PE1667/J
Petitioner submission of 07 June 2018

NEED FOR EFFECTIVE SAFEGUARDS

Introduction

When mental health and incapacity mental health is reviewed, account should be taken of the possibility that any amended legislation will not be be law unless it contains effective safeguards to ensure that adults are not wrongly deprived of their legal capacity and hence of their right to refuse medical treatment. The reason for this is that any legislation passed by the Scottish Parliament must be compatible with the European Convention on Human Rights (ECHR) by virtue of section 29 of the Scotland Act. That legislation is unlikely to be ECHR compatible if it is not compatible with judgments of the European Court of Human Rights which require such safeguards. Reference is made in this paper to two recent judgments of this nature. It is hoped that the Scottish Government will carefully study the information provided about these and related matters with a view to ensuring that the current legislation is suitably amended.

Points to ponder

Following several judgments of the European Court of Human Rights since the passage of the Adults with Incapacity Act (the AWI Act) and the 2003 Mental Health Act (the 2003 Act) it would appear that neither of those Acts could now be regarded as ECHR compatible. There is reference to two of those judgments in the submission PE1667/H in support of petition PE01667. This paper contains information about another two, one of which is the judgment in the 2017 case of A-MV v Finland. Paragraph 90 of this judgment makes clear that in domestic legislation there must be effective safeguards to prevent abuse as required by international human rights law as per Article 12.4 of the Convention on the Rights of Persons with Disabilities (CRPD). It was appropriate that the Court took account of the CRPD, a binding international human rights treaty, since the applicant had been assessed as having decision-making skills corresponding to those of a child between six and nine years of age. Although that case made no reference to medical treatment, the judgment is relevant since a deprivation of the right to make decisions about medical treatment exposes a person to the risk of abuse.

The principles contained in Part 1 of the AWI Act do not provide the necessary effective safeguards nor do those in the 2003 Act since those principles are not enforced. That is a serious matter because under the current legislation, adults can be too easily deprived of their right to refuse medical treatment and can subsequently be subjected to treatment which falls within the prohibited inhuman or degrading category and which can even lead to the premature death of the victims.

It is clear that adults are too easily deprived of their right to refuse treatment under the provisions of the 2003 Act because of the nature of its capacity test: under section 44 of that Act, an adult can be deprived of this right if an approved medical

practitioner considers it likely that the adult has a mental disorder and, because of the disorder, the patient's ability to make decisions about medical treatment is significantly impaired. This test of capacity is commonly referred to as the SIDMA (significantly impaired decision making ability) test and is, in practice, of no value in judging whether an adult has sufficient capacity to make a decision about medical treatment. That is particularly true in cases where the adult has dementia or a learning disability.

When considering whether the SIDMA test of capacity in the 2003 Act should be replaced, account should also be taken of the judgment of the European Court of Human Rights in the 2009 case of Salontaji-Drobnajak v Serbia. In paragraph 155 of this judgment it is stated that "*there had been a violation of 6(1) of the Convention as regards the fairness of the proceedings resulting in the partial deprivation of the applicant's legal capacity*". The procedure specified in the 2003 Act for depriving adults of their legal capacity to make decisions about their medical treatment could not, by any stretch of the imagination, be described as fair. Hence, in order to comply with that 2009 judgment of the European Court of Human Rights, it would be necessary to replace the SIDMA test by a procedure which can more reliably assess an adult's ability to make decisions about medical treatment. The test in the GMC's consent guidance is worthy of consideration as one part of that procedure since it takes account of both case-law and the CRPD. For example, within section 64 of the guidance it is stated that "*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*". Another part of the procedure might require those assessing decision-making ability to comply with something along the lines of recommendation 41 in the Law Commission's paper entitled "Mental Capacity and Deprivation of Liberty", i.e. to stipulate that, if an assessment has the potential to deprive an individual of his or her right to make decisions, then the person making the assessment must produce a written record containing specified pieces of information including:

(1) the steps taken to establish that the person lacks capacity;
(2) the steps taken to help the person make the decision;
(3) why it is believed that the person lacks capacity;
(4) the steps taken to establish that the act is in the person's best interests.

Finally, the procedure must provide for a right of appeal against any assessment that deprives an adult of some aspect of legal capacity. This follows from the Salontaji-Drobnajak judgment referred to above. In paragraph 155 of that judgment it is stated that "*there had also been a violation of Article 6(1) of the Convention as regards the applicant's right of access to a court concerning the restoration of his full legal capacity*". Thus this judgment implied that if an adult has been deprived of the right to make certain decisions then that adult must have the right of access to a court in order to appeal. Article 12.4 CRPD contains a similar requirement "*... measures relating to the exercise of legal capacity ... are subject to regular review by a competent, independent and impartial authority or judicial body*".

Also, in paragraph 90 of the judgment in the case of A-MV v Serbia it is made clear that any interference with a person's rights must be " *subject to review by competent, independent and impartial domestic courts*".

Under the provisions of the 2003 Act, a person who has been detained in hospital for the purpose of receiving involuntary treatment for a mental disorder has the right of appeal to a mental health tribunal. However, the fact is that, in general, mental health tribunals in Scotland lack the competence, independence and impartiality required by the European Court of Human Rights. I have provided evidence in support of this allegation elsewhere, but note should also be taken of the observation made about mental health tribunals in paragraph 52 in the report dated 28 March 2017 by a Special Rapporteur on the right of everyone to the highest attainable standard of physical health: "***Of particular concern is the growing prevalence of mental health tribunals which, instead of providing a mechanism for accountability, legitimize coercion and further isolate people within mental health systems from access to justice***".

Appeals against a deprivation of legal capacity should be made to the courts which, unlike mental health tribunals, normally attempt to carefully test the evidence, something which requires witnesses to be cross-examined and to give evidence on oath. Incredibly, mental health tribunals tend to accept without question the evidence from the medical "experts" and do not require them to give evidence on oath even though those tribunals are required to determine whether mental health patients should not only continue to be deprived of their liberty but should also continue to be subjected to involuntary treatment. Regarding the involuntary treatment, in paragraph 64 of his report of 1 February 2013, a UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment stated that, **to the extent that they inflict severe pain and suffering, involuntary treatment and other psychiatric interventions in health-care settings violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.**

Although the test of capacity specified in section 1(6) of the AWI Act is preferable to that in the 2003 Act, the fact remains that this Act also makes it too easy for a medical practitioner to deprive an adult of the right to make treatment decisions: all that is required is for the practitioner to certify that he or she is of the opinion that the adult is incapable about the medical treatment in question. Many who do certify that elderly care home residents with dementia are incapable then prescribe them antipsychotic drugs in spite of the serious risks which these drugs pose to their health. The procedure for assessing the decision-making ability of adults with dementia or adults with a learning disability should, therefore, be the same as that for those whose decision-making ability might be impaired because of a mental illness.

In order to comply with the CRPD it is necessary to do more to amend the AWI Act than add to it a new procedure for assessing decision-making ability. Section 47(7) of the AWI Act authorises the medical practitioner primarily responsible for the care of an "incapable" adult to use force to treat the adult if that appears to be

immediately necessary. That provision would appear to be incompatible with Article 12.4 CRPD since this requires that "*measures relating to legal capacity respect the rights, will and preferences of the person*". Further, this use of force can cause great distress. I am aware of this because I have represented two women who were each held down by several nurses while being injected with drugs. In one case the woman, a Mrs A, was so traumatised that she required psychotherapy afterwards. I complained to the Scottish Public Services Ombudsman on her behalf. The complaint was upheld and in his report the Ombudsman required the Health Board concerned to issue an apology to Mrs A for the failings identified in the report. He concluded by stating that "*For the sake of patients and health practitioners, lessons from this disturbing incident must be learned not only across the Board concerned but across the NHS in Scotland*".

I was informed by the Investigations Manager that "*A copy of this report will also be sent to Scottish Ministers and a copy will be laid before the Scottish Parliament*". So far as I am aware the Scottish Ministers have taken no action to ensure that lessons were learned. Perhaps is now the time for the Scottish Ministers to consider the implications of this report for the reform of Scottish mental and incapacity legislation, especially since in both of the cases to which I have made reference the forced treatment was not only unnecessary but was also liable to harm each of the women concerned. In another case, I represented a man whose elderly mother, Mrs D, died only 18 days after entering a care home. After learning that she had been administered a nephrotoxic drug in spite of her known renal impairment, I reported this fact to local procurator fiscal's office. A procurator fiscal subsequently had the matter investigated by the police and then submitted a report to the Crown Counsel. Unfortunately the Crown Counsel instructed that there be no Fatal Accident Inquiry so no lessons were learned from this particular case. However, it is no secret that doctors do mistakes which harm patients. For example, in the Telegraph of 23 February 2018 it was reported that researchers had estimated that each year in England about 237m medication errors are made and that these cause about 1700 deaths and contribute to up to another 22,000. It should be recognised that medical practitioners can and do make mistakes. Scottish mental health and incapacity legislation should not be based on the premise that this can never happen: it is essential that, if amended legislation does authorise non-consensual treatment, then it includes the necessary effective safeguards.

<u>Concluding remarks</u>

When Scottish mental health and incapacity legislation is reviewed, account should be taken not only of the ECHR and the CRPD but also of:

- the views of Special Rapporteurs to the Human Rights Council of the General Assembly of the United Nations;
- **the judgment in the 2002 case of Re B (Adult, refusal of medical treatment) since this established that competent patients have a right to refuse treatment even where such refusal might result in their death;**

- the view of the CRPD Committee that Article 12 requires states which have ratified the CRPD to abolish legislative provisions that allow forced treatment;
- relevant judgments of the European Court of Human Rights since a failure to do so might lead to the amended legislation not being compatible with the European Convention on Human Rights and hence not law; and
- the fact that medical practitioners make mistakes which harm patients.