Independent Review of Mental Health Law in Scotland
Response by Faculty of Advocates
To
Independent Review of Mental Health Law in Scotland

RESPONSE TO PART B – (Organisations or individuals who work with the law)

1. The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") came into force in 2005 – how well does it work at the moment?

The Act works well in practice, in the view of the Faculty. It was a very substantial step forward from its predecessor, the 1984 Act. The European Convention on Human Rights ("**ECHR**") was clearly in contemplation at the time that the Act was created. As a result, the criticisms made of the 1984 Act, namely being no longer fit for purpose and being outdated, are not applicable to the Act.

Issues arise from the influence of the United Nations Convention on the Rights of Persons with Disabilities ("**UNCRPD**"). The increased focus upon supported decision-making rather than substituted decision-making is one such example. However, it must be recognised that the Act reflects the ECHR rather than the UNCRPD approach.

The lack of compatibility between the existing regime and the UNCRPD may be a matter of concern. It may be difficult for Scotland to incorporate entirely

the UNCRPD into its law while at the same time respecting its other international obligations (for example, in relation to the ECHR). That said it ought to be possible to reduce the friction that might otherwise exist.

2. Are there certain things that hinder the Act from working effectively? What would improve things?

There are a number of issues that might be addressed to improve the functioning of the Act. Most of these are at a specific level – there are comparatively few significant issues.

SIGNIFICANT ISSUES

i. Limitation of principles

The principles that underpin the Act only relate to statutory functions within the Act, not to all activities that might be undertaken in relation to patients. Currently, the principles are not generally relevant to a decision relating to a group of patients (for example, the policy of a hospital in relation to a ward) but are relevant to a decision in relation to a specific patient.

One way to address this would be to apply the principles to any decisions or actions in relation to mental health patients, so far as relevant and practicable.

ii. Reform of principles

It may be possible to reduce the friction between the existing legislation and the UNCRPD by introducing an explicit hierarchy in the principles. This could provide for views (or will and preference) to take priority over other principles. Alternatively, the underlying principles could be reframed. The Scottish Government recently consulted on the principles in the AWI legislation with such an aim.

iii. Delayed discharge

This is dealt with in detail below.

LESS SIGNIFICANT ISSUES

iv. Conditional discharge of restricted patients

The Tribunal is unable to review the conditions of conditional discharge. It may be considered desirable to allow the Tribunal to do so.

v. Prisoner patients

There are issues with the small number of patients who, with the benefit of hindsight, have wrongly entered the mental health system rather than the prison system. The process for transferring patients from one system to another is not certain (for example, **Johnston v HMA [2013] HCJAC 92**). An appropriate mechanism would allow such convicted patients (often of culpable homicide on the basis of diminished responsibility) to be transferred to the prison estate.

vi. Safety and security

The present situation in relation to safety and security may be considered to be unsatisfactory. The Act deals with possession and removal of certain items but does not deal with the use of those items. Anecdotally, there are reports of prohibitions being put in place other than through the use of regulations under the Act.

vii. Unlawful detention

Section 291 creates a number of issues. It is unusual as it requires the Tribunal to consider matters of lawfulness and legality. It arguably ousts the jurisdiction of the Court of Session to apply for liberation in cases which it covers. This has the potential to leave patients uncertain as to which option to pursue.

At least one unlawfully detained patient has continued to be unlawfully detained because the establishment at which they were detained was not considered to be a hospital, which meant the Tribunal could not make an order.

Options to address these issues include removing the Section entirely, which would leave patients recourse to the common law, or extending it to include a wider range of facilities or patients.

In the course of reviewing AWI legislation, the Scottish Government has canvassed the option of introducing a process similar to Section 291 of the Act, which is currently omitted from the Adults with Incapacity (Scotland) Act 2000. The Faculty considers that any solution adopted should address both Patient Groups equally, given that breaches of Article 5 of the ECHR are of equal significance.

viii. <u>Recorded matters</u>

There is no provision for recorded matters in respect of non-restricted compulsion order patients. The reasoning behind the lack of recorded matters for this patient group is not clear to the Faculty.

There may also be an issue with the lack of enforceability of recorded matters. This can be linked to delays in discharge. It may be considered appropriate to provide a mechanism for the enforcement of recorded matters to prevent such delays.

ix. <u>Relevant persons</u>

The Faculty considers the importance of welfare guardians should be appropriately reflected in the amendments to relevant persons.

3. **Are there any groups of people whose particular needs are not well served by the current legislation? What would improve things?**

The Faculty observes that since the passing of the Act, considerable increases have occurred in demand for child and adolescent mental health services. The Scottish Government's mental health strategy is seeking to address the issue by increasing the scope of resources and services, but the Faculty notes that in the 333 Sections of the Act, only two expressly address children and young persons with a mental disorder, with the result that the Act itself is extensively process-driven and weighted towards adult patients. The Faculty considers it important that the Scottish Government, which is committed to implementing the UN Convention on the Rights of the Child in domestic law, pays close attention to incorporating provisions more closely tailored to the needs of children and young people, and allows care and treatment to be provided in a properly responsive manner.

There is also a small group of female prisoners who have no option allowing them to be held in high security accommodation in Scotland. It is acknowledged to be unsatisfactory when patients are detained or treated at considerable distances from their families, and the death of Theresa Riggi in Rampton Secure Hospital is an illustration of how such matters are dealt with. Moreover, there may be circumstances where detention of female prisoners with significant degrees of mental disorder in the prison system is questionable and inappropriate.

The overall position of such prisoners has been the subject of recent adverse comment by the UN Rapporteur on Prevention of Torture, but has yet to be addressed fully by any of the statutory bodies – including the Mental Welfare Commission for Scotland - despite the evident disparity in treatment provided for similar male prisoners. The Faculty considers that such disparity on the grounds of sex is incompatible with a human rights culture.

4. **The Act has a set of legal tests to justify making someone subject to compulsion. Would you suggest any changes to these?**

The Faculty is aware of various issues in relation to the tests for compulsion but has no particular view. It may be that consideration should be given to reducing differences between minor criminal justice offenders and civil justice patients. At present the "SIDMA" test is only applicable to civil justice patients. The reason for this distinction is not clear.

5. **The Act requires a local authority to provide such services for people with a mental disorder who are not in hospital, which should be designed to minimize the effect of mental disorder on people and enable them to live as full a life as possible (sections 25 and 26 of the Act):**

(a) Do you think this requirement is currently met? Does more need to be done to help people recover from mental disorders? You may wish to provide an example or examples?

In **R(G) v Barnett 2004 2 AC 208**, paragraph [13]: Lord Nicholls of Birkenhead said, in relation to the duties imposed on local authorities in relation to social welfare: *"As a general proposition the more specific and precise the duty the more readily the statute may be interpreted as imposing an obligation of an absolute character. Conversely, the broader and more general the terms of the duty, the more readily the statute may be construed as affording scope for a local authority to take into account matters such as cost when deciding how best to perform the duty in its own area."* – quoted by Lord Brodie delivering the opinion of the court at paragraph [13] of **Q v Glasgow City Council 2018 SLT 151**.

The Faculty observes that while subsections 25(1)(a) and 26(1)(a) impose respectively a duty on a local authority to provide services which provide care and support and services which are designed to promote the well being and social development of persons in respect of whom the duty is owed, "care and support" and "services designed to promote the well being and social development" are non exhaustively defined in sections 25 and 26 respectively. In subsection 25(2) "services" is defined by reference to the intended outcome of the provision of the services.

The Faculty observes that as a consequence of the way in which "services", "care and support" and "services designed to promote the wellbeing and social development" are defined, it is not clear what services ought to be provided, as well as how, when and for how long they ought to be provided, in furtherance of the duty imposed on the local authority in subsections 25(1)(a) and 26(1)(a),. This can be a cause of difficulty in securing the provision of relevant services for those who have or have had a mental disorder, as it is open to a local authority to argue in a particular case that it does not have resources to fulfill the duty by the provision of a particular service. This leads to provision of community services for patients who have or have had a mental disorder being inconsistent throughout the country.

In relation to subsections 25(1)(b) and 26(1)(b), it is observed that the subsections have the potential to delay persons who are in hospital and who have or have had a mental disorder being discharged into the community as the language of the subsections is permissive and not mandatory. Delays in local authorities making provision of services in the community for persons who are in hospital and who have or have had a mental disorder can be inconsistent with the aim of providing care and support services for such persons. Anecdotally, it appears that there may be cases where the permissive language of subsections 25(1)(b) and 26(1)(b) can lead to delays in the discharge from hospital to the community, of patients who have or have had a mental disorder and who

are in hospital. Not only can such delays prevent the movement of patients from hospital to the community but they can also prevent the movement of mentally disordered patients within a hospital due to an unavailability of beds in lower secure units. Such delays can create an outcome that is contrary to the stated aims of minimising the effect on people of a mental disorder by enabling them to live as full a life as possible and helping them to recover from a mental disorder.

The Faculty considers that if the intention is to minimise, via sections 25 and 26, the effect on people of a mental disorder and to enable them to live as full a life as possible, greater specification of the words/expressions "services", "care and support" and "services designed to promote the wellbeing and social development" in respect of the duty on the local authority in terms of each section might be beneficial. In terms of subsections 25(1)(b) and 26(1)(b), the Faculty believes that consideration could be given to either changing the permissive language in the subsections or making provision for an alternative mandatory duty to provide services when a person who has or has had a mental disorder is in hospital but is ready to be discharged into the community.

(b) Does the law need to have more of a focus on promoting people's social, economic and cultural rights, such as rights relating to housing, education, work and standards of living and health? If so, how?

This is a matter of policy on which the Faculty makes no comment.

(c) Do you think the law could do more to raise awareness of and encourage respect for the rights and dignity of people with mental health needs?

The Faculty considers it important that access of patients to Advocacy Services is clearly established, and that consideration is given to creating

express rights for Advocacy Workers to be notified of and to attend Case Conferences and Tribunal Hearings.

6. **Based on your experience are there any difficulties with the way the Act, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 work separately or the way they work together? What improvements might be made to overcome these difficulties?**

   There can be difficulties with the general disqualification from legal capacity that guardianship involves, though that is perhaps more an issue with that regime.

   The AWI process takes a long period of time which results in the preferential use of the mental health system in many cases.

   The mental health system can authorise detention whereas there is some dubiety about the AWI regime.

   A great number of patients could be dealt with under either the AWI or MH regimes. It would seem appropriate for there to be no differential treatment between the regimes, for these patients.

7. **Is there anything else you wish to tell the Review?**
   No.