Dear Peter

Post-legislative scrutiny of the Mental Health (Care and Treatment) (Scotland) Act 2002

Earlier in the year the Public Audit and Post-legislative Scrutiny Committee sought views from the public on which Acts would benefit from post-legislative scrutiny.

From the 24 Acts suggested the Committee agreed a shortlist of those it wished to take forward in the first instance. For the above Act the Committee agreed to write to the Scottish Government asking it to take the issues raised into account as it implements its Mental Health Strategy.

I would be grateful if you could provide a reply by Friday 9 March 2018.

A copy of the information provided in the submissions can be found in the Annexe.

A link to our post-legislative scrutiny page can be found here:

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/105094.aspx

Yours sincerely,

Alison Wilson
Assistant Clerk
Submission A

This Act is very unfair and someone can easily be treated for a mental illness which they do not have. The medication can shorten someone’s life by 15-20 years. The Act has led to many injustices. No-one (including the Mental Welfare Commission) will investigate individual cases. There are no effective safeguards. Monitoring authorities are dominated by lawyers with vested interests.

I would like a fresh investigation into the experiences of my wife Claire Muir and others. After examining these experiences it will become clear that the Act needs fundamentally changed or repealed as recommended by the United Nations (also included in the Conservative Party manifesto & Queen’s Speech in 2017).

The following statistics are damning:

a) 50% of people in retrospect thought forced treatment was wrong for them
   *Experiences of the Early Implementation of the Mental Health (Care & Treatment) (Scotland) Act, 2003: A Cohort Study – Julie Ridley et al (2009).*

b) People taking psychiatric medications die 15-20 years earlier
   *The British Journal of Psychiatry (2011)*

(c) No professional has ever been charged with making a false statement on a document
   26 June 2013 Jackie Baillie (Dumbarton) (Scottish Labour): (S4W-15662)

(d) 78 people die each year whilst being compulsory treated
   *The number of deaths for people treated under the Mental Health Act in 2012/13:*

   Fiona Sinclair asked the Mental Welfare Commission on 1 November 2013 and reported this in an email on 7 November 2013:

   (e) 98% of Mental Health Tribunals agree with the psychiatrist

   (f) 44% of emergency detentions are illegal
   [http://www.bbc.co.uk/news/uk-scotland-37492949](http://www.bbc.co.uk/news/uk-scotland-37492949)

Submission B

The Act deals with compulsory care and treatment of people with mental disorders and was at the time a world leading example of mental health law reflecting human rights principles. However, in the past decade, there have been significant developments in international human rights standards which have called into question several aspects of the law, particularly caselaw regarding the European Convention on Human Rights, and the UN Convention on the Rights of Persons with Disabilities.

Furthermore, experience of the Act suggests that the legislative intention of ensuring that people have rights to appropriate care and treatment in the least restrictive
setting has not always been achieved, particularly as resources have reduced. Even some of the basic legal safeguards, such as the role of an independent Mental Health Officer in emergency detention proceedings, have been degraded due to pressures on resource.

There is now a widespread view that a fundamental aim of mental health policy should be to reduce the use of coercion. The experience of the last 10 years is that the use of detention and compulsory treatment has continued to rise.

The attached report on Scotland’s mental health and capacity law sets out more detail of the case for a review of this legislation.

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

The Act has been in force for 12 years. It was a major piece of law reform, with clear policy goals to empower people with mental illness and learning disability, protect their rights, and improve their care and treatment. There were changes made to the Act in the Mental Health (Scotland) Act 2015, but these were technical and procedural, and the debate on that Act highlighted many of the major issues not addressed by it.

The Government has committed to reviewing the place of learning disability and autism within the 2003 Act, but this only affects a small minority of those affected by the legislation, which is very largely directed at people with mental illness.

Submission C

Two Acts which urgently require post-legislative scrutiny are the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act).

Part 5 of the AWI Act and the 2003 Act both give health professionals authority to deprive individuals of their right to make treatment decisions. This has, for example, led to many dementia patients dying prematurely as a consequence of the widespread practice of giving them potentially harmful antipsychotic drugs without obtaining their informed consent. It is not sufficient for there to be an advocacy service which can support patients deemed to lack capacity because, in Scotland, health professionals are not under any obligation to act in accordance with the wishes of a patient certified as lacking capacity or a mental health patient who has been detained in hospital: in practice health professionals are permitted to ignore the past and present wishes of these people and also the views of close relatives and carers in spite of the general principles set out in section 1 of each of the two Acts in question. This might not be a cause for concern if the health professionals could be relied on to act in ways that were likely to benefit such patients and where the potential benefit was likely to outweigh the known risks, but unfortunately that is not the case. The fact is that there are no effective safeguards to ensure that there is compliance with the principles of either the AWI Act or the 2003 Act. Nor is there any effective safeguard to ensure that the “treatment” is carried out in accordance with the advice in the British National Formulary: too much weight is given to the “professional judgment” of the health professional. Unfortunately it is common for
health professionals to make mistakes which harm patients, mistakes which some believe to be the third most common cause of death after heart disease and cancer.

The provisions of the 2003 Act make it too easy for an individual to be detained in a mental health hospital. For example, the Act contains no mechanism which can ensure that proper procedures are followed prior to the detention of an individual. As a consequence, the proper procedures are not always followed and hence many detentions are unlawful. Not only are many detentions unlawful but, in some cases, an approved medical practitioner who grants a short-term detention certificate is mistakenly considered it likely that each of the requisite criteria has been met: the 2003 Act permits a short-term detention certificate to be granted on this basis. That would not be such a serious matter if the 2003 Act did not authorise the commencement of forced treatment prior to the establishment of the facts: hence the 2003 Act authorises mental health patients to be subjected to forced treatment without that treatment having been shown to be a medical necessity. Paragraph 52 of the judgment of the European Court of Human Rights in the 2012 case of Gorobet v Moldova would seem to imply that forced treatment in those circumstances breaches Article 3 ECHR, the right not to be subjected to inhuman or degrading treatment. Since this is an absolute right, the section of the 2003 Act which permits forced treatment to commence before an appeal has been heard is one that should be carefully examined.

It should be noted that in 2012 Germany's Federal Supreme Court banned coercive antipsychotic treatment across Germany. Following representations from Germany's professional association for psychiatry, changes were made to Germany's federal law, changes which allowed coercive treatment under strict criteria and with additional procedural safeguards. These included the right of appeal by the patient prior to the commencement of the proposed treatment. (See "Germany without Coercive Treatment in Psychiatry - A 15 Month Real World Experience")

It might be an improvement to the 2003 Act if it were amended follow the German example, i.e. to allow for an appeal prior to the commencement of any proposed treatment. However, while such an amendment would be an improvement it would not be sufficient if the appeal were to be made to the Mental Health Tribunal: because of their remit and composition, mental health tribunals are not impartial and, as a consequence, mental health patients cannot be guaranteed a fair hearing when they appear before one: this is a fact that has been established empirically. This is another matter which should be carefully considered during the forthcoming post-legislative scrutiny.

When post-legislative scrutiny is undertaken, careful attention should be paid to those parts of the Scotland Act which deal with legislation enacted by the Scottish Parliament, in particular with sections 29, 35, 57 and 58 of that Act. Among relevant matters is the requirement for Scottish legislation to comply with the international treaties which the UK has ratified. These include the Convention on the Rights of Persons with Disabilities (CRPD). This was adopted by the UN General Assembly in 2006, it came into force in 2008 and was ratified by the UK in 2009. It would be grossly negligent if no account were taken of its provisions during the post-legislative scrutiny of the AWI Act and the 2003 Act. Particular attention should be paid to Article 12 CRPD, an article which requires that those states which have ratified the Convention "recognise that persons with disabilities enjoy legal capacity on an equal
basis with others in all aspects of life" and also that these states "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity".

The relevance of Article 12 CRPD to the issue of the forced treatment of mental health patients was made clear in the General Comment issued by the CRPD Committee in April 2014. In section 17 of that General Comment it is stated that "The right to enjoyment of the highest attainable standard of healthcare (art 25) includes the right to healthcare on the basis of free and informed consent". In both the AWI Act and the 2003 Act there is an assumption that health professionals, including psychiatrists, can identify patients who lack the capacity to give informed consent and that it is lawful to treat such patients without obtaining that consent. Basically, the CRPD Committee has stated that there must be no such assumption and that State Parties must "ensure that accurate and accessible information is provided about service options ... and provide access to independent support". In reality not all people with dementia and not all mental health patients detained in hospital require support. However, if there is any doubt about their capacity to make a treatment decision then, as set out in Article 12 CRPD, support should be provided to help them make one. Given that case-law has established that adults with capacity have an absolute right to refuse treatment it would seem to follow that adults who, with support, have the capacity to make a treatment decision must also have the right to refuse treatment. That is the clear message set out in section 18 of the General Comment. However, the recommendation that "State parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned" would appear to go too far: even with support, there can be no guarantee that all people with disabilities would have sufficient capacity to give informed consent.

Given the ratification by the UK of the Convention on the Rights of Persons with Disabilities it would appear that Scottish mental health and incapacity legislation should be amended in such a way that makes clear that persons with the capacity to make a treatment decision must not be treated without their informed consent. Further, it would seem desirable to stipulate that the test of capacity to make a treatment decision is the one approved by the European Court of Human Rights, i.e. the test of capacity set out in Re C (Adult, refusal of treatment)[1994]. It should be recognised that the SIDMA test as outlined in subsection 44(4)(b) of the 2003 Act is unsatisfactory since there is no objective way of determining whether a patient's ability to make a decision about the provision of medical treatment is so significantly impaired that the patient is entirely incapable of making such a decision. As a consequence, there is a general failure to determine whether the SIDMA test has been failed when there is an appeal by a patient to a mental health tribunal against the grant of a compulsory treatment order: the evidence is that tribunals accept without question that a patient has significantly impaired decision making capacity if the responsible medical officer asserts that is the case, possibly claiming that the patient "lacks insight" to justify the assertion. It may be going too far to claim that the ratification by the UK of the CRPD implies that medical treatment should only be carried out with the informed consent of the patient. However, the ratification by the UK of that international human rights treaty does seem to imply that there should never be non-consensual treatment of a conscious adult unless it has been properly established that the adult lacks the capacity to make a treatment decision.