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Post-legislative scrutiny suggestion	
Your suggestion for post-legislative scrutiny (this can either be an Act or part of an Act)	
Mental Health (Care and Treatment) (Scotland) Act 2003	
Why should this act be examined (e.g. what outcome would you hope is achieved)?	
<p>As an organisation, we are concerned about how the Act has been and continues to be implemented, particularly since 2010 in the context of austerity and more recently the pursuit of efficiency savings through health and social care integration. Below we cover some of the main issues, although do not delve into all aspects that we believe need consideration (for example, the role and selection of a named person and their right to legal and advocacy services).</p> <p>Use of Compulsory Powers</p> <p>In 2010, SAMH highlighted to the Equal Opportunities Committee which was undertaking scrutiny of the Act, that there was geographical variation in the use of compulsory powers, for which, the Committee accepted, there was no definitive explanation and thus warranted further investigation.</p> <p>For example, a Herald investigation found that only 28% of people who were urgently detained between April 2014 and April 2015 in NHS Greater Glasgow and Clyde had the support or approval of a Mental Health Officer (MHO), and 33% the following year. This is a situation that is only meant to occur in exceptional circumstances. However, due to difficulties with recruitment and retention of MHOs and the resource implications of having them available, it is a situation which on the basis of this investigation is becoming more widespread.</p> <p>Use of Compulsory Treatment Orders</p> <p>In terms of Compulsory Treatment Orders (CTOs) specifically, the evidence base is weak. Indeed, the Oxford Community Treatment Order Evaluation Trial (OXTET), which dealt with patients experiencing psychosis, found that there was “an absence of any obvious benefit in reducing relapse despite significant curtailment of liberty”. The researchers asserted, “Our findings are stark and uncomplicated”, and confirm the findings of the previous two RCTs on CTOs conducted in USA previously.</p> <p>In 2009, in a review of the 499 individuals subject to a community-based compulsory treatment order (CCTOs), 81% had a schizophrenia-related illness and 10% had a bipolar disorder; 57% of the total were prescribed a long-acting injection of antipsychotic medication. We would argue that this may be a result of longstanding</p>	

issues of stigma and discrimination against individuals with schizophrenia.

Furthermore, because of the negative side effects of schizophrenia-related medication on physical health, it is even more imperative that the findings and recommendations within the Mental Welfare Commission's 2011 report, [Lives Less Restricted](#), are acted upon, including that people subject to CCTOs receive regular, documented physical health reviews, and that RMOs review the need for CCTOs in between mandatory reviews. This would go some way towards enabling the right to the highest attainable standard of physical and mental health.

The OXTET researchers go further than this report and suggest that community mental health teams should seriously consider whether they should continue using CTOs. They argue for a moratorium on CTOs and suggest that practitioners "refocus our efforts into restoring enduring and trusting relationships with patients."

As was [argued](#) by Royal College of Psychiatrists in 2008 before implementation of the equivalent 2007 Act covering England and Wales, there is an inherent risk that implementation of CTOs is risk-based, not capacity-based, and thus "pit[s] patient autonomy against professional paternalism". Given that a repeat national survey of psychiatrists [found](#) that psychiatrists' opinions on CTOs have not changed since 2010, despite mounting evidence from research and clinical practice that CTOs do not improve outcomes, we would argue that this risk has now been realised.

National and International Context

The United Nations' Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [latest report](#) acknowledges the difficulties in moving away from coercive methods, however posits that there's an unacceptably high prevalence of human rights violations within mental health settings. It argues "coercion in psychiatry perpetuates power imbalances [...] exacerbates stigma and discrimination [...] Instead of using legal or ethical arguments to justify the status quo, concerted efforts are needed to abandon it."

Similarly, the United Nations Committee on the Rights of Persons with Disabilities have taken the position that all compulsory treatment for people with a mental disorder should stop and be replaced by supported decision making, and that any form of compulsory treatment based, even in part, on a diagnostic label and capacity assessments, is inherently discriminatory.

The Mental Welfare Commission and the Centre for Mental Health and Capacity Law recently issued a [report](#) calling for a reform of Scotland's mental health and capacity legislation. Specifically, to:

- Ensure compliance with the European Convention on Human Rights and the United Nations' Convention on the Rights of Persons with Disabilities;
- Maximise autonomy and respect for a person's rights, will and preference;
- Rationalise and synergise national mental health legislation;
- Explore the appetite for incremental steps in the short to medium-term towards unified legislation in the longer-term, with a particular emphasis on the involvement of people who use support and services.

Access to Advocacy and the Preventative Agenda

Another key issue to consider is access to advocacy, which is enshrined within the act. It's important that even when stretched MHOs feel confident and capable of explaining rights to patients, and linking in with other civil society and non-governmental organisations that may be of assistance, e.g. advocacy services. In 2010, SIAA [drew attention](#) to the fact that this had unintentionally drawn resources towards those in crisis – those at risk of detention, or who are facing a tribunal.

We support Scottish Independent Advocacy Alliance's submission which raises issues around funding arrangements for advocacy organisations, year on year decreases in funding whilst demand increases, extremely limited provision of advocacy services for children and young people, and more. Whilst the aspiration of Scottish Government policy (for example, Public Bodies (Joint Working) (Scotland) Act 2014 and the Health and Social Care Delivery Plan) for there to be a shift towards prevention and early intervention is laudable, we are concerned that in the current context this is being lost. Specifically, access to advocacy can ensure that people are able to receive the appropriate care and support at an earlier stage and more should be done to raise awareness and increase provision.

Participation

Health and social care settings must do more to empower people to realise their rights, participate meaningfully in decisions about them at a level they feel comfortable with, and to make their own informed choices about their health. Without concerted effort to raise awareness of advocacy, patient rights, Advance Statements, and so on, people experiencing mental health difficulties are more likely to experience stigma and discrimination and also be less empowered to take action to address it whenever it is encountered.

Summary

In conclusion, we believe it is important that the Act is looked at with a fresh perspective, now that it has had over a decade to have an impact; the evidence base has developed in that time, as has the international moral and legal context within which it sits. Whilst we believe the ethos and principles enshrined within the Act still have merit, we are recommending that it is examined to ensure it is still fit for purpose. Indeed, with a new national mental health strategy running until 2027, we would suggest that any future review of Adults with Incapacity Legislation is coupled with a review of the Mental Health (Care and Treatment) (Scotland) Act 2003 itself to ensure that our legal frameworks are justifiable and aligned with national policies in the longer term, and that they lead to better outcomes and experiences for the people for whom they have the most tangible impact.

As far as you are aware, does your suggestion fit with the criteria set out in the checklist? *(Please note that the clerks will check each suggestion against the checklist)*

Yes