Scottish Mental Health Law Review
Call for evidence – SAMH submission

Introduction

SAMH has represented the voice of people most affected by mental health problems in Scotland for more than 90 years.

Today, in over 60 communities we work with adults and young people providing mental health social care support, services in primary care, schools and further education, among others. These services together with our national programme work in See Me, respectme, suicide prevention and active living, inform our policy and campaign work to influence positive social change. SAMH is dedicated to mental health and wellbeing for all: with a vision of a society where people are able to live their lives fully, regardless of present or past circumstances.

SAMH campaigned to improve the Mental Health (Care and Treatment) (Scotland) Act 2003 and also the revisions that were made to the Act in 2015. Specifically, in 2015 SAMH successfully campaigned for default named persons to be scrapped and for the right to challenge security status to be extended to people in medium secure wards. Building on this work, SAMH hopes that our evidence to the Scottish Mental Health Law Review will result in positive changes for people who experience compulsory care and treatment.

SAMH had prepared to undertake a consultation process in March with service users and staff about their experience of the Mental Health Act, in order to inform our response to the Scottish Mental Health Law Review. However, we have been unable to conduct consultation work so far, due to the outbreak of coronavirus. We still hope to carry out this consultation work and feed it into the Review at a later stage. To ensure that our response to this call for evidence is informed by people's experiences of compulsory care and treatment, we have drawn on research that we undertook for the Scottish Parliament Health and Sport Committee's inquiry into social care and the Review into Forensic Mental Health Services.

As part of our research for the Health and Sport Committee's social care inquiry, we visited three SAMH services. We asked service users about their experiences of being treated under the Mental Health Act and accessing their rights. We also asked staff about their experience of supporting service users who receive care and treatment under the Act. To inform our submission to the review of Forensic Mental Health Services, we received written responses from six SAMH service managers. The findings from these consultations have helped to inform SAMH's response to the Scottish Mental Health Law Review's call for evidence.

We have also examined research from other organisations, and note that, according to the Mental Welfare Commission for Scotland (MWC), developments in international human rights law and practices call into question the fundamental assumptions that underpin Scotland's existing mental health and capacity legislation.[1] Specifically, the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and recent interpretations of the European Convention on Human Rights (ECHR) pose a challenge to elements of the legislation in Scotland.[2],[3] In our response, these challenges are explored alongside the experiences of our service users and staff.

In this paper, we provide detail on areas where we feel that further exploration of solutions is required. SAMH would like the review to explore:

- How the Millan Principles can be met in practice, in particular the principle of reciprocity.
- Other assessment processes, specifically assessment processes that focus on the support required to make decisions rather than a person's inability to make decisions.
- A single assessment process for all non-consensual interventions.
- A threshold or scope for Significantly Impaired Decision-Making Ability (SIDMA), if it is proposed that SIDMA should continue to be used.
- The Australian Law Reform Commission's (ALRC) recommended model for supported decision making, as well as specific methods of supported decision making, consulting people who have experience of participation in such methods.
- How supported decision making can be embedded, to avoid the possibility of low uptake of supported decision making methods.
- The use of a single judicial forum for all cases of non-consensual interventions, taking learning from the Scottish Mental Health Tribunal.
- Additional safeguarding measures for the use of involuntary treatment.

There are also a number of changes SAMH is calling for related to mental health law in Scotland, regardless of law reform. SAMH would like:

- The Scottish Government to undertake a public awareness raising campaign to inform people about their rights, with a view to decreasing de facto detention (where a person does not give valid consent for their admission to

[1] MWC, 'Scotland's Mental Health and Capacity Law: the Case for Reform', May 2017
[2] UN, 'Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland', October 2017
[3] MWC, 'Scotland's Mental Health and Capacity Law: the Case for Reform', May 2017

hospital but is not detained under the Mental Health Act)[4] and increasing the use of advance statements and named persons.

- The Scottish Government to take action to increase the uptake and understanding of advance statements, so that they are used to their full potential.
- The right to challenge security status to be extended to people being cared for and treated in low secure wards.
- For people under the age of 16 to be given the right to nominate their named person, with appropriate safeguarding measures.
- The Scottish Government to provide sustainable funding for independent advocacy services for people experiencing mental illness, to ensure that they can access independent advocacy as is their right within legislation.
- The Community Care and Health (Scotland) Act 2002 to be amended so people receiving social care on a compulsory basis under the Mental Health (Care and Treatment) (Scotland) Act 2003 are not charged for their care.

You can read our SAMH's View on Compulsory Care and Treatment here.

The Millan Principles

The Millan Principles were included on the face of the Mental Health Act in order to guide how the law is put into practice.[5] There are 10 principles in total, including: reciprocity; participation of the person receiving care and treatment; and providing an intervention that is of benefit to the person.[6]. SAMH welcomed the Millan Principles, which are still necessary today and should be retained and enhanced as part of any future legislation.

However, while the Millan Principles are an important aspect of the legislation, they are not always put into practice in the most effective way. For example, some of the SAMH service users that we spoke to told us about their lack of freedom when receiving compulsory care and treatment in hospital. The service users described feelings of not being in control and not having the autonomy to make small decisions about day-to-day living. They also highlighted a lack of activities and opportunities when receiving care and treatment in hospital. One service user said:

> *"You have no human rights in hospital … you need permission to go out."*

Moreover, a recent report by the Mental Welfare Commission recommended that rehabilitation services within inpatient wards should start benchmarking the delivery

[4] MWC, Visiting and monitoring report: enhanced observations, 2014/15
[5] MWC, The Principles of the Act
[6] Scottish Government, The New Mental Health Act: What's it all about?, 2004

of physical healthcare and the provision of purposeful and meaningful activities.[7] While the report found that inpatients were generally able to access healthy lifestyle interventions and engage in the local community, the types of activities they were offered were limited and not always aligned with people's preferences.

Taking into account the service users' experiences and the findings from the Mental Welfare Commission report, SAMH would like the Scottish Mental Health Law Review to consider how the Millan Principles can be met in practice, in particular the principle of reciprocity. We would like the Review to consider, in consultation with the Mental Welfare Commission, if the active use of the Principles can be monitored.

SAMH would also like reciprocity to be viewed in as wide a context as possible, and not simply in relation to providing medical care and treatment. The Review should work with the Mental Welfare Commission to establish how readily the community care services measure (included within Compulsory Treatment Order applications) is utilised when practitioners apply for an Order, in particular for people who are transitioning from hospital to the community.

The provision of community care services is covered by sections 25 and 26 of the Mental Health Act. However, SAMH suggests that the community care measure could be used more readily by practitioners, so that people are more likely to receive integrated health and social care, rather than just medical treatment.

Indeed, better integration of health and social care services would help to achieve the principles of reciprocity and benefit in practice, as would continuity of care. SAMH already works with a number of inpatient wards, to provide therapeutic support and to help people move back into the community. SAMH's work with inpatients not only helps people to get the most out of their stay in hospital, but continuity of care where it can be provided also helps people to stay out of hospital.

The SAMH service managers who provided feedback to us about forensic support emphasised the importance of and called for better integration and communication between health and social care. One SAMH service manager also recounted an experience they had that demonstrates the benefits of effective integration:

> *'…previously while in hospital this person declined support, however on this occasion staff supported the service user while [they were] an inpatient in the forensic unit and helped support [them] to prepare [themselves] and [their] flat to return home. So far this appears to have helped as the [person] has continued to engage with support and is doing well.'*

[7] MWC, Scotland's mental health rehabilitation wards, January 2020

Finally, SAMH has experience of service users who have been charged for their social care despite this being an obligation through a Community Compulsory Treatment Order. This is in direct conflict with the principle of reciprocity, which imposes an obligation on the state to provide safe and appropriate care and treatment where a person is receiving that care and treatment on a compulsory basis. As such, SAMH is calling for an end to social care charging for people receiving who are receiving their care and treatment under the Mental Health Act.

Significantly Impaired Decision Making Ability

In order to legally detain someone for the purpose of providing medical treatment for a mental disorder, an Approved Medical Practitioner (AMP) or the Scottish Mental Health Tribunal (the Tribunal) must determine that the person's decision making ability is significantly impaired as a result of a mental disorder. However, there is no legal definition of or threshold for Significantly Impaired Decision Making (SIDMA).[8]

While guidance on assessing SIDMA does acknowledge that decision making capacity fluctuates,[9] it remains that the scope for establishing SIDMA is undefined and could differ between medical practitioners. This undefined scope creates uncertainty for people who have a mental disorder, particularly people who have prior experience of compulsion, as there is little to no information about how their decision making ability will be assessed.

Moreover, in the context of Emergency Detention Certificates (EDC) and Short Term Detention Certificates (STDC), an AMP only needs to be satisfied that it is 'likely' that someone's decision making is significantly impaired.[10] The possibility (however unlikely) of unnecessary detentions within this scenario, in addition to the undefined scope for assessing SIDMA, has the potential to create more uncertainty for people with a mental disorder in relation to compulsory care and treatment.

While the principle of SIDMA as a basis for compulsory care and treatment is an important safeguard, ways of defining SIDMA (or any future assessment model) more clearly or establishing a threshold need to be explored. This would help to give people more certainty around the assessment process and also create more trust in the system. Indeed, a number of SAMH service users expressed a lack of trust, in particular in relation to clinical decision making. One service user said:

> "*We need to take away the authority from psychiatrists"*

[8] Scottish Government, Approved Medical Practitioners – Mental Health (Care and Treatment) (Scotland) Act 2003 Training Manual, 2005
[9] Scottish Government, Approved Medical Practitioners – Mental Health (Care and Treatment) (Scotland) Act 2003 Training Manual, 2005
[10] Scottish Government, Approved Medical Practitioners – Mental Health (Care and Treatment) (Scotland) Act 2003 Training Manual, 2005

While SAMH recognises that psychiatrists undoubtedly play a crucial role in ensuring that people get the care and treatment they need, providing a more clearly defined and transparent scope for assessment would help to address a lack of trust within the system.

Supported and Substitute Decision Making

Interpretations of the UNCRPD have suggested that the Committee recommends abolishing all forms of substitute decision making. This interpretation is based on the UNCRPD's assertion that denying someone the right to consent to care and treatment (legal capacity) on the basis of a disability is discriminatory.[11] The Committee emphasises that people who experience a mental disorder are more at risk of having their right to consent to medical treatment taken away from them.[12] This point was echoed by a SAMH service user:

> *"People have human rights, but see when people have disabilities they don't know about their rights, they should be given something."*

If Scotland was to follow this interpretation of the UNCRPD, the current system of practice would need to be replaced by a system of supported decision making. This would ensure that people were supported to make their own decisions about their care and treatment, bringing an end to non-consensual decision making and involuntary care and treatment. This poses a challenge to Scottish mental health legislation, which seeks to make provisions for urgent care and treatment for people whose decision making is impaired.

A recent UN report seems to imply that it recommends the implementation of the Australian Law Reform Commission's (ALRC) approach to supported decision making. [13], [14] The UN's report states that '[d]espite the recommendations of the Australian Law Reform Commission, the Committee is concerned about the lack of progress to abolish the guardianship system and substituted decision-making regime, particularly in decisions concerning forced psychiatric treatment, and at the lack of a timeframe to completely replace that regime with supported decision-making systems.'

The ALRC proposes two new roles related to supported decision making: supporter and representative.[15] The supporter is an individual or organisation appointed by a

[11] UN, General comment No. 1, 2014
[12] UN, General comment No. 1, 2014
[13] UN, Concluding Observations: UN Report on Australia's Review of the Convention on the Rights of Persons with Disability (CRPD), September 2019
[14] Alex RK, 'The CRPD Committee and legal capacity – a step forwards?', October 2019
[15] Australian Law Reform Commission, Equality, Capacity and Disability in Commonwealth Laws, August 2014

person to support them to make a decision. A representative is someone who is appointed to make decisions for someone as a last resort. The ALRC outlines that a representative must seek to determine and express the person's will, preferences and rights when making decisions. Where this is not possible, a representative must consider the person's human rights when making decisions. It is specific that in cases of representative decision making, when it is not possible to determine will and preferences, decisions should be made in the context of human rights and not assumed 'best interests'.

The UN's indication that the ALRC's proposals should be adopted by Australia indicates that it sees this approach as a way forward in realising supported decision making. As such, the ALRC's proposals should be closely considered by the Scottish Mental Health Law Review, with a particular focus on the potential benefits of representative decision making in comparison to the current model of substitute decision making in Scotland.

Using this model, or something similar to it, would still require an assessment process. The ALRC emphasises that the focus should be on assessing someone's ability to exercise their right to legal capacity and enabling them to realise this right. SIDMA is an assessment of someone's ability to make decisions (albeit based on mental capacity), so it could possibly be used to determine when representative decision making should be used. However, this should be explored further, as should alternative assessment frameworks.

In relation to the supporter role recommended by the ALRC, there has been little empirical research into supported decision making methods and their efficacy for people with severe and enduring mental health problems.[16] The Scottish Mental Health Law Review should explore existing methods and their efficacy by speaking to people with experience of participating in supported decision making, and should also consider what further research is required to inform future practice.

The Mental Welfare Commission for Scotland has developed good practice guidance, which highlights different forms of supported decision making that are already in use, including peer support, advocacy, technological support and advance planning.[17] The guidance also outlines the requirements that are needed in order for these methods to be effective. The Scottish Mental Health Law Review should explore how these requirements can be met and how the methods that are already in use can be expanded and up-scaled.

While the UN appears to have endorsed the ALRC's proposed model, the fact that the supporter and representative roles are appointed by the person is an issue that

[16] Dilip V. Jeste et al., Supported Decision Making in Serious Mental Illness, 2018
[17] MWC, Good Practice Guide: Supported Decision Making, 2016

requires careful consideration. Given the generally low uptake of advance statements and named persons, there is a question around how higher uptake of supporters and representatives could be realised; especially if a requirement is that someone must have capacity using the current model of assessment (SIDMA).

There are also many people with prior experience of compulsory care and treatment who do not believe that their wishes and their preferences will be taken into account. This is in spite of safeguards like advance statements, which are designed to support people to express their wishes and preferences in relation to care and treatment. One SAMH service user explained why they don't have an advance statement:

> *"Aye I knew about that [advanced statement], but I didn't have one, I felt they wouldn't listen to it."*

While medical practitioners need to have the ability to give the person the care and treatment they need, people also need to be given confidence in the system. If supported decision making is to be realised, this needs to be considered; how can the system balance a person's personal wishes and preferences with their need for care and treatment?

Despite the lack of trust some people have, the SAMH service users we spoke to were positive about independent advocacy, particularly when in hospital. One SAMH service has also designed a 'Hospital Passport' – similar to an advance statement – which people complete with their Support Worker. The passport contains information about people's mental health problems, their medication, their behaviours and even lifestyle choices like personal food preferences. This was also viewed positively.

Non-Discriminatory Legislative Framework

Another challenge for mental health legislation in Scotland is the fact that it can lawfully deprive people of the right to make their own decisions about care and treatment (legal capacity) on the basis of impaired decision making as a result of a mental disorder (mental capacity). According to the UNCRPD this approach is discriminatory: 'The Committee reaffirms that a person's status as a person with a disability or the existence of an impairment (including a physical or sensory impairment) must never be grounds for denying legal capacity or any of the rights provided for in article 12.'[18]

However, the ALRC argues that with appropriate safeguards and if approached from a rights perspective, an assessment of decision making ability (functional assessment) is not necessarily discriminatory: 'The ALRC considers that, with appropriate safeguards, and a rights emphasis, there is no '"discriminatory denial of

[18] UN, General comment No. 1, 2014

legal capacity" necessarily inherent in a functional test—provided the emphasis is placed principally on the support necessary for decision-making and that any appointment is for the purpose of protecting the person's human rights.'[19]

As a functional assessment, SIDMA comes close to achieving this. However, it focuses on determining what decisions a person is unable to make, rather than what support is necessary in order for someone to be able to make those decisions. The Scottish Mental Health Law Review should consider how the assessment process could be reformed to focus on providing support for decision making. If reframed in this way within practice, the Scottish system would come significantly closer to achieving the non-discriminatory approach set out by the ALRC, of which the UNCRP has indicated a level of approval.[20]

The Scottish Mental Health Law Review should consider this approach for both Mental Health and Adults with Incapacity (AWI) legislation and should also explore the possibility of fused legislation. Currently there are two different functional assessment processes relating to capacity, one for authorising non-consensual interventions related to mental health care and treatment under the Mental Health Act (SIDMA) and the other related to other non-consensual interventions under AWI (capacity assessment).

Given that people with mental health problems can be subject to both Acts, fused legislation and one assessment approach could make the system less confusing for people, practitioners, families and carers. Having a single piece of legislation that is based on functional decision making impairment, rather than mental disorder, would also be a less discriminatory approach – albeit people with mental disorders would be disproportionately subject to the legislation.

A Single Judicial Forum

Currently in Scotland, there are two judicial forums that oversee cases of non-consensual care and treatment. The Mental Health Tribunal for Scotland (MHTS) oversees decisions in relation to compulsory care and treatment for a mental disorder, while the Sheriff Court oversees other aspects of non-consensual decision making as related to Adults with Incapacity (AWI) legislation.

In its report, The Case for Reform, the Mental Welfare Commission for Scotland recommends that a single judicial forum should be used to oversee all types of non-consensual interventions, and indicates that the MHTS would be the most appropriate forum.[21] This position is also supported by the Law Society for

[19] Australian Law Reform Commission, Equality, Capacity and Disability in Commonwealth Laws, August 2014
[20] UN, Concluding Observations: UN Report on Australia's Review of the Convention on the Rights of Persons with Disability (CRPD), September 2019
[21] MWC, 'Scotland's Mental Health and Capacity Law: the Case for Reform', May 2017

Scotland.[22] SAMH would like the Scottish Mental Health Law Review to consider the use of a single judicial forum, taking into account the advantages of the MHTS over other judicial forums. The Centre for Mental Health Law at Napier University is undertaking research into the MHTS and, as such, we would advise that the Review takes into account this research once it is published.

People with mental health problems, in particular those with severe and enduring mental health problems or additional support needs, can be subject to the AWI Act as well as the Mental Health Act. [23], [24], [25] This means that people subject to both Acts may have to engage with two separate judicial forums and participate in several different hearing processes. Having a single judicial forum has the potential to make the system less confusing and less onerous for people subject to both Acts and their families and carers.

Moreover, SAMH agrees with the Mental Welfare Commission that there are key features to an effective judicial forum of this kind, namely: maximum participation of the person about whom the hearing is being held; an awareness and experience of the needs of people with mental health problems and other related support needs; and a consistent approach across Scotland.[26] The Sheriff Court does not prioritise these features in the same way that the MHTS does. As such, SAMH would like to see an end to the use of the Sheriff Court for cases of non-consensual interventions.

Involuntary Treatment

As discussed above, SAMH is recommending that the Scottish Mental Health Law Review consider how supported decision making can be realised both in legislation and in practice. However, any future legislation will still have to account for instances of involuntary treatment and provide appropriate safeguards.

While the Mental Health Act does include safeguards for specific kinds of medical treatments that are invasive and for the involuntary use of medication for a period of over two months, there are fewer safeguards for short-term involuntary treatment.[27] This is particularly a problem for people who are given care and treatment under a Short-Term Detention Certificate (STDC).

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[22] Law Society of Scotland, 'Response to Scottish Government Consultation on the Scottish Law Commission's Report on Adults with Incapacity', March 2016
[23] MWC, Scotland's mental health rehabilitation wards, January 2020
[24] MWC, Medium and low secure forensic wards, August 2017
[25] MWC, Autism and complex care needs, October 2019
[26] MWC, 'Scotland's Mental Health and Capacity Law: the Case for Reform', May 2017
[27] Scottish Human Rights Commission, PE1667/F Scottish Human Rights Commission submission, December 2017

The European Court of Human Rights has ruled that when someone is detained, this does not automatically authorise the use of 'forced' medical treatment.[28] This is problematic for the legislation in Scotland because once an STDC is granted a person can be given treatment against their will, without any additional scrutiny or oversight into how treatment is administered. This needs to be explored by the Scottish Mental Health Law Review, so that any future legislation provides appropriate levels of safeguarding for involuntary treatment, whilst also ensuring that people can get the care and treatment they need.

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[28] ECHR, Case of X v. Finland, 2012