I would like to respond to this, especially questions 7 & 8

7. Which parts of the previous mental health strategy have been the least successful?

The Mental Health Act is a massive fraud.

8. What would you identify as the key priorities for the next mental health strategy?

To get justice for those people abused by The Mental Health Act and to amend this Act so that abuse does not happen in the future.

I also endorse Hunter Watson’s attached paper (Annexe A)
There is much to be welcomed in the proposed new mental health strategy for Scotland. Particularly to be welcomed is the intention to “embed a human-rights based approach across our priorities and actions”.

The Scottish Government is seeking suggestions as to how the success of its strategy should be measured. Given its emphasis on human rights it seems clear that account should be taken of its success in protecting the human rights of those with mental health problems. In part this would involve determining whether those people could access appropriate treatment as easily as people with physical health problems. However, to ensure that mental health was given true parity with physical health it would also seem to be necessary that the forced treatment of mental health patients be ended except, perhaps, in exceptional circumstances with the agreement of a court. If Scottish mental health legislation continues to permit the detention and forced treatment of mental health patients who have committed no offence then that legislation will not respect their human rights. Hence, if the new strategy does not lead to the ending of forced treatment then it will not have been a success. In addition, if the new strategy does not lead to a dramatic reduction in the number of people detained purely under mental health legislation then, again, it will not have been a success. Further, the new strategy will not have been a success if the life expectancy of those with severe and enduring mental health problems continues to be from 15 to 20 years less than that of the rest of the population.

In order to ensure that the new mental health strategy is human-rights based it is essential to amend mental health legislation in such a way that it is made compatible with the UN Convention on the Rights of Persons with Disabilities (CRPD). This is a legally binding international treaty which sets out the rights of persons with disabilities. The CRPD, which came into force on 3 May 2008 and which has been ratified by the UK, seeks to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity”. The Convention specifies that persons with disabilities include those with long-term mental or intellectual impairments.

Article 3 sets out the general principles which should guide the implementation of all articles of the CRPD. One of those general principles is the following: “respect for the inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons”. Note the need for there to be freedom to make one’s own choices, something denied to those patients who are given non-consensual treatment.

The general principle to which reference has been made is related to Article 12 CRPD which is entitled “Equal recognition before the law”. This contains the following provisions:

“States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”.

“States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”.

In April 2014 the UN’s CRPD Committee issued a General Comment on Article 12, observing that:
“As has been stated in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the right to personal integrity (art. 17), freedom from torture (art. 15), and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention.”

“The Committee recommends 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.”

When considering those comments, note should be taken of the report which Juan Mendez submitted to the Human Rights Council of the UN General Assembly on 1 February 2013. His report focused on “certain forms of abuse in healthcare settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment”. The report was critical of “non-consensual psychiatric treatment” such as “forced medication or electroshock”. It further states that “treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine”. The Government should reflect carefully on this assertion. The Government should also take account of the following statement in the report: “Capacity is a rebuttable presumption; therefore, ‘incapacity’ has to be proven before a person can be designated as incapable of making decisions”. This statement should be read in the context of the GMC consent guidance: “You must work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.”

This GMC consent guidance, which is derived from case law, is perfectly consistent with Article 12 CRPD, with the General Comment on that Article by the UN CRPD Committee and with the views of Juan Mendez, the UN’s Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Further, there should be no claim that the non-consensual treatment authorised by the 2003 Act does not lead to some involuntary patients suffering treatment that falls within the prohibited inhuman or degrading category: the evidence submitted in support of my petition PE01494 on mental health legislation established that some patients suffered horribly as a consequence of having been detained and forcibly treated; at least two died prematurely as a consequence. The Government, therefore, should consider seriously the recommendation by the UN’s CRPD Committee 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”. In order for there to be informed consent information must, of course, be provided about the significant risks associated with proposed treatment, the probabilities of those risks occurring and the probability that the treatment will benefit the patient. There should be no assumption that persons with mental disorders would be incapable of having a basic understanding of such matters, especially if given help to do so.
When a decision is made as to whether persons with a learning disability or autism should continue to be liable to be detained under the provisions of the 2003 Act note should be taken of Article 14 CRPD. Within this it is stated that “the existence of a disability shall in no case justify a deprivation of liberty”. Account should also be taken of a statement on Article 14 CRPD made in September 2014 by a human rights committee of the UN: “The involuntary detention of persons with disabilities based on presumption of risk or dangerousness tied to disability is contrary to the right to liberty.” This is a view that deserves to be properly debated since risk can only be estimated.

It is not in dispute that it is appropriate to detain persons who have committed a serious offence and that such persons should be offered treatment if they have a mental illness. What is in dispute is that it is appropriate to detain persons who have been diagnosed with a mental illness, but who have committed no offence, on the grounds that the illness might predispose them to commit one. Also in dispute is the assumption that persons diagnosed, possibly incorrectly, with a mental illness can be treated against their will.

For a number of reasons any claim that the 2003 Act is already compatible with the CRPD would be false. In particular, as noted above, Article 12 CRPD emphasises the importance of legal capacity and of equal recognition before the law. The 2003 Act pays, at best, only lip service to legal capacity. Section 44 of the Act permits an approved medical practitioner to grant a short-term detention certificate if he or she considers it likely that, among other matters, the individual has significantly impaired decision-making capacity. Significantly impaired decision-making capacity is something that cannot be properly assessed and, more importantly, does not correspond to legal capacity as recognised by the European Court of Human Rights. Under common law, as set out clearly in the GMC consent guidance, persons with legal capacity have the right to refuse treatment. However, once an individual has been detained under the provisions of the 2003 Act he or she is deprived of that right. Section 242 of the Act even authorises a patient’s responsible medical officer to disregard a refusal of treatment made by a patient with capacity!

There should be no assumption that a mental health patient would benefit by being subjected to non-consensual treatment. This was evident from submissions made in support of petition PE01494. Also, in an article published in the Guardian on 1 November 2015 it was stated that “According to Peter Gotzsche, professor of research design and analysis at the University of Copenhagen, prescription drugs are the third most common cause of death after heart disease and cancer. In an analysis published in the BMJ, he estimated that every year psychiatric drugs, including anti-depressants and dementia drugs, are responsible for half-a-million deaths in those aged over 65.” Clearly people should have the right to refuse to be administered drugs liable to harm them.

Account should also be taken of an article which appeared in the Irish Examiner on 26 April 2014: it was reported that the Irish psychiatrist, Siobhan Barry, had said that the long-term use of some psychiatric drugs could reduce life expectancy by up to 20 years, “mirroring the position publicly adopted by the UK’s Royal College of Psychiatrists”. It should be accepted that it is a breach of Article 2 ECHR, the right to life, to force patients diagnosed with severe and enduring mental health problems to take drugs which are likely to hasten their deaths. It is possible that if they were treated only with their informed consent, as recommended by the CRPD Committee,
then their life expectancy would improve. It is well known that patients diagnosed with severe and enduring mental health problems have a poor life expectancy. It is also well known that those are the persons who are most likely to be forced to take psychiatric drugs for a considerable length of time. The possibility that the first fact is a consequence of the second should not be lightly dismissed.

There is much of which account should be taken during the forthcoming review of Scottish mental health legislation though in this paper attention has been focused mainly on matters relating to the deprivation of liberty and the non-consensual treatment of mental health patients. It is to be hoped that careful consideration can be given to the evidence presented and that it can help to inform the debates which should take place during the review.