PE1667/Q
Petitioner submission of 3 September 2019

1. Introduction

On 19 March 2019 the Minister for Mental Health made a statement to the Scottish Parliament about a review of mental health and incapacity legislation. In her statement, she made clear that one would take place and that it would take account of the Convention on the Rights of Persons with Disabilities (CRPD), an international human rights treaty which was ratified by the UK in 2009.

On 21 March 2019 the Minister and three of her officials gave oral evidence to the Public Petitions Committee about my petition, PE01667. In her evidence the Minister confirmed that there would take place a review of mental health and incapacity legislation and that this would take account of the CRPD as well as the European Convention on Human Rights (ECHR). The Minister, in response to a question from the Convener, stated that "*We also abide by the appropriate case-law emanating from the European Court of Human Rights".*

Petition PE01667 called for a wide review of Scottish mental health and incapacity legislation that took due account of recent developments in international human rights law. It made reference to the need to take account of the CRPD and also judgments of the European Court of Human Rights since these help to clarify the scope of the ECHR. Given the assurances which the Minister gave to the Public Petitions Committee it might have been expected to close petition PE01667. It is my view that in choosing to leave the petition open the Committee is demonstrating that it was unhappy with the answers which it received to some of the probing questions asked.

2. Forced treatment

The ECHR right not to be subjected to inhuman or degrading treatment is an absolute right: it is prohibited in all circumstances in Scotland because the UK has ratified the ECHR. When the Minister appeared before the Public Petitions Committee on 21 March 2019 the Convener asked her whether the Government would take account of the possibility that forced treatment might be inhuman or degrading.

The Minster accepted the Dr Mitchell's offer to answer this question. This is what he said: "*Article 2 of the ECHR, which is the right to life, is an absolute right. That means that there is a duty not to take away anyone's life and a duty to take reasonable steps to protect life. Article 14 is the right not to be discriminated against, which could be interpreted in terms of people having the right to the same effective treatments as other*

people. Article 25 is the right to the highest attainable standard of physical and mental health. Those are illustrations of the counterpoint between the different articles, and protecting an individual while still protecting these absolute rights is challenging".

It is noteworthy that Dr Mitchell did not seek to deny that forced treatment might fall within the definition of inhuman or degrading treatment. Instead he gave an answer which implied that the giving of forced treatment can be justified on the grounds that it protects the Article 2 ECHR right to life. I disagree with this line of reasoning for a number of reasons.

2.1 Far from protecting the life of an involuntary mental health patient, forced treatment can lead to the premature death of the patient. Two of the submissions in support of PE01667, namely PE1667/B and PE1667/C give examples of such cases. Also, within the past twelve months there have been reports in the press about four deaths which are attributable to the use of forced treatment. The three deaths in question were those of Oliver McGowan, Julia MacPherson and Tom Jackson.

In the Observer report of 23 December 2018 about Tom Jackson it was stated that he "*died in August 2016 at the age of 24 as a result of 'clozapine toxicity, pneumonia and treatment resistant schizophrenia according to the coroner's report".* After being diagnosed with psychosis, Jackson had been detained in St George's Hospital, Stafford, where he was given clozapine for over a year.

2.1.1 The Minister has been sent information about a young man called John who has been diagnosed with treatment resistant psychosis and who has been given depot injections of antipsychotic drugs against his will for around 21 months. John, like Oliver McGowan, has epilepsy, and experts in this condition advise that epileptics should not be given antipsychotic drugs unless absolutely necessary; they particularly advise against giving epileptics antipsychotics by depot injection. Those responsible for the care of John have been made aware of this and yet they have persevered with this treatment. It is a near certainty that not only is John's life being made a misery by this forced treatment but that it will also be shortened by it.

2.2 It is not obvious why Dr Mitchell gave the interpretation he did of Article 14 ECHR. The fact is that, by common law, everyone with legal capacity has the right to refuse treatment for a physical disorder whatever the risk of that refusal might be. However, Scottish mental health legislation permits people to be subjected to forced treatment if an approved medical practitioner considers it likely that the necessary conditions have been met. These are somewhat flimsy grounds for depriving a person of the right to withhold consent to treatment. If Article 14 ECHR were properly applied then

presumably people with a mental illness would have the same right to withhold consent to treatment as do those with a physical illness. It is noteworthy that in her evidence to the Public Petitions Committee the Minister stated that the Scottish Government is committed to ensuring that mental health is given parity with physical health. If it is given parity, then the forced treatment of mental health patients would have to end except, perhaps, in a tiny number of particular cases where it was sanctioned by a court.

2.3 It is also difficult to understand why Dr Mitchell made reference to an Article 25. He seemed to imply that Article 25 ECHR makes reference to the highest attainable standard of health but it makes no such reference; instead it is Article 25 CRPD which makes reference to this. Further, far from this Article providing a justification for forced treatment, it does the opposite: Article 25(d) CRPD requires "*health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent ..."*

3. Chemical restraint

The Health and Social Care Standards at page 18 make reference to the use of "chemical restraint". The Minister was asked whether the Scottish Government intended to amend those standards so that they no longer condoned the use of chemical restraint and whether that could be done without legislative change.

An affirmative answer should have been given to the second part of the question: all that is required is the removal of the phrase "chemical restraint" from those standards; that does not require legislation.

The Minister invited Dr Mitchell to answer. When he did so he again gave curious answer. He stated that "*... there is concern about an increased risk of falls and an effect on blood pressure when antipsychotics are used on elderly people. These are very real risks. As with any treatment, on a day-to-day basis, clinicians have to weigh up the side-effects versus the benefits. If, for example, somebody with dementia is in a distressed and agitated state, there might be more risk to their health from falls, so they might not be treated rather than treated."*

That answer is curious for a number of reasons, one being that it seems to imply that clinicians will always weigh the known risks against the potential benefits when they receive a request from a care home to prescribe a drug as a chemical restraint. The fact, however, is that some doctors too readily prescribe a drug to elderly care home residents when asked to do so by care home staff and that they do not always weigh the risks against the benefits - see section 5.

Dr Mitchell's answer was also curious in that he failed to mention other serious risks of giving antipsychotic drugs to elderly people with dementia even though, being Scotland's Principal Medical Officer, he should be well aware of these since there is reference to them in the BNF.

The BNF is a publication which is regularly updated and which addresses the prescribing needs of healthcare professionals. In the September 2017 edition, it was stated that "*The MHRA has reported (2009) a clear increased risk of stroke and a small increased risk of death when antipsychotic drugs are used in elderly patients with dementia".* However, an article which appeared in the Pharmaceutical Journal dated 26 March 2015 was entitled "***Greater risk of death by antipsychotics in dementia patients, research suggests***". I have in the past provided the Scottish Government with a copy of that research which involved a retrospective case-control study involving 46,008 patients with dementia. Dr Mitchell should have been provided with that copy in case he had not been aware of this research.

3.1 When giving his answer to the question about forced treatment, Dr Mitchell correctly stated that Article 2 ECHR, the right to life, means that there is a duty to take reasonable steps to protect life: in the Guide to the Human Rights Act it is stated at 3.12 that "...*you have the right to have your life protected by law"* and at 3.17 "*The Government must also take positive steps to protect life in all kinds of situations."* The Scottish Government should recognise that its authorisation of the use of chemical restraint in the Health and Social Care Standards is not compatible with its duty to protect life in all kinds of situations.

4. <u>Covert medication</u>

When Dr Mitchell was pressed further to make known whether Scotland's health and social care standards could be amended without going down the legislative route, he again gave a rather curious answer. His first answer was curious in that he seemed to imply that any refusal of a person with dementia to take a drug prescribed as chemical restraint would be respected even though that is unlikely. His second answer was curious because it seemed to link the use of chemical restraint to the use of covert medication: in that answer Dr Mitchell stated "*As the Minister has said, the use of chemical restraint is authorised under certain circumstances. There is very clear guidance for clinicians. The Mental Welfare Commission for Scotland has explicit guidance on the use of covert medication ... Very detailed guidance for practioners on consent and capacity considerations and the use of covert medication, which people are aware of, is already available in Scotland, and I am not aware that any further amendment would be needed beyond the necessary consideration of that guidance as part of the total review".*

That statement should be viewed in the light of the evidence given earlier by Kirsty McGrath, the Head of the Adults with Incapacity Review Team: she reported findings that there had been a general failure on the part of those making use of the Adults with Incapacity Act to comply with its principles. It would be unwise, therefore, to assume that those taking advantage of Part 5 of that Act to treat elderly care home residents without their consent would follow guidance regarding consent and capacity. Indeed, research based on visits to a sample of 30 care homes found that only 20% of managers and staff were even aware of the existence of such guidance - see page 65 of the 2009 report *Remember, I'm still me.* Thus while the very detailed guidance does exist, it is questionable to give the impression that all care home managers and staff are aware of it and will comply with it. It may also be questionable to imply that the ECHR rights of care home residents would not be breached even if there were compliance with that guidance.

4.1 In August 2019 I sent the Scottish Government a copy of my paper entitled "Overmedication of the Elderly". This drew attention to the contents of a number of recent reports including the following:

Daily Express (February 9, 2017) *A 'generation' of OAPs are left in over-medicated hazes by care homes say NHS bosses.*

Human Rights Watch (2018) "*They Want Docile" How Nursing Homes in the United States Overmedicate People with Dementia.*

Thomas K (2018) *How overmedication is injuring and killing the elderly - a world first study.*

Lown Institute (2019) *REPORT - Medication Overload: How the drive to prescribe is harming older Americans.*

If it continues to insist that covert medication is "permissible", as it does in section 2.60 of the Code of Practice for Part 5 of the Adults with Incapacity Act, then the Scottish Government will be failing to protect the elderly; there is no guarantee that those who conceal medication in the food or drink of care home residents will do so in accordance with the law as required by the Code of Practice. Few people, in fact, are aware of what the relevant law is. Further, it should be recognised that covert medication is not compliant with the CRPD though this, unlike the ECHR, has not been incorporated into UK law.

5. Psychotropic Medication

In 2014 the Mental Welfare Commission for Scotland issued a report about what it found when it visited 52 NHS units providing longer-term care for people with dementia. On page 17 of that report, *Dignity and respect: dementia continuing care*

visits, it was stated that 84 % of the 336 people looked at were on at least one psychotropic medication and that 35% were on three or more. From the graph illustrating the situation, it appears that 52% of the residents were on an anxiolytic, 48% were on an antipsychotic and 41% were on an antidepressant. Smaller percentages were on other psychotropic drugs. All of these drugs have side-effects which can cause adverse drug reactions. It is a reasonable hypothesis that most of those people with dementia were given those drugs as chemical restraint and that, in a high proportion of cases, their health suffered as a consequence. In fact, in its report, the Mental Welfare Commission expressed concern, noting for example that "*All antipsychotic medications increase the risk of stroke and death, many can impair mobility and increase the risk of falls".*

5. Concluding remarks.

In 2017, in his report to the thirty fourth session of the Human Rights Council, the United Nations High Commissioner for Human Rights stated "*Forced treatment and other harmful practices, such as solitary confinement, ... and overmedication (including medication administered under false pretences and without disclosure of risks) not only violate the right to free and informed consent, but constitute ill-treatment and may amount to torture"* (para 33 of the report).

Article 1 ECHR requires states which have ratified the ECHR to secure to everyone within their jurisdiction the rights and freedoms defined in Section 1 of the Convention. Since the UK has ratified the ECHR, the Scottish Government is required to ensure that people within Scotland, including mental health patients and adults with incapacity, do not have their Convention rights violated without sufficient cause and that on no occasion are they subjected to torture or to inhuman or degrading treatment or punishment. The Scottish Government has being failing badly in this regard. It should, therefore, take account of that statement made by the UN High Commissioner for Human Rights in 2017 and reform Scottish mental health and capacity legislation and related guidance in such a way that people will have less cause to fear what might befall them if they are diagnosed with a mental illness or if, because of incapacity, they are placed a care home: the situation at present is arguably that all involuntary mental health patients are subjected to inhuman or degrading treatment and that some have their lives cut short as a consequence. In the case of adults with incapacity, particularly elderly people with dementia, the non-consensual treatment to which many are subjected when in care will be inhuman or degrading and, in addition, it will cause many to die prematurely.