the ECHR.

The balance between the power of the state and the rights of patients is not being fulfilled in practice

One of the defining features of the 2003 Act and AWI Act is that they were based on principles; including that interventions should be for the benefit of the affected person, and should be the least restrictive option. Both acts also relied very heavily on the role of the local authority mental health officer (MHO) as a safeguard.

The 2003 Act also established a vital principle of reciprocity – that if the state is to interfere with someone's liberty, it owes a duty to that person to provide appropriate care and treatment, in line with these wider principles.

In support of that, the 2003 Act introduced important safeguards, including a legal right to advocacy, and specific duties on local authorities (sections 25-27) to provide after-care, accommodation, support for employment and so on. It also introduced a provision that tribunals could hold the NHS and local authorities to account through their power to make a 'recorded matter' specifying measures which should be taken to ensure that the principles were upheld.

Over the last ten years, the use of both Acts has greatly increased[7], and there is evidence that the safeguards have been eroded.

The Commission has frequently come across cases where the tribunal has made a recorded matter that a patient should be moved from detention to a community setting, but this has not happened, and detention is repeatedly renewed for lack of a better alternative. We are also concerned that local authorities are not sufficiently aware of their duties under sections 25-27.

We have reported on the decreased input of MHOs in emergency detention[8], and in providing social circumstances reports in longer term detention. There is also evidence that there is insufficient capacity to provide MHO reports for the AWIA Act and to effectively supervise welfare guardianship.

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[6] [2012] M.H.L.R. 318

[7] See the MWC AWI and MHA monitoring reports for 2016-17, available at http://www.mwcscot.org.uk/publications/statistical-monitoring-reports/

[8] http://www.mwcscot.org.uk/media/321062/edc_report_2016.pdf

The MHO role was developed on the basis that a local authority officer was completely separate from and could act as a check on health professionals. This is more problematic following health and social care integration.

We welcome the fact that the Scottish Government is considering how to give greater effect to human rights, particularly social and economic rights, in law and policy. The 2003 Act and AWI Act were early examples of this approach, but we need to learn and apply the lessons of the last ten years for those rights to be fully delivered.

Having three separate but overlapping Acts creates practical difficulties and may no longer be ethically justified

Northern Ireland has recently replaced outdated mental health and incapacity law with a single law – the Mental Capacity Act (Northern Ireland) 2016. There are strong arguments in favour of this unified approach, including

- It promotes non-discrimination and parity of esteem between physical and mental conditions
- It is more likely to be compliant with the UNCRPD
- It can make the law more consistent and clear in relation to problem areas such as
    - The treatment of physical conditions which are related to mental disorder
    - Public bodies using one Act to get round the requirements of another Act
    - The use of force and restraint
    - The investigation of abuse or inappropriate use of powers
    - Access to support for decision making.

If Scotland is to regain the position it held at the beginning of the last decade as a world leader in rights based mental health and incapacity law, this is the direction it needs to take. That would require a comprehensive approach to reform, as was adopted in Northern Ireland through the Bamford Review which led to the new Act.

We will be happy to supply further information on any of these points