PE1667/F
Scottish Human Rights Commission submission of 5 December 2017

Thank you for your letter of 7 November 2017. The petition raises a number of issues, including covert medication, chemical restraint and forcible treatment. From a human rights perspective, these all concern the question of non-consensual treatment. We address, in our response, recent developments on non-consensual treatment in human rights standards, which have a bearing on the question of review of mental health and incapacity legislation, together with our views on the priorities for action.

We have previously called for a comprehensive review of the framework regarding non-consensual care and treatment to reflect supported decision-making in our response to the Scottish Government's consultations on the Mental Health Strategy and on the Scottish Law Commission Report on Adults with Incapacity, and in reporting to the UNCRPD Committee as part of the UK Independent Monitoring Mechanism.

Recent developments

First and foremost, the Scottish Human Rights Commission ('the Commission') is concerned about whether mental health and incapacity legislation enables people subject to these measures to enjoy their human rights in actual practice. The Commission is therefore concerned about the continually rising levels of

both compulsory mental health treatment and guardianship since the Mental Health (Care and Treatment)(Scotland) Act 2003 (the MHA) and the Adults with Incapacity (Scotland) Act 2000 (the AWIA) were introduced[1]. We share the Mental Welfare Commission's concerns about the increasing use of emergency detention, which carries with it fewer safeguards for the individual's rights. We believe these figures indicate a need for reflection as to how well the legislation is serving those it aims to serve.

In addition, there have been a number of developments since the passage of the MHA and AWIA which indicate reason for review. It is worth noting that the Adult Support and Protection (Scotland) Act 2007 (ASPA) also interacts with these pieces of legislation and merits consideration.

[1] . MWC (2017) Mental Health Act Monitoring 2016-17 http://www.mwcscot.org.uk/media/387603/mental_health_act_monitoring_report_2016-17.pdf and MWC (2017) Adults with Incapacity Act Monitoring Report 2016-17 http://www.mwcscot.org.uk/media/389068/awi_monitoring_report_2016-17.pdf

European Court of Human Rights - *X v Finland*[2]

The position of the European Court of Human Rights has long been that medical treatment which is imposed without consent will not amount to a violation of the right to inhuman and degrading treatment (Article 3 ECHR) if it is a "medical necessity" [3]. However, more recently, in *X v Finland*, the Court considered involuntary treatment as an interference with the right to private and family life (Article 8 EHCR), separately from the question of detention. This case raises questions as to whether Short Term Detention Certificates and Compulsory Treatment Orders under the MHA contain sufficient safeguards around the question of *involuntary treatment* as opposed to the question of detention in hospital.

The Court said

"The Court considers that the forced administration of medication represents a serious interference with a person's physical integrity, and must accordingly be based on a "law" that guarantees proper safeguards against arbitrariness. In the present case such safeguards were missing. The decision to confine the applicant for involuntary treatment included an automatic authorisation to proceed to forcible administration of medication if the applicant refused the treatment. The decision-making was solely in the hands of the doctors treating the patient, who could take even quite radical measures regardless of the applicant's wishes. Moreover, their decision-making was free from any kind of immediate judicial scrutiny: the applicant did not have any remedy available whereby she could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication, or to have it discontinued. On these grounds the Court finds that the forced administration of medication in the present case was implemented without proper legal safeguards."[4]

The Court therefore determined that involuntary treatment (the forced administration of medication) does not follow from detention. Rather, there must be separate substantive and procedural safeguards. At present, the MHA permits treatment, with the use of force, for patients who refuse treatment or who are incapable of giving consent (whether they object or not), where it is considered by the Responsible Medical Officer to be in their "best interests"[5]. This may present the same pitfalls as were found in *X v Finland,* however, it has not yet been determined by a court.

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[2] [2012] M.H.L.R. 318
[3] *Herczegfalvy v Austria* (1993) 15 E.H.R.R. 437
[4] Para 220
[5] Section 242 2003 Act

UN Convention on the Rights of Persons with Disabilities (CRPD) - General Comment No.1

The UK is a signatory to the CRPD and the Scottish Parliament must observe and implement such international treaty obligations[6].

The UN Committee on the Rights of Persons with Disabilities, which interprets the Convention, has published a General Comment[7] on the right to equal recognition before the law (Article 12). It states that legal capacity cannot be denied on the basis of disability (as this would constitute discrimination) and that decision-making must be supported not substituted. This requires that all forms of substitute decision-making be abolished and replaced with regimes for supported decision-making. This expressly includes regimes of guardianship and involuntary mental health detention and treatment.

The UK, including Scotland, was reviewed by the CRPD Committee in August 2017. The Committee recommended in their Concluding Observations:

"…that the State party, in close consultation with organisations of persons with disabilities, including those representing persons from black and minority ethnic groups and in line with the Committee's general comment no. 1 (2014), ***abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in line with the Convention to initiate new policies in both mental capacity and mental***

health laws*. It further urges the State party to step up efforts to* ***foster research, data and good practices of, and speed up the development of supported decision-making regimes."*** *[emphasis added]*

While the more absolute aspects of the CRPD Committee's General Comment have been controversial, it is clear that it will be necessary to shift as much as possible towards systems built around support for disabled people in exercising choice and autonomy.

The UN's Special Rapporteur on the right to health recently considered this issue taking into account both the CRPD position, the views of medical professionals and those with lived experience[8]. His recommendations are a useful and measured summary of the priorities for action, which we consider could be instructive in the Scottish context. He recommends five concrete actions:

a) *Mainstream alternatives to coercion in policy with a view to legal reform;*

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[6] s.7(2) Sch.5 Scotland Act 1998
[7] General comment No. 1 (2014) https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement
[8] https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement

b) *Develop a well-stocked basket of non-coercive alternatives in practice;*
c) *Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders;*
d) *Establish an exchange of good practices between and within countries;*
e) *Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.*

Existing recommendations

A number of recommendations have already been made in Scotland, regarding changes which would be required to address these issues and to achieve CRPD compliance.

Essex Autonomy Project 'Three Jurisdictions Report'

The Essex Autonomy Project (in which the Commission participated) is a research project considering recommendations to reform mental capacity legislation in order to achieve CRPD-compliance, across the three jurisdictions of the UK.[9] Recommendations for legislative reform include:

- operating with "the rebuttable presumption that effect should be given to the person's reasonably ascertainable will and preferences, subject to the constraints of possibility and non-criminality. That presumption should be rebuttable only if stringent criteria are satisfied.

  Action which contravenes the person's known will and preferences should only be permissible if it is shown to be a proportional and necessary means of effectively protecting the full range of the person's rights, freedoms and interests."
- Incorporating an attributable duty to undertake all practicable steps to determine the will and preferences of persons with disabilities in applying any measure designed to respond to impairments in that person's capabilities.
- Expanding the scope of statutory requirements regarding the provision of support to encompass support *for the exercise of legal capacity*, not simply support *for communication*[10]
- Statutory provisions regarding support in the exercise of legal capacity must be attributable. The AWIA does not expressly state that support must be offered and evidenced prior to the consideration of any intervention, nor are there any specifically attributable duties to provide support.

[9] The Essex Autonomy Project, Three Jurisdictions Report, 6 June 2016, http://autonomy.essex.ac.uk/eap-three-jurisdictions-report
[10] as the Adults with Incapacity (Scotland) Act 2000 s1(6)) currently provides

- Principal mental capacity/adult incapacity legislation should be structured to ensure that provisions and procedures necessary to ensure CRPD compliance apply throughout the legal system, and not only to measures relating to the exercise of legal capacity contained within the principal legislation.

The report also recommends strengthening the role of existing supported decision-making mechanisms, such as independent advocacy and powers of attorney, with robust safeguards against abuse.

Mental Welfare Commission and Napier University 'Scotland's Mental Health and Capacity Law: the Case for Reform'

We believe the Mental Welfare Commission will address, in their response, their detailed consideration of these matters in their joint report 'Scotland's Mental Health and Capacity Law: the Case for Reform[11]. The report contains much cogent discussion and highlights a need to develop a plan for comprehensive reform, which we also consider a priority:

"There should be a long-term programme of law reform, covering all forms of non-consensual decision making affecting people with mental disorders. This should work towards a coherent and non-discriminatory legislative framework which reflects UNCRPD and ECHR requirements and gives effect to the rights, will and preferences of the individual. Further, in accordance with Article 4(3)

UNCRPD, persons with lived experience of mental disorder must be actively consulted in any reform process."

It is worth noting that recent legislation in Northern Ireland and the Republic of Ireland has attempted to do this, with the Northern Irish legislation drawing the framework together into a single Act.

Work underway

It is important to acknowledge that steps have been taken by the Scottish Government to respond to some of these areas and there is already a range of work underway. We are aware that a commitment has already been made, in the Mental Health Strategy 2017-2027, to review AWIA legislation to fully reflect the requirements of the CRPD, with particular emphasis on provision of supported decision-making, addressing issues around deprivation of liberty and the interaction of AWIA legislation with the legislation on mental health and adult support and protection. We are also aware of the separate review of the inclusion of learning disability and autism in the MHA. We support these reviews, however, we believe the task of achieving contemporary human rights standards in this area requires broader, concerted action across the legislative framework.

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

In summary, taking both the developments in human rights standards and the existing work into account, the Commission is of the view that the time has come for a review of the framework for non-consensual care and treatment, to reflect the principle of supported decision-making.

The Commission believes that the following areas should be priorities for action:

- Set out a road map for reform of the full legislative framework (the MHA, AWIA and the ASPA), with the participation of people with lived experience
- Ensure supported decision-making is at the heart of AWIA reform already underway
- Coordinate the existing/proposed reviews in line with CRPD, with the aim of achieving supported decision-making.
- Devote resources to exploring supported decision-making in practice
- Implement the five actions proposed by the Special Rapporteur on the Right to Health.