PE1667/I
Petitioner submission of 07 June 2018

A RADICAL PROPOSAL

1. Introduction

In her response of 5 December 2017, PE1667/G, to the petition calling for a wide review of Scottish mental health and incapacity legislation, the Minister for Mental Health stated that "*Scottish mental health and incapacity legislation is based on rights and principles".* The Minister did not specify what she understood by "rights" but presumably under this heading should be included the right for persons with legal capacity to make decisions about their own medical treatment.

The Minister also stated that a full consultation on AWI legislation would be launched "next year". That consultation has now been completed and this paper reproduces some of the responses to it. It also comments on the implications of those responses and then goes on to make comments about the Minister's defence of the 2003 Mental Health Act (the 2003 Act).

Finally, in section 6 a proposal is made about how Scottish mental health and incapacity legislation could be reformed with minimal delay.

2. Responses to the AWI Act consultation

2.1 In its response to the consultation about the reform of the Adults with Incapacity Act, Alzheimer Scotland stated that it "*is aware of of the inherent problems with the Adults with Incapacity (Scotland) Act 2000 and welcomes the Scottish Government's review of the legislation. However, we believe that a number of the issues with the current approach are to do with the implementation of the 2000 Act in practice; therefore, some of the proposals are likely to experience the same issues.*

We therefore believe that the 2000 Act does not require extensive reform, rather, more consideration should be given to its implementation and how compliance can be ensured."

2.2 People First is an organisation which campaigns on the rights of people with learning disabilities or autism. In its response it stated that "*We consider that the original principles of the AWI Act were well constructed and clearly intended to make guardianships and intervention orders "last resort" and to achieve significant autonomy and control over their own lives for adults who have impaired intellect. The principles did not achieve that outcome since they have been consistently ignored and even reinterpreted to allow plenary guardianships (covering all possible powers) and lifetime guardianships so that adults have their legal capacity removed from them and are denied citizenship for life.*

We see nothing in the proposal which addresses the consistent disregard and flouting of the principles by Sheriffs, guardians, approved medical practitioners and Mental Health Officers".

2.3 The Scottish Human Rights Commission, in its response, stated that "*The Commission has long expressed concerns regarding the rising levels of non-consensual interventions in the affairs of individuals with "mental disorder", via mental health and incapacity legislation, accompanied by safeguards that have not proved effective. We have repeatedly called for a review of the framework for non-consensual care and treatment, to reflect the principle of supported decision-making".* The Commission also stated that *"It is well known that the principles are not consistently applied in practice. We consider therefore that the duties attached to them, and the scrutiny of the performance of those duties, require to be more robust".*

2.4 In its response, the Mental Welfare Commission for Scotland stated "*The precise wording of the principles is less important that the extent to which they are given effect, including in the processes of determining a person's powers. We do not believe the principles are always applied in, for example, court processes and certification of incapacity by doctors. We note that some sheriff courts are increasingly taking an interest in what support has been given to establishing the will and preference of the adult, but a more fundamental shift to seeking to do this for all interventions is required.*

Also, the interventions which need to respect the principles generally happen in the exercise of the powers, not at the time of appointment, so it is important to consider how to make those principles more likely to be observed. Too often guardians, care staff etc. don't know the principles exist or what they mean".

3. Implications of responses

As noted in the introduction, the Minister for Mental Health stated that Scottish mental health and incapacity legislation is based on rights and principles. It was not specified what those rights are, but if their being respected depends upon an adherence to the principles then it follows that mental health patients and adults with incapacity are often being denied those rights since there seems to be little or no attempt to ensure that there is compliance with the principles. Their existence, therefore, is not a sufficient justification for not carrying out the desired wide review of mental health and incapacity legislation. There should, of course, be no doubt that, as well as being a failure on the part of many to comply with the principles of the AWI Act, there is also a similar failure to comply with those of the 2003 Act.

4. An inadequate defence

In her paper PE1667/G, the Minister stated:

"*Our mental health legislation promotes patient's rights and provides safeguards. The Mental Health (Care and Treatment) (Scotland)Act 2003 ("the 2003 Act)* (sic) *provides support for patients in expressing their will and preferences. The principles include that any function should be carried out for the maximum benefit of the patient, with the minimum necessary restriction on the freedom of the patient and having regard to the views of the patient".*

I have in my possession much material which demonstrates that the reality is very different from the picture painted by the Minister. That material includes the report about Mrs A to which reference was made in submission PE1667/B. That report, written by a daughter, is 51 pages in length and is entitled "**The Tragic Case of the Treatment of an Elderly Woman in the 21st Century NHS**". The report describes treatment which would appear to fall within the prohibited inhuman or degrading category and which almost certainly led to the premature death of Mrs A. Fifteen of the report's pages describes in detail the failure of the supposed safeguards in the 2003 Act to protect Mrs A from what, with some justification, could be described as torture. (As noted in section 5, a UN Committee is of the opinion that forced treatment can constitute torture.)

The report is dated December 2012 and shortly thereafter was presented to the then Minister for Health and Sport. I have suggested to the current Minister for Mental Health that she reads that report. If she could do that, then it would become clear to her that the 2003 Act lacks effective safeguards.

In her submission PE1667/G the Minister also made the statement that "*The 2015 Act strengthens measures in the 2003 Act which promote support for decision making*". Eventually data will become available which will reveal whether measures in the 2015 Act have led to more attention being paid to the importance of legal capacity as is required by Article 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD). However, given the widespread failures to comply in the past with the principles of mental health and incapacity legislation it will come as no surprise if the measures in the 2015 Act do nothing to improve the situation especially since the provisions of the 2003 Act include the following:

- patients are detained in hospital on the basis of a short-term detention certificate for the purpose of giving them medical treatment (s 44) (the impliction is that they are detained for the purpose of the giving of unwanted treatment);
- if a patient is deemed incapable of consenting, then ECT may be given even though the patient resists or objects provided that a designated medical pactitioner certifies that it is necessary (s 239);
- if the patient is capable of consenting to treatment other than ECT (and hence has the capacity to make a decision about medical treatment) but does not consent then the treatment may be given if the responsible medical officer determines that would be in the patient's best interests (s 242)!

These measures are incompatible with Article 12 CRPD, a fact that necessitates the making of fundamental changes to the 2003 Act.

5. Legal capacity

Article 12.2 CRPD requires those states which have ratified the Convention to "*recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life"*. Article 12.3 CRPD requires those states to "*take*

appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity".

It should be recognised that the meaning of "legal capacity" differs from that of "mental capacity": it is not necessary to have mental capacity in order to have legal capacity. As far as Scotland is concerned, the definition of legal capacity is given in an Act of Parliament, namely the Age of Legal Capacity (Scotland) Act 1991. Section 1(b) of that Act states that *"a person over the age of 16 shall have legal capacity to enter into any transaction".*

It is possible to deprive adults of their legal capacity to enter into certain transactions, i.e. to partially deprive them of their legal capacity. However, as noted elsewhere, in 2009 the European Court of Human Rights made clear that any proceedings designed to do this must be fair. Unfortunately the proceedings detailed in Scottish mental health and incapacity legislation for depriving adults of their legal capacity to make decisions about their medical treatment are not fair: under the AWI Act the medical practitioner has merely to certify that he or she is of the opinion that the adult is incapable in relation about the medical treatment in question; under the 2003 Act, the reality is that little more is required prior to the grant of a short-term detention certificate than for the approved medical practitioner to consider it likely that various conditions have been met. It follows that under Scottish mental health and incapacity legislation it is too easy for persons to be deprived of aspects of their legal capacity and hence that this legislation no longer meets the requirements of international human rights law.

When considering international human rights law, attention should be paid to the interpretation of the CRPD by the UN's CRPD Committee. In its General Comment on Article 12 this Committee implied that, in its opinion, persons should not be deprived of their legal capacity to make decisions about their medical treatment. For example, in paragraph 38 of that General Comment is the observation that "*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 rights to personal integrity (art. 17), freedom from torture (art. 15), and freedom from violence, exploitation and abuse. This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention."* In the same paragraph the CRPD Committee stated that policies and legislative provisions that allow or perpetrate forced treatment must be abolished and it noted that involuntary mental health patients "*have experienced deep pain and trauma as a result of forced treatment".*

Also in paragraph 38 is the recommendation that "*State parties* (i.e. states that have ratified the CRPD) *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*". This recommendation has particular relevance to the AWI Act, since advantage has been taken of this Act to prescribe and administer potentially harmful

medication as restraint to many elderly care home residents without their informed consent. There should be no question of permitting this use of medication to continue merely because it makes it easier to operate care homes without an adequate number of well-trained staff.

6. A radical proposal

The reform of Scottish mental health and incapacity legislation should include a repeal of those parts of the current legislation which are used to deprive persons of their legal capacity to make decisions about their medical treatment, i.e. it should include a repeal of the 2003 Act and Part 5 of the AWI Act. The work that is currently underway to reform the AWI Act should be extended to meet the needs of those with incapacity because of mental health problems.

There should be no doubt that there is a need for legislation to meet the needs of adults who are or become unable to manage their own finances or to look after themselves. Hence a need for some form of incapacity legislation remains. Account should be taken of the fact that those who responded to the AWI Act were generally satisfied with that Act apart from the failure to enforce its principles.