Mental health advance statements: crossing the divide from clinical to law enforcement settings

Introduction

It is clear that police in many jurisdictions are increasingly being called out to situations involving persons with mental distress. In Scotland, for example, notifications of Place of Safety Orders to the Mental Welfare Commission for Scotland increased from 130 in 2006/2007 to 1133 in 2016/2017 (Mental Welfare Commission for Scotland, 2018). Whilst this may reflect better police reporting (Mental Welfare Commission for Scotland, 2018) and these figures only account for those persons assessed in Accident and Emergency departments and not elsewhere (McGeough and Foster, 2018) this nevertheless represents a significant increase. Aside from the wider question of the extent to which attending to the needs of persons in mental distress should fall to law enforcement agencies, particularly where no crime has been committed, it raises important issues concerning effective joint police and health service working.

Appropriate and timely responses to persons in mental distress are essential. This results in better outcomes for the individual involved and greater confidence by clinicians and law enforcers that actions taken will lead to better support and service provision. Moreover, the requirement for effective responses are linked to realising international human rights such as, but not confined to, the rights to the highest attainable standard of physical and mental health, to life, to liberty, autonomy, appropriate care, access to justice and to be free from abuse and from inhuman or degrading treatment or punishment. Elements of this requirement often find expression in 'human rights-based approaches' adopted by service providers including health bodies and police forces.

Advance planning, in the form of mental health (or psychiatric) advance statements, or directives, are increasingly seen as assisting part of the shift towards greater autonomy in mental health care and treatment (Weller 2012; Stavert 2013). However, whilst their therapeutic benefits have been noted in clinical settings their usefulness where persons experiencing serious mental illness and mental health crises come into contact with law enforcement agencies remains much less unexplored, particularly from a human rights imperative perspective.

This article will therefore consider the potential advantages and challenges presented by extending the scope of mental health advance statements to address the needs of persons in mental distress who come into contact with law enforcement agencies. In doing so, it will describe the relevant human rights framework requiring advance planning and consider the general issues related to the use of mental health advance statements as well as, in order to provide context, making some observations about current law and practice in Scotland. An awareness of the potential for use of advance statements in law enforcement situations, together with an appreciation of the current challenges related to this, will assist mental health professionals in exploring the development of their appropriate use for the benefit of persons with lived experience.

Human rights imperatives and arguments

Equality and non-discrimination in protection and rights enjoyment

The importance of ensuring both personal and public protection whilst at the same time respecting the wishes of persons in mental distress on an equal and non-discriminatory basis with others has been a notable human rights development in recent years.

In Europe, when interpreting the rights to liberty (Article 5) and to respect for private life (Article 8) identified in the European Convention on Human Rights (ECHR) in the context of involuntary interventions the European Court of Human Rights has been increasingly emphasising the importance of respecting the autonomy of persons with mental disability (Shtukaturov v Russia (2012); Sykora v Czech Republic (2012); A-MV v Finland (2017). This has included making it clear that even where a person's lack of mental capacity justifies proxy decision-making due regard must still be afforded to that person's views. A corresponding approach can be seen reflected by the Committee on Human Rights' interpretation of the same rights identified in the International Covenant on Civil and Political Rights.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), extends this requirement to ensure that the voice of a person with mental distress is always respected. Firstly, it adopts a social model of disability that interprets mental disability not in terms of a diagnosis and related impairment but rather in terms of resulting from state and societal obstacles that may hinder a person's full and effective participation in society on an equal basis with others (Article 1 CRPD). It is therefore possible to argue that 'mental disability' in the context of the CRPD can be interpreted as including both persons with a formal diagnosis of mental disorder and those without such a diagnosis but who are exhibiting possible underlying mental distress through, for example, actual or threatened self-harm and intoxication.

Secondly, the CRPD reminds us of the overarching international human rights principle that everyone, including those with mental disability, are entitled to enjoy all rights equally and without discrimination (Article 1 CRPD). This includes respect for autonomy, the right to life and to the highest attainable standard of physical and mental health, and protection from harm and abuse. There are various elements to this. One is that states must ensure that there is access to support for persons experiencing difficulties with decision-making and communicating their wishes, or 'will and preferences' (Article 12(4) CRPD), at any given time so that their wishes - or their legal capacity (an integral component of individual autonomy) - is respected on an equal basis with others (Articles 12(1)-(3) CRPD). Actions overriding such will and preferences would arguably only be permissible in order to prevent a civil or criminal wrong and must not be based on the existence of disability (Flynn and Arstein-Kerslake, 2017; Gooding and Flynn, 2015). Another element of this is that persons with mental disabilities must be protected from harm and abuse on an equal basis with others. This means that protective measures that prevent the person from exercising their rights are not justified where the risk of, or actual, harm arises from something or someone else or perceptions of risk or harm based on misconceptions associated with a person's mental disability (Articles 5 (equality and non-discrimination) and 16 (freedom from exploitation, violence and abuse) CRPD; Committee on the Rights of Persons with Disabilities, 2018).

Supporting and respecting the wishes of a person with mental distress equally with others

The CRPD advocates that ensuring respect for the will and preferences of a person in mental distress can be achieved through providing access to support for the exercise of legal capacity (the ability to give legally enforceable effect to one's decisions), often referred to as 'supported decision-making' (tailored to individual needs) (Article 12(4) CRPD). However, there is also recognition that where it has been proven to be genuinely impossible to ascertain what these are then a best interpretation of the person's will and preferences can be made (Committee on the Rights of Persons with Disabilities, 2014).

There is some academic and professional debate over whether support for the exercise of legal capacity and supported decision-making amount to the same concept, with the former being somewhat narrower in scope than the latter. However, for the purposes of this article they will be considered to be the same.

The Committee on the Rights of Persons Disabilities, which is responsible for oversight of CRPD implementation by state parties to the treaty, has stated that such supported decision-making includes, amongst other things, advance planning (Committee on the Rights of Persons with Disabilities, 2014). Mental health advance statements are generally regarded as a form of advance planning although, for the reasons discussed below, they may not currently fully comply with CRPD supported decision-making requirements. However, their potential in all situations where an individual may be unable to effectively communicate their wishes is nevertheless worthy of serious consideration.

Mental health advance statements defined

Mental health advance statements, also referred to, for example, as psychiatric advance directives or Ulysses contracts, have found expression in legislation and practice in several jurisdictions such as Scotland, England and Wales, the United States, India and Canada (Maylea et al, 2018). Their form and content (particularly in terms of how directive of care and treatment they are) and the extent to which they legally bind both the maker and clinicians may differ between jurisdictions. However, broadly speaking they are documents that provide a means by which individuals can express their wishes in terms of their psychiatric care and treatment in the event that they are unable to communicate such wishes.

Representing developments in international human rights law towards much stronger support for autonomy mental health advance statements are envisaged as ensuring that a person's voice, expressing their authentic wishes, is communicated when it might be otherwise difficult for them to do this (Weller, 2012). They are an acknowledgement of respect for the fact that the individual concerned may often have the best knowledge of their needs and what works for them in times of crisis. Indeed, to ignore the wishes expressed in an advance statement which reflect an individual's rights to autonomy, least restrictive interventions, respect for dignity and the right to health may arguably, and legitimately, result in claims of human rights violations (Stavert, 2013).

Suggested benefits of mental health advance statements in clinical settings

There is evidence to suggest that mental health advance statements yield several perceived benefits in psychiatric clinical settings, both in terms of patient experience and

patient-clinician relationships. These include improved experiences of clinical crises and planning for these (Ruchlewska et al, 2016), increased acceptance of medication (Wilder et al, 2010) and reduced use of coercion (Swanson et al, 2008; Morrissey, 2010).

Indications also exist that mental health advance statements may be useful in assisting recovery and improving care through providing opportunities to support holistic experience approaches to recovery rather than focusing on clinical understandings of diagnosis and symptoms (Maylea et al, 2018; Deegan, 1996). This, coupled with the aforementioned increasing human rights emphasis on autonomy and equality and non-discrimination in rights enjoyment in all spheres of the lives of persons with mental disability, suggest the potential for extending the use of mental health advance statements beyond clinical settings to encompass cross-agency working including law enforcement bodies. That being said, despite these attributes several challenges exist in this respect which will now be considered.

Challenges for mental health advance statements beyond clinical settings

There are a number of existing challenges concerning mental health advance statements which remain to be addressed before or in addition to their use beyond clinical environments.

Despite the perceived benefits of mental health advance statements there nevertheless does appear to be low uptake by persons with mental disability as well as a general lack of awareness of their existence or scope (Morriss et al, 2017; Maylea et al, 2018). Given that most are entered into after a previous episode or episodes of mental distress this might be a reflection of the desire not to revisit these episodes. However, it is arguable that this might be ameliorated to some extent if the making of mental health advance statements were part of routine health care planning.

A lack of knowledge about advance statements and related rights, and clinical and other support for their making (Morriss et al, 2017) as well as perceived sense of futility relating to their legal weight may also explain the low engagement (Stavert, 2013). Indeed, in many cases, subject to various criteria, it is possible for clinical teams and tribunals to override wishes expressed in mental health advance statements (Maylea et al, 2018). Under the Mental Health (Care and Treatment) (Scotland) Act 2003, for instance, all decisions about psychiatric care and treatment must be cognisant of the Act's human rights informed general human rights principles. The Mental Health Tribunal and clinicians must also have regard to the care and treatment wishes expressed in an advance statement. However, it is possible to override these wishes, provided the legislative and human rights principles are followed and the decision to do so is justified and appropriately recorded (Sections 275-276 Mental Health (Care and Treatment) (Scotland) Act 2003).

A further issue in advance planning, and in particular psychiatric advance statements, is their traditional linkage with mental capacity assessments. They are made when a person has capacity to do so and come into effect only after they lose mental capacity. This creates the potential to not only lock someone into treatment decisions and wishes expressed earlier but which may have changed in the interim (Maylea et al, 2018). It also does not necessarily provide an assurance of respect for the treatment wishes of a person who may still be assessed as having mental capacity but who is experiencing difficulty expressing those preferences as a result of mental distress.

These concerns are reflected by the Committee on the Rights of Persons with Disabilities in its interpretation of Article 12 CRPD (equal recognition before the law). It makes it clear that in order to ensure the non-discriminatory exercise of legal capacity "The point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity." (Committee on the Rights of Persons with Disabilities, 2014). This is a serious consideration for those states who are parties to the CRPD who are contemplating introducing advance planning mechanisms or have already adopted such measures but which are aligned to mental capacity assessments. It is, however, suggested that as the CRPD requires ensuring a focus on ascertaining and giving effect to the authentic will and preferences of individuals in mental distress, using the supported decision-making and 'best interpretations' approaches, the solution may lie more in working to ascertain an individual's authentic wishes at any given time by considering their well-established and overriding values.

The cross-agency sharing of personal information can present significant issues. That being said there is already evidence of existing inter-health and law enforcement agency sharing of patient information (for example, linkage systems in the United States). Moreover, as the making of an advance statement is in the discretion its maker it is entirely compatible with Article 12 CRPD requirements for respect for autonomous decision making if the maker agrees to the sharing of its content. That being said, the nature and scope of such information sharing would have to be made very clear.

The resourcing implications of such cross-agency arrangements and potential increase in uptake of mental health advance statements are an additional factor to be considered. However, it might be argued that this more an issue of reallocation rather than increased resources with savings for all agencies in terms of use of emergency or acute provision being a result.

Conclusion

It is acknowledged that mental health advance statements will not cover every eventuality when a person experiences mental distress. However, it may complement other forms of support and enablement. The potential for the extension of the use of mental health psychiatric advance statements from clinical to law enforcement agencies to achieve better outcomes therefore clearly needs to be further explored.

More empirical research as to how and what would work is required and, equally, legal enforceability and institutional 'buy in' is essential. However, as discussed, there is a strong human rights imperative, notably stemming from the CRPD, for this. The ability to effectively give effect to the CRPD requirements reinforcing such an approach within individual states will depend on their constitutional and political approaches to international human rights treaties. However, the over 170 states which have ratified the CRPD have, at the very least, an international law obligation to give effect to it nationally and, indeed, many states are seeking to accommodate it within their policies and law reform.

The extended use of mental health advance statements also provide opportunities to improve practice under existing legislation. In Scotland, for example, they could be used to support improved and appropriate use of 'Place of Safety' provisions in the Mental Health

(Care and Treatment)(Scotland) Act 2003 (section 297). These provide that if a police officer reasonably suspects that someone in a public place has a mental disorder and is in immediate need of care and treatment the officer can, in the person's interest of for the protection of others, remove that person to a 'place of safety' where they can be kept for up to 24 hours. A 'Place of Safety' is defined as being as hospital, care home, or any other suitable place willing to take the person temporarily (section 300). Amongst other things, in its most recent place of safety monitoring report the Mental Welfare Commission for Scotland has recommended that "…to improve mental health outcomes for people in the justice system, and to respond better to distress, the Scottish Government and local agencies should develop models of service for people who are acutely distressed but do not require detention under the Mental Health Act." (Mental Welfare Commission for Scotland, 2018).

The Act and its Code of Practice emphasises that police stations should only be used as Places of Safety in exceptional circumstances and for only so long as no other place of safety is immediately available. Moreover, in the above-mentioned report the Mental Welfare Commission for Scotland noted the very low number of persons who were taken to a Place of Safety but who were subsequently detained under mental health legislation. For instance, seventy-nine per cent had no orders under the Mental Health (Care and Treatment) (Scotland) Act 2003 in the period of two months before and two months after the Place of Safety intervention. This is highly suggestive of the fact that although the person concerned is highly distressed other interventions or measures are required in these circumstances. Mental health advance statements may be the means by which to provide guidance on what works best for the person concerned and thus have value here.

The ability to give effect to the CRPD requirements reinforcing such an extended use of mental health advance statements approach within individual states will depend on their constitutional and political approaches to international human rights treaties. However, states that have ratified the CRPD have, at the very least, an international law obligation to give effect to it nationally and, indeed, many states are seeking to accommodate it within their policies and law reform.Recent law reviews and reforms in Australia, England and Wales and Scotland are examples of this.

References

1. Deegan, P. 1996. Recovery as a Journey of the Heart. *Psychiatric Rehabilitation Journal.* 19, 91–97. doi:10.1037/h0101301
2. Flynn, E., and Arstein-Kerslake. A. (2017). State intervention in the lives of people with disabilities: the case for a disability-neutral framework. *International Journal of Law in Context*, 13(1), 39-57. doi:10.1017/S1744552316000495
3. Gooding, P., and Flynn, E. 2015. Querying the Call to Introduce Mental Capacity Testing to Mental Health Law: Does the Doctrine of Necessity Provide an Alternative?', *Laws,* 4(2), 245-271. doi:10.3390/laws4020245
4. McGeough, E., and Foster, R. 2018. *What Works? Collaborative Police and Health Interventions for Mental Health Distress*, Justice Analytical Services, Scottish Government, retrieved online from https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2018/08/works-collaborative-police-health-interventions-mental-health-distress/documents/00537517-pdf/00537517-pdf/govscot%3Adocument/00537517.pdf

5. Mental Welfare Commission for Scotland. 2018. Place of Safety Monitoring Report 2018. Retrieved online from https://www.mwcscot.org.uk/sites/default/files/2019-06/Place%20of%20safety%20report%202018_0.pdf
6. Maylea, C., Jorgensen, A., Matta, S., Ogilvie, K. and Wallin, P. 2018. Consumers' Experiences of Mental Health Advance Statements. *Laws*, 7(2), 22. doi: 10.3390/laws7020022
7. Morriss, R., Mudigonda, M., Bartlett, P., Chopra, A. & Jones, S. 2017. National survey and analysis of barriers to the utilisation of the 2005 mental capacity act by people with bipolar disorder in England and Wales. *Journal of Mental Health*. doi:10.1080/09638237.2017.1340613
8. Morrissey, F. 2010. Advance Directives in Mental Health Care: Hearing the Voice of the Mentally Ill. Retrieved from https://aran.library.nuigalway.ie/handle/10379/1146
9. Ruchlewska, A., Kamperman, A.M., Wierdsma, A.I., van der Gaag, M. and Mulder, C.L. 2016. Determinants of Completion and Use of Psychiatric Advance Statements in Mental Health Care in the Netherlands. *Psychiatric Services* 67, 858–63. doi: 10.1176/appi.ps.201400495
10. Stavert. J. 2013. Added value: using human rights to support psychiatric advance statements. *Edinburgh Law Review.* 17(2), 210-223. doi:10.3366/elr2013.0155
11. Swanson, J.W., Swartz, M.S., Elbogen, E.B., Van Dorn, R.A., Wagner, R.H., Moser, L.A, Wilder, C. and Gilbert, A.R. 2008. Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions. *Journal of Mental Health.* 17 255–67. doi:10.1080/09638230802052195
12. Weller, P. 2012. *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose*. Abingdon. Routledge.
13. Wilder, C.M., Elbogen, E.B., Moser, L.L., Swanson, J.W. and Swartz, M.S. 2010. Medication Preferences and Adherence among Individuals with Severe Mental Illness and Psychiatric Advance Directives. *Psychiatric Services*; 61, 380–85. doi:10.1176/ps.2010.61.4.380
14. Committee on the Rights of Persons with Disabilities. 2014. General Comment No.1 (2014) *Article 12: Equal recognition before the law*. 19 May, CRPD/C/GC/1
15. Committee on the Rights of Persons with Disabilities. 2018. General Comment No.6 (2018) *on equality and non-discrimination*, 26 April CRPD/C/GC/6