SMHLR

SCOTTISH MENTAL HEALTH LAW REVIEW

Final Report

September 2022

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Message from the Chair of The Review

In submitting our final report to Scottish Ministers, I wish to take the opportunity to express my gratitude to several people.

My main thanks go to my colleagues on the Executive Team – Alison Rankin, Karen Martin, Graham Morgan, Professor Jill Stavert and Professor Colin McKay. They are all experts in this area. They inspired me and kept me right.

Likewise, I am grateful to the members of our secretariat who have seen us through the challenging period of the pandemic to final publication.

Our advisory groups and reference groups greatly assisted us in taking our work from initial thoughts to provisional proposals on which we were able to consult. I wish to thank the many individuals who gave their time, shared their knowledge and acted as liaisons to wider networks of practitioners and lived experience voices (always including the voices of carers).

The many consultation responses we received also helped to shape our final recommendations.

That we have managed to complete this major review in just over three years is due to the knowledge, lived experience, common sense, commitment, humour and enthusiasm of all of these colleagues and contributors.

When I took up my role as a Judge in May, I was anxious to see this review through to the end. I am therefore grateful to the Lord President, Lord Carloway, and the Minister for Mental Wellbeing and Social Care, Kevin Stewart, for agreeing to allow me to do so.

I am grateful to the many practitioners who have helped us to identify improvements as well as current good practice. Their collaborative approach has made our job easier.

We have also been greatly assisted by discussions with international colleagues who have helped us to gauge progress against developing human rights standards across the world.

Finally, I wish to record my sincere appreciation for the generosity of those who have shared their lived experience with us in the hope that others would fare better in our mental health systems. I feel humbled to have heard what they shared and join in their hope that what follows will be better for everyone.

John Scott KC Solicitor Advocate

Edinburgh

26 September 2022

Glossary of terms

Below are some common terms used within the report. There will also be definitions of other terms in relevant sections of the report.

2000 Act or AWI Act	The Adults with Incapacity (Scotland) Act 2000
2003 Act or Mental Health Act	The Mental Health (Care and Treatment) (Scotland) Act 2003.
Adult Support and Protection Act (ASP)	The Adult Support and Protection (Scotland) Act 2007

Advance Statement	Under sections 275-276C of the 2003 Act, an advance statement is a statement by a patient setting out the way in which they want to be treated or treatment they do not want for their mental health condition. Doctors and the Mental Health Tribunal for Scotland need to pay attention to the advance statement and should not override it without justifying why they have done so. The Mental Welfare Commission holds a register of advance statements.
Advocacy	Under section 259 of the 2003 Act, people affected by the Act have a right to independent advocacy, and health boards and local authorities must ensure independent advocacy services are available. ‘Advocacy services’ are defined as ‘services of support and representation made available for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, that person’s care and welfare as is, in the circumstances, appropriate.’
Autonomy	The ability to be the author of one’s own life and have one’s will and preferences respected.

Capacity	Capacity in mental health and incapacity law can mean either mental capacity or legal capacity. Mental capacity is the ability to understand and make a decision. Legal capacity is the ability in law to undertake legally valid transactions, like consent to treatment or to hold a particular status like owning property.
Child and young person	The UNCRC states that a child is anyone under the age of 18. In Scotland, for most purposes a child is someone aged under 16. In general, duties on public bodies or professionals to pay special attention to children and young people apply to anyone aged under 18, but provisions regarding the decision-making ability of the child, such as on medical consent, or appointing a named person, apply to children aged under 16. We use the term ‘child and young person’ to mean someone aged under 18.
Collective Advocacy	A group of people who are all facing a common problem and have had similar experiences get together to work on specific issues and have their voices heard. The group as a whole may campaign on an issue that affects them.

Compulsion	A provision for a person to be treated or detained without their consent. There are several different types of orders authorising compulsion under the Mental Health (Care and Treatment) (Scotland) Act. These include: emergency detention certificates (up to 72 hours); short term detention certificates (up to 28 days); and compulsory treatment orders. These orders are sometimes known as civil orders. Some provisions of the Adults with Incapacity Act or Adult Support and Protection Act may also involve compulsion.
ECHR	European Convention on Human Rights

Equality and Non-Discrimination	All human rights should be enjoyed equally by everyone without discrimination. The UNCRPD makes it clear that: • A diagnosis of mental disability or mental incapacity can never justify restrictions of autonomy through, for example, detention and other non-consensual interventions or protective measures. • Support is required to ensure equal rights enjoyment by persons with mental disabilities. ·Any decision taken without a person's consent and related restriction of their rights must be based on the same criteria as for all persons.
GRT	Gypsy, Roma, Traveller persons

Human Rights	We all have human rights. These are basic rights and freedoms, based on our common humanity. Human rights are outlined in law and they set out a minimum standard for how we should all be treated by state organisations, including the NHS and local authorities. At an individual level, while we are all entitled to respect for our own human rights, we should also respect the rights of others. Human rights apply to everyone, regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. They cannot be taken away except in specific, pre-determined situations and according to law. However, it’s important to recognise that there are different types of rights. In particular there are absolute rights and qualified rights.
Human rights-based approach	Empowering and enabling people to know about and claim their rights and increasing the ability and accountability in giving effect to these rights.

ICESCR	International Covenant on Economic, Social and Cultural Rights
Mental disorder	Currently defined under section 328(1) of the 2003 Act as: a. Mental illness; b. Personality disorder; or c. Learning disability. The Act also states that certain behaviours or personal characteristics do not, in themselves, constitute mental disorder, including sexual orientation, anti-social behaviour, or acting imprudently.
Mental Health Officer (MHO)	A social worker with a special qualification who is able to carry out various functions under the 2003 Act and the Adults with Incapacity Act, including approving emergency and short term detention and reports in relation to compulsory treatment orders and guardianship.

Mental Welfare Commission for Scotland (MWC)	A public body established under Part 2 of the 2003 Act to protect the human rights of people with mental illness, learning disability, dementia and related conditions. The Commission visits hospitals, prisons and other institutions, investigates cases of possible deficiency in care, promotes good practice and provides advice and guidance.
PCREF	Patient and Carer Race Equality Framework
Protected Characteristics	You are protected under the Equality Act 2010 from these types of discrimination: • Gender Reassignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion Or Belief • Sex • Sexual Orientation • Age • Disability

PSED	Public Sector Equality Duty
Risk	The possibility of loss, danger or harm to self or others.
SIDMA	Significantly impaired decision making ability. To trigger civil compulsory care and treatment (emergency detention, short term detention and compulsory treatment orders) under the Mental Health Act the patient’s mental disorder must cause, or be likely to cause, significantly impaired decision-making ability about medical treatment.
Supported decision making	Supporting a person’s decision-making ability to ensure that their will and preferences are respected. In law this is referred to as a person exercising their legal capacity.
The Executive Team	The Executive team is the independent group of people who are making recommendations about changes to the law in this area. The chair is John Scott, KC, Solicitor Advocate. Full details of the team are found on the Review website.

The Mental Health Tribunal for Scotland (the Tribunal or MHTS)	A Tribunal established by the Mental Health (Care and Treatment) (Scotland) Act 2003 to check whether it is right that a person needs compulsory treatment under the Act. Tribunal meetings which makes such decisions involves a group of three people, known as the panel. Of these three people one will be a lawyer, one will be a doctor and the third will be a person who knows about mental disorder such as a nurse or a social worker. Some panel members have lived experience or provide unpaid care to someone with lived experience. Tribunal meetings are often called hearings.
The Rome Review	The Independent Review of Learning Disability and Autism in the Mental Health (Care and Treatment) (Scotland) Act 2003, chaired by Andy Rome, reported at the end of 2019.
UNCRC	United Nations Convention on the Rights of the Child.

UNCRPD	United Nations Convention on the Rights of Persons with Disabilities.

Introduction

Lived experience and human rights are at the heart of the Scottish Mental Health Law Review. This Review is the vehicle chosen by the Scottish Government to start the process of re-establishing our mental health and capacity law as among the foremost in the world.

In line with human rights thinking and principles, the voices of lived experience – of people - have been represented throughout every aspect of our work – on our executive team which is at the heart of our decision-making, on all advisory groups and on a specific lived experience reference group established following discussion with colleagues with lived experience (although we are well aware that these demarcations can be clumsy and fail to reflect that many who come forward with lived experience are also practitioners and many who come forward as practitioners have lived experience). These voices have been crucial in informing our work and our vision of mental health, incapacity and adult support and protection law as outlined in the recommendations in this report. They have served as a constant reminder that the significance of the law is in how it affects the lives of people, of individuals, in their everyday lives. The Review was established in recognition of agreement across lived experience and practice that we can do better. Apart from listening carefully to the varied voices of lived experience – including always the voices of unpaid carers -, how best to proceed in order to improve our law? This is where human rights come into focus again but more widely than the civil and political rights which are those most commonly discussed.

The first draft of our Terms of Reference in 2019 included specific mention of economic, social and cultural rights including the Convention on the Rights of Persons with Disabilities (UNCRPD) (signed by the UK in 2007, in force in 2008 and formally ratified by the UK in 2009). That was particularly reassuring. Setting up an independent review with economic, social and cultural rights in the remit is an unusual and a bold statement of intent. It can be seen as part of a wider recognition by the Scottish Government of the implications of international human rights treaties.

Human rights also underpinned the last fundamental review of the law in this area, undertaken in 1999/2000 by the committee chaired by the late Rt. Hon. Bruce Millan. That review followed the introduction of the Human Rights Act 1998 (and Scotland Act 1998) which incorporated ECHR into our national law. (Our Executive Team members Graham Morgan and Colin McKay both played important roles in that review as well as in ours, assisting us with continuity as well as recognition of areas where the law had failed to achieve some of the ambitions of the Millan Committee).

Our current Adults with Incapacity law also has a history of progressive thinking, dating back to the early 1980s when, amongst others, Adrian Ward MBE, (Convenor of the Law Society of Scotland’s Mental Health and Disability Committee) wrote papers advocating for major reform. This led to a 1995 report by the Scottish Law Commission which included a draft Bill which formed the basis in 2000 of the first major piece of legislation passed by the Scottish Parliament, the Adults with Incapacity (Scotland) Act 2000. That legislation followed pressure from the Alliance for the Promotion of the Incapable Adults Bill, an impressive coalition of over 70 professional, voluntary and user groups.

Our current law on adult support and protection, the Adult Support and Protection (Scotland) Act 2007, also comes from work by the Scottish Law Commission going back to 1997 and earlier.

Human rights are critical to our recommendations but talk of human rights sometimes risks missing the people, the individuals whose rights are least recognised. That is where the voices of lived experience, including unpaid carers, assisted in guiding us.

It is right that the law in these areas should be kept under review periodically, especially when there have been relevant changes in society and the law. The 22 years that have passed since Millan, the 2000 Act and the 2007 Act have seen a number of developments in culture, thinking, classification and law in the field of mental health, including human rights. The Covid-19 pandemic has also highlighted the importance of social contact for mental health as well as our vulnerability, not least to isolation and loneliness.

The UNCRPD has been a significant catalyst in promoting the rights of people with disabilities both mental and physical. While not as widely known or understood as ECHR, it has been a source of hope for disabled people who want society to recognise its inherent role in creating disability and do something to address this.

Our courts have had 23 years to develop our jurisprudence on human rights, mindful of, but often questioning, the developing jurisprudence of the European Court of Human Rights. The as yet unincorporated UNCRPD has not had anything like this recognition in our domestic law. That should change with the Scottish Government's forthcoming Human Rights Bill. In the National Taskforce for Human Rights Leadership March 2021 report, Professor Alan Miller, co-chair of the National Taskforce, described such a move as 'by far the biggest step taken in Scotland's human rights journey'. He continued, 'This proposed new framework would, for the first time, put in a single place the range of internationally recognised human rights – civil, political, economic, social, cultural and environmental – which belong to everyone'.

Mental health, capacity and adult support and protection law must be an important part of the new framework.

Developments in the area of mental health law have occurred nationally and internationally. Despite some progress, significant issues remain in Scotland. There are concerns about the extent of deprivation of liberty of those diagnosed with 'mental disorder' as defined by current legislation in Scotland. Despite the hopes of the Millan Committee, stigma persists in society and practice and continues to find a place in the language of deficit inherent in some crucial legal terms (“mental disorder” being just one example). We aim to continue the journey of the language in this area towards names, words and phrases that better reflect the feelings of the individual and meaningful enablement – what they can do, rather than what they cannot do without greater support, adjustment and accommodation.

Although there is wide recognition that things can be done better, there are many impressive individuals already pushing for and implementing improvements within existing legal frameworks in various countries throughout the world. Often this is done by ensuring continuity of personnel and the development of trusted relationships. This is an area of law and practice in which it is helpful to see our country as part of an international community that is trying, learning, succeeding and failing, all in the pursuit of something better. That is how we have viewed it and, especially in the last year, we have been helped by input from a range of experts in international law and practice, including those who are experts by dint of lived experience.

Our overall lifespan has been a little over 3 years. We have consulted widely – twice now by way of significant calls for evidence or consultation. Obviously the pandemic has affected how we were able to engage and how others were able to engage with us. Despite this, we have been overwhelmed throughout the time of our work by the contributions from individuals and organisations across lived experience, including unpaid carers, and practice. Many people made great effort to ensure that we heard from them. We did our best to reach out to hear from others. Practitioners and their organisations have also greatly assisted us in our work, helping us in our aims to be ambitious but also informed by the reality of stretched resources and services with fewer practitioners than are needed even with the law as it is.

We have sought to ensure that few of our recommendations come as a surprise. Indeed, many will recognise their input in what we recommend. We shaped proposals based on consultations, evidence and feedback. Our final recommendations represent the development of those proposals after further consultation in recent months. We are grateful to all who have taken the time to assist us with evidence, thoughts and suggestions.

We have sought throughout to follow the PANEL principles –

- **Participation**
- **Accountability**
- **Non-discrimination and Equality**
- **Empowerment**
- **Legality**

We have engaged over the last 2 to 3 years with many individuals, groups and professional and lived experience (including unpaid carers) organisations. It is clear that our work is being followed carefully by many and that we bear a weight of expectation as well as nervousness.

We appreciate it is unlikely that all who follow our work will be happy with the eventual recommendations – too little, too late or too much and too soon. We are encouraged and reassured that so many people have stayed the course with us and have continued engaging with us even during the last few months. It is typical of the openness and generosity with which so many have shared their thoughts and experience with us. We hope that the Government can find a way to use some of the expertise that has assisted us in the realisation of our recommendations. The voices of lived experience, including unpaid carers, should continue to be central to future planning and implementation and is indeed required by Article 4(3) UNCRPD.

The recognised human rights principle of progressive realisation is not for everyone. Some see human rights, in particular UNCRPD and its interpretation by the UN Committee, as a means of tearing down the whole house - pulling all our existing systems down and starting from scratch. Those who have followed our work will know that we have not been persuaded that an absolutist approach is as yet possible or even necessarily desirable. In part, our approach has been informed by listening to some of the voices of lived experience, including unpaid carers, who have said to us – if it’s all pulled down, what is to become of us? Who will support us and even, in some situations, protect us from ourselves or others? And such an approach neglects the important work which has been, and is being done, saving or restoring many lives along the way.

Recognising that they do not speak with a single voice or hold a single view, we have heard from those with lived experience (including unpaid carers) including those who work in the Review at every stage, and they know that our systems can be better than they are but see the benefit of progressive realisation, especially when the vision of the UN Committee on the Rights of Persons with Disabilities has not, despite UN recognition and approval of progress in a small number of countries, been fully realised anywhere on the planet. While we still aim to be reach further than we can currently see, it would be irresponsible to accelerate far beyond what we know can be safely achieved with existing resources and services. However, at the same time, the issue of resourcing and service capacity must not be unnecessarily or discriminatorily used to prevent or delay progress. Our proposed reframing of the law around an expanded appreciation of human rights will move us forward although we recognise that it does not offer a final destination. These are areas of law that should always be kept under review and subject to detailed reconsideration as we keep track of developments in knowledge, practice, culture and human rights.

It is probably uncontroversial to say that this area of law should be about putting the individual at the centre. No doubt that has been the aim in the past. Using human rights and an asset-based or capabilities approach, it may be easier to see the individual in the round – as a citizen, as a person - rather than a service-user or a patient. This ties in with the healthy approach to human rights which has been a hallmark of the Scottish Government and Scottish Parliament in recent years.

Our vision is of renewed emphasis on the decision-making of the individual, with autonomy at its heart and support whenever necessary. Empowerment or, as we have called it, enablement of the rights of the individual will proceed on that foundation. The law will be more about positive recognition of autonomy and rights of the individual rather than restricting what the State can do to them. Such restrictions on the power of the State will still be important but our proposed reframing will be a big step towards a rights respecting culture.

What happens next is obviously key. Some of the change we have in mind, that can be achieved without changes in the law, should start now or soon. To be effective, changes in the law often need to be accompanied by changes in culture. That is a process in which we all have a part to play. It will take some time but can start now. Not all the progress intended by the Millan Committee has taken place despite the passage of 22 years. We hope that the progress envisaged by that Committee and this Review will be achieved in much less time than that.

When law and culture shift together, the end result can be inspirational and lasting.

The pandemic has changed much in society, although, for better and worse, we are starting to see some things return to how they were before. One of the striking aspects of the last three years has been increased discussion of mental health as something for everyone. We hope that such discussions can assist in moving us on as a society, underpinned by our recommendations for changes in the law.

As acknowledged by the Millan Committee, we are aware that resources and services will be key to the success of any changes. That is beyond our terms of reference but has been a key part of much of the evidence we have heard. Without more resources and practitioners, the scope for continuity of personnel and developing trusted relationships between the individual and those whose role is to support and assist them will not happen.

In addition, some of the changes we recommend will involve greater co-ordination across services, areas of practice and Government portfolios. The work of co-ordinating all essential parts of current and future systems will not be easy. We hope that it will be guided, as we have been, by the voices of lived experience (including unpaid carers) and practice.

Chapter 1: A law built on equality and human rights

1.1: Introduction

This Review was tasked with improving the rights and protections of persons who may be subject to mental health, incapacity or adult protection legislation, because of a mental disorder. We were asked to consider how equal and non-discriminatory enjoyment of rights can be achieved and make recommendations that give effect to the rights, will and preferences of the individual.

From the outset it was clear to the Executive team of the Review that what was needed to achieve this was more than simply adjusting the current legislation to ensure it upholds the human rights we may be familiar with in a more effective manner. We are living in a time of change where outdated models of disability and mental health support are slowly but surely making way for approaches reflected in this quote from Thomas Hammarberg, a former Council of Europe Commissioner for Human Rights.

> ‘From viewing disability as a personal problem that needs to be cured (the medical model), we have come to see the source of the problem: the society’s attitude towards persons with disabilities. This means that we have to act collectively as a society in order to remove the barriers that hinder persons with disabilities from living among us and contributing to our society, and to fight against their isolation in institutions or in the backrooms of family homes. Finally, there has been a shift from welfare policies and charity as the only tools for dealing with disability, to an approach based on human rights and equality.’

In the recommendations in this report we go beyond changes to the law as we currently know it, because we consider more radical change is needed to deliver mental health, capacity and adult support and protection law grounded in human rights.

Human rights law and principles do not exist in a vacuum. To be meaningful and effective, they must exist in more than the prose and occasional lyricism of international treaty obligations. They must be known, understood and put into practice at all relevant moments. Often, rights are inter-related and incapable of enjoyment without effective realisation of other rights, for example, social and economic rights often underpin meaningful enjoyment of civil and political rights.

Gerard Quinn, UN Special Rapporteur on the Rights of Persons with Disabilities has said that:

> ‘Transformation of mental health service provision must, however, be accompanied by significant changes in the social sector. Until that happens, the discrimination that prevents people with mental health conditions from leading full and productive lives will continue.’

He made this comment at the launch of the World Health Organisation’s (WHO) new ‘Guidance on community mental health services: promoting person-centred and rights-based approaches’ which affirms that mental health care must be grounded in a human rights-based approach, as recommended by the WHO Comprehensive Mental Health Action Plan 2013-2030 endorsed by the World Health Assembly in May 2021.

When we talk about rights in this report, we mean the rights in the international human rights treaties most relevant to mental health and capacity law, which include the European Convention on Human Rights (ECHR), the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the International Covenant on Economic Social and Cultural Rights (ICESCR) and the United Nations Convention on the Rights of the Child (UNCRC). We have also considered rights under the Equality Act 2010 and the Public Sector Equality Duty which are explained later in this chapter.

At present, ECHR rights carry greater legal weight in Scotland owing to their incorporation into the UK and devolved Scottish legal frameworks. This means that they have greater leverage in terms of enforceability. The combined effect of the UK-wide Human Rights Act 1998 and the Scotland Act 1998 is that individuals may enforce their rights through the national courts or tribunals and public bodies must act in accordance with individuals' ECHR rights. The positive obligations placed by the ECHR on the UK to give effect to its rights are also such that the State is likely to be responsible for actions of private bodies delivering health and social care services that are contrary to ECHR rights. Additionally, courts and tribunals must interpret the law in accordance with European Court of Human Rights jurisprudence. In Scotland, devolved legislation that is incompatible with ECHR rights is invalid, unenforceable and can be struck down by the courts.

The UNCRPD, ICESCR and UNCRC do not currently have the same legal status or effect as ECHR rights in the UK and Scotland although the Scottish Government is committed to their incorporation into the Scottish legal structure. The rights identified in these treaties are still highly influential in the meantime.

The growing influence of, in particular, the UNCRPD and UNCRC in Scotland has been apparent in recent years. This was evident in the Scottish Government's 2016 UNCRPD Delivery Plan, the 2018 Scottish Government Review of the Adults with Incapacity (Scotland) Act (AWIA) and requirement to reflect the UNCRPD in the AWIA in Scotland's Mental Health Strategy 2017-2017, as well as the 2018-2019 Independent Review of Learning Disability and Autism in the Mental Health Act. And, not least, in the terms of reference for this Review.

In response to the UNCRPD requirements, the Mental Welfare Commission for Scotland published supported decision-making guidance in 2016 and, in the same year, the Sheriffdom of Lothian and Borders introduced directions relating to Adults with Incapacity (Scotland) Act applications reflecting aspects of UNCRPD requirements. The process of embedding UNCRC rights in the Scottish legal framework also commenced with the 2020 introduction of the United Nations Convention on the Rights of the Child (Incorporation) Bill into the Scottish Parliament.

Human rights can sometimes be explained or represented in an exclusionary manner. Often, they are thought of as something for lawyers, courts or ‘other people’. The truth, as yet not even nearly fully appreciated, is that they are for us all. They may be most important, however, for the most vulnerable, the poorest and the most deprived. International bodies like the United Nations, as well as our own Scottish Government, are grasping this truth and attempting to make it real.

Our work is part of that process, and it involves improved awareness (for the public and practitioners), participation by those with all types of relevant lived experience, dissemination of good practice (not requiring changes in the law) and improved and shared vocabulary (continuing to move away from the language of deficit and discrimination). Finally, it will require changes in the law. Our work may well lead to significant change, but it is also likely to require some changes to be made in stages, not least for practical reasons relating to allocation of resources and shortage of key personnel in some areas, both of geography and practice.

Throughout the report we explain what we think these changes should be and how they could be achieved.

We need to remember, however, when considering all these changes, we are talking about people. Not cases, examples, studies, but people who are impacted by changes made to legislation and practice in mental health, capacity and adult support and protection law.

You will see throughout this report references to people's experiences of the current law. Often they make for concerning reading. We have heard of many positive examples but, equally, many people have told us of their experiences which fall far below the level of care any of us would be prepared to tolerate.

In thinking about how to tackle this, we were drawn to the Independent Care Review for children and young people (Independent Care Review – The root and branch review of Scotland's care system.) That review had a very strong focus on experiences of services and identified what mattered to people. It led to 'The Promise', an implementation programme built on foundations, including that 'there must be a compassionate, caring, decision-making culture focussed on children and those that they trust'.

The need for compassion and care doesn't end with childhood. We all need to experience belonging, connection, safety and humanity. Law can set a framework in place to nurture these things, and investment can promote them but neither can 'make' these happen.

We hope that by promoting a human rights-based approach to law and practice, that fully takes into account the whole range of a person's rights and equality in the enjoyment of these rights, as has been developing since our existing law came into force, a culture change across mental health, capacity and adult support and protection law can be encouraged, and flourish in a way that so far it has not had the opportunity to do. Sometimes this has been because staff have what seem like impossible targets and restricted resources to carry out their work, and so, when operating under extreme pressure with limited time, find they lack space to offer the truly empathic support that many people crave and they would wish to give.

Increased resources are clearly needed, but culture is not only about available resources.

The main report of the Independent Care Review for children and young people stated that :

> ‘To ensure the experience of being loved is possible and more probable, Scotland must create an environment and culture where finding and maintaining safe loving respectful relationships is the norm. That will involve fundamentally shifting the primary purpose of the whole of Scotland’s ‘care system’ from protecting against harm to protecting all safe, loving, respectful relationships’.

In a similar way, as will be seen in more detail in the next chapter, we are looking for a shift in the law from one which is primarily focussed on authorising and regulating actions which may limit a person’s autonomy, to one where a person’s rights are respected, protected, enabled and fulfilled. This will require a culture change, building on legislative changes, to develop safe, compassionate and respectful relationships between professionals and people with lived experience, including unpaid carers. Relationships between professionals should also be considered here, as well as relationships between people with lived experience.

This cannot be achieved in isolation. The recommendations for change made throughout this report need to be developed and taken forward with full and equal participation of people with lived experience of mental or intellectual disability, including unpaid carers with lived experience of caring for someone with mental or intellectual disability. It is only by sitting alongside and learning from people with such experience that we can truly improve the daily experience of those affected by the issues we are trying to resolve.

When we talk about full and equal participation with people with lived experience and unpaid carers, we mean enabling and supporting those people with the resources that they need to participate in the work on an equal footing with others, and giving equal weight to those contributions alongside professional contributions. At the end of this report we talk about some of the lessons learnt in this Review. One of the biggest lessons is how we can improve the way lived experience has an equal voice. But, throughout the report, we emphasise the need to include people with lived experience and unpaid carers at every juncture, be it making board membership more equitable, ensuring proper representation on policy development forums or in developing and delivering training. The duty on user focus in the Public Services Reform (Scotland) Act 2010 is a useful starting point for this, but we suggest that in order to achieve true equity for people with lived experience, including unpaid carers, we need to go beyond this.

To enable that involvement to be on an equal footing we need to think about the resource required to deliver that. It could be the right IT equipment, payment or recompense, the use of accessible language, a support person to talk things through with, culturally aware interpreters, respite care, replacement care costs or even simply allowing people a little more time. It will be different for every person and this needs to be recognised and accounted for.

We recognise that changes cannot be made overnight. There is a well-developed framework for giving effect to economic, social and cultural (ESC) rights of progressive realisation. This means a State must take steps, to the maximum of its available resources, towards achieving full realisation of these rights through all appropriate means, including legislation.

The progressive realisation approach is of particular relevance in these very constrained times. We are well aware that services are buckling under a perfect storm of post-covid recovery plans, lack of resources on all fronts, rising energy costs, and costs in general. Our recommendations will require significant input in funding as well as increase in staffing and service delivery. But for the realisation of the right to health, and for all economic, social and cultural rights, as we detail in chapter 6, progressive realisation is required.

And as is noted in chapter 11 on accountability, Scotland is required to take steps to its maximum available resources to achieve these rights, through strategies and programmes which are deliberate, concrete and targeted, and developed in line with UN recommendations. Scotland should refrain from acting in ways that would undermine or result in reducing each right (respect rights) and take actions to prevent others from interfering with enjoyment of those rights (protect rights).

To fulfil these rights, Scotland will need to meet several specified requirements, including in relation to budgeting, allocating resources, and demonstrating how resources are deployed. These rights must be fulfilled without discrimination, with understanding and inclusion of all vulnerable groups, and with the aim of achieving “substantive equality”. Minimum core requirements for implementing these rights include adopting a basic minimum threshold below which no one should fall. Scotland must also exercise restraint in limiting rights and act to avoid regression.

We suggest a human rights-based approach to budgeting should be considered by the Scottish Government. The Scottish Parliament has addressed human rights budgeting through the work of the Equalities, Human Rights and Civil Justice Committee.This means distributing resources in a way that puts people first. It involves thinking how people’s rights are impacted by the way that money is raised, allocated and spent. Specifically, budget decisions should reflect human rights standards and the process of formulating, approving, executing and auditing the budget should reflect human rights principles. Human rights are relevant to budgeting because all governments must respect, protect and fulfil human rights. The way they generate, allocate and spend money plays a key role in this.

We recognise we are making significant demands in very difficult times. But we were tasked with making recommendations for legislative change that would reflect

UNCRPD and ECHR requirements, and without proper resourcing, any change would be severely limited.

1.2: Equality

1.2.1: Where we started

The Equality and Human Rights Commission (EHRC) states that equality is about ensuring that every individual has an equal opportunity to make the most of their lives and talents, and believing that no one should have poorer life chances because of where, what or whom they were born or because of other characteristics. This includes individuals enjoyment of human rights.

At the heart of the Convention on the Rights of Persons with Disabilities is equality. The Committee on the Rights of Persons with Disabilities has stated:

> ‘The broadening of anti-discrimination laws and human rights frameworks has led to extended protection of the rights of persons with disabilities in many States parties. Nevertheless, laws and regulatory frameworks often remain imperfect and incomplete or ineffective, or reflect an inadequate understanding of the human rights model of disability. Many national laws and policies perpetuate the exclusion and isolation of and discrimination and violence against persons with disabilities. They often lack a recognition of multiple and intersectional discrimination or discrimination by association; fail to acknowledge that the denial of reasonable accommodation constitutes discrimination; and lack effective mechanisms of legal redress and reparation. Such laws and policies are commonly not regarded as disability-based discrimination because they are justified as being for the protection or care of the persons with a disability, or in their best interest.’ (Committee on the Rights of Persons with Disabilities 2018)

We must ensure that this does not happen here in Scotland for persons with mental or intellectual disabilities.

Unlike some of the rights in the conventions and treaties mentioned earlier, the right to equal treatment for those with protected characteristics is already enshrined in law. The Public Sector Equality Duty (or general duty) in the Equality Act 2010 came into force in 2011. This was developed to extend the race equality duty across the protected characteristics. This means that Scottish public authorities must have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity between those who share a protected characteristic and those that do not, and foster good relations between those who share a protected characteristic and those who do not. Compliance with the duty is a legal obligation.

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. (Equality and Human Rights Commission). It states that compliance with the duty may involve treating some people more favourably than others.

To achieve this, each listed authority must publish a set of equality outcomes which it considers will enable it to better perform the equality duty and, in doing so, take reasonable steps to involve persons who share a relevant protected characteristic or are seen to be representative of those persons. A report on the progress made to achieve these outcomes should be published by authorities at intervals of no more than 2 years (The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012).

The Review talked to organisations and individuals involved in the wider mental health system who had worked with, or been subject to, mental health and incapacity legislation. We heard about the diverse experiences of people who felt discriminated against due to a protected characteristic. Protected characteristics are the grounds upon which discrimination under the Equality Act 2010 is unlawful. We collected feedback from third sector specialist ethnic minority organisations and a small number of ethnic minority people with lived experience of accessing mental health services. We didn’t speak to as many unpaid carers as we would have liked to.

Our engagement showed that there is a great deal of confusion about the public sector equality duties. Based on the feedback we received, it seems that lack of accountability and effective monitoring has meant that statutory bodies are marking their own homework. We heard that the combination of equality duties and ESC human rights obligations has exacerbated the confusion as both sets of duties are often operating in parallel, often poorly.

We have considered recommendations which the Mental Welfare Commission made to this Review in last year’s report on Racial inequality in Scotland . They outlined the following suggestions:

> ‘Consider the findings on differential use of the law in its on-going review of Scots Law in mental health. Consult specifically with organisations that represent ethnically diverse communities. Publish the findings of these consultations as part of the Review.
>
> Consider the findings noting how some safeguards appear to be less well used for ethnically diverse communities. Ensure that any recommendations for changes to mental health laws protect the civil and political rights for all of Scotland’s ethnic communities equitably.
>
> Consider the findings on socio-economic disadvantage and detention under the Mental Health Act, and how this is pronounced for people of colour. Ensure that mechanisms to promote the economic, social and cultural rights of people who are detained promotes these rights particularly for those that are most

> disadvantaged and who have been subject to greater restrictions on their liberty.'

We also recognise the Fairer Scotland Duty, set out in legislation as Part 1 of the Equality Act 2010, which requires Scottish Ministers (and named public bodies) to consider actively what more can be done to reduce the inequalities of outcome caused by socio-economic disadvantage when making strategic decisions.

This section covers the many issues raised by the different groups and organisations we spoke to. Despite the diverse nature of the groups, the consistent message we heard was that more needs to be done to achieve equal and non-discriminatory enjoyment of rights as outlined in the Review's terms of reference.

All the groups we spoke to described a shared general experience of discrimination, hate and harassment. Although they may have different needs, they have encountered similar experiences under mental health and incapacity law.

We specifically consulted with organisations that support ethnic minority communities and LGBT+ groups. Unfortunately, we didn't manage to hear from Gypsy, Roma & Traveller communities but carried out our own desktop research to identify the needs of these groups.

People with severe mental illness have on average 15-20 years shorter life expectancy than the general population. Most of this reduced life expectancy is due to a higher rate of physical conditions such as cardiovascular disease. Some of the drugs used to treat severe mental illness can cause obesity and thus increase cardiovascular risk. Mental disability has also been linked to lower socio-economic status so people are more likely to be living in poverty, having difficulty getting or keeping a job, being lonely and isolated, all of which might lead to a reliance on welfare benefits from the State. When these factors are coupled with discrimination due to other protected characteristics, such as belonging to an ethnic minority and/or being LGBT+, then the experience of discrimination will likely become more intense and be experienced as multiple or intersectional discrimination.

There are several different terms used to describe race which are often used interchangeably, e.g. Black and minority ethnic; Black, Asian and minority ethnic. For ease, we have decided to use the term ethnic minority people or communities, although we have not changed terms used by respondents when quoting from responses.

Also, for ease and inclusivity we have used LGBT+. That covers a range of people and we are aware that not everyone will share the same barriers.

Sensory impairment is the common term used to describe Deafness, blindness, visual impairment, hearing impairment and Deafblindness.

We received responses from organisations representing and working with Deaf, deafened and partially hearing people. We refer to this group as Deaf, deafened and hard of hearing collectively whilst recognising they won’t all share the same experiences or cultural references.

1.2.2: What people told us

Below we describe the experiences of people we heard from. To avoid repetition, we highlight the issues which were raised by more than one equality group.

We were told that there is an imbalance of power between the mental health professionals working in the system and people who access services. Our engagement with the LGBT+ community highlighted that, for people who don’t fit the societal ‘norm’, this feeling is further magnified.

Racial inequality

The MWC Racial Inequality in Scotland report includes research into the experiences of ethnic minority people in the mental health system. It provides a stark insight into the multiple barriers faced by people. The findings from our discussions reflected the findings of the MWC and reinforce the disparities about how the law is applied to ethnic minority communities.

Our engagement has shown us that ethnic minority people are more likely to experience poor mental health and need interventions from services, but because of barriers which we will explore in more detail throughout this section, they are less likely to receive the support and treatment they need. The reasons for poorer physical and mental health are multifaceted and it is critical that services understand the reasons behind this in order to provide appropriate support.

Through our consultation it has become clear that, often, we do not recognise the multiple barriers people will face.

People told us about their experiences of hate crime, reported by both ethnic minority and LGBT+ communities - a crime, it was felt, that the police did little about and omitted to report in many cases. Through our engagement we encountered frustration about the gaps between the Scottish Government policy position on issues around race and racism and the implementation of those policies and the experiences of ethnic minorities.

The rates of racist hate crimes reported to police far outnumber other forms of hate crime, yet often ethnic minority people who do report acts of racism have told us that they don’t feel listened to or taken seriously. Participants in our engagement events told us about how these experiences contribute to poor mental health. This echoes many of the findings of the MWC report.

Some of the examples we heard illustrated how reports of racism can be perceived as evidence of paranoia or being overly sensitive. People felt that there was a lack of recognition about the corrosive impact of everyday experiences of discrimination and racism, such as hate crime, on the mental health and wellbeing of ethnic minority people. Questions such as “where are you really from?” emphasise a feeling that the person doesn’t belong even if they were born here. This can have an impact on mental health, sense of belonging and exacerbate feelings of isolation and ‘otherness’. It would be helpful to build upon the evidence base on mental illness amongst ethnic minorities in Scotland, including any notable differences between groups, particularly as trends indicate increasing numbers of ethnic minorities living in Scotland.

Sir Simon Wessely led a recent review of England and Wales’ Mental Health Act. The final report from that review wrote that (Wessely et al, 2018, p.56):

> ‘The [UK] government noted with concern the disproportionate number of people from black and minority ethnicities detained under the Mental Health Act. Whilst experiences vary across different ethnic minority groups, we were particularly concerned by the excessively poorer experiences and outcomes of individuals from black African and Caribbean communities...”

The Wessely Review recommended a targeted approach to addressing racial inequality, inequality which was particularly evident in the disproportionate use of Community Treatment Orders with Black people under England’s mental health law. That Review’s final report set out a wide range of measures, including some general approaches (Wessely et al, 2018, page 57), but concluded that:

> ‘The key to our proposals to reduce disparities and discrimination is via the [Patient and Carer Race Equality Framework] PCREF across health and care services. The input of regulatory organisations such as the Care Quality Commission and the Equality and Human Rights Commission is key to supporting improvement in equality of access and outcomes across public

> bodies, ensuring consistent due regard to existing statutory duties such as those under the Equality Act.”

We spoke with Jacqui Dyer MBE and Zoe Reed, who are leading South London and Maudsley NHS Trust’s work on PCREF. Once developed, PCREF will be rolled out by NHS England across all mental health trusts and will form part of Care Quality Commission (CQC) assessments. PCREF is the NHS England accountability framework to eliminate the unacceptable racial disparity in Access, Experience and Outcomes of Black, Asian and Minority Ethnic communities, and to significantly improve their trust and confidence in mental health services. The PCREF accountability framework comprises three components - Statutory and Regulatory Obligations; Organisational Competencies; and Patient and Carer Feedback mechanism.

That approach has the potential to address discrimination in a targeted way, alongside actions which address discrimination through ‘mainstream’ measures. We see value in a combination of measures to address racial discrimination in general, plus measures to address racial discrimination specifically in the use of orders and in the use of coercion (as described in chapter 9). In our view, Scottish Government should address racial discrimination though both targeted and mainstream approaches.

Recent work by the Mental Welfare Commission has shown how orders have been used disproportionately with different ethnic communities in Scotland as discussed in chapter 9 (MWC, 2021). It is clear that Scotland, like England, has a serious issue with racial inequality in the use of mental health detention, and compulsory care and treatment. If Scotland takes a targeted approach similar to England to address this issue, this could include an equivalent of the PCREF being developed by the NHS in England, with a comparable approach to enforcement. In Scotland, enforcement may involve the Equality and Human Rights Commission (ECHR), the Mental Welfare Commission, the Care Inspectorate and Healthcare Improvement Scotland.

There may also be a need for targeted approaches for other communities which are discriminated against. For each community, there will be a need to link developments to that community's own sense of identity and culture, in addition to universal approaches to improving the application of the law and experiences of services for all.

We expect that our recommendations on economic, social and cultural rights will contribute to addressing inequality in general, including ethnic inequalities. These are recommended in chapter 6.

In our view, the development of community-driven and alternative, non-institutional support structures is fundamental to tackling mental health inequalities for ethnic minority communities. There must be considerable engagement with groups affected by these practices to effectively understand rising rates in detention. Culturally appropriate collective advocacy is needed to give a voice to those communities who experience racism in relation to mental health law and services**.** Collective advocacy is important in general, as described in chapter 11, but we think that it will have a particular importance in this area. People who experience both mental ill health and racial discrimination will be particularly discriminated against, may be exceptionally isolated and disempowered, and may be particularly vulnerable if they raise challenges. Regional and/or national approaches to this collective advocacy may be required, but this must be determined by the people who would use it.

It is clear to us that with a few exceptions, Scotland has not invested in understanding the impact which systemic racism has on mental health in general, and specifically in relation to rates of detention and compulsory treatment. It is our view that effective solutions to this issue can only emerge by resourcing and empowering leaders in Scotland's minoritised ethnic communities to find, develop and implement solutions within their communities.

Language and communication

Language was frequently mentioned as a barrier to needs being met. Many of the people we spoke to highlighted the importance of effective language services, including BSL interpreters which were seen as a very important enabler for deaf people and English interpreters for people with low English proficiency, for accessing the support that they needed.

> ‘Most deaf people are not aware of the services available to the general public; even if they are, they still face a longer wait (compared to their hearing peers) due to factors such as mental health practitioners having difficulty finding an available BSL/English interpreter’ (British Deaf Association)

The lack of provision of aids to communication conflicts with the reasonable adjustments duty required under section 20 of the Equality Act 2010, which requires service providers and those exercising public functions to take positive steps to ensure that disabled people can access those services. It should be noted that this duty is anticipatory and therefore it is not sufficient for service providers to make adjustments on a case by case basis.

This section of the Equality Act also extends to the provision of information. Many people we spoke to felt like they had persistently raised this issue but had seen little improvement. All materials providing information about mental health, capacity and adult support and protection law and services should be available in a format that everyone can understand whether this means the ability to translate into different languages or a format that recognises and is accessible for those who have sensory impairments. This extends to all information published by the Scottish Government and statutory services.

Cultural awareness and stigmatisation

We were told that information and services aren't always developed with sensory impairments and cultural competence in mind. Some people described how many GP practices are now only holding appointments over the telephone. This does not accommodate for deaf people or people with low English proficiency and is incongruous with the duties set out above.

> 'Deaf BSL users have always felt on the fringes of the dominant hearing society. This is often the case due to previous past experiences of oppression, discrimination and unconscious bias coupled with a lack of understanding and BSL awareness.'(British Deaf Association response to consultation).

Stigmatisation was frequently mentioned as a barrier to seeking help and working with mainstream services.

We spoke to a third sector organisation that specialised in supporting people from Eastern Europe. They explained that the stigma attached to mental health in Poland is such that people are reluctant to seek help for their symptoms. This is of particular significance for men. The 'Mental Health and Suicides amongst Polish Men in Scotland' report found that 'The self-stigmatisation of men with problems as being inferior and not masculine enough leads them to avoiding the reflections and their feelings and emotions for fear or being judged.'

We were told many times about the importance of providing appropriate services for men and women, bearing in mind that women can sometimes find it easier to ask for help, whereas, with men, the service might need to be 'disguised'. This might happen through initiatives such as Men's Sheds, where men access support in a relaxed non-threatening environment and are often signposted to statutory services.

This sense of stigma and reluctance to acknowledge early symptoms of mental disability has been echoed by other third sector organisations supporting people from ethnic minority communities with links to Africa and South Asia.

We learnt that in some cultures there are negative associations attached to the language that we use to describe mental or intellectual disability in Western culture. This was illustrated in the recent racial inequality report by the Mental Welfare Commission. A group of carers for ethnic monitory people explained that the term ‘mental health’ translates as ‘mad’ in some languages and people ‘did not want to advertise their problems to others around them, including in faith groups’ (Racial Inequality Report Scotland)

It is important that services recognise how stigma can affect people seeking help from different communities and work flexibly to ensure that everyone has the same opportunities.

Equally it is important that gateways to seeking support are culturally sensitive. Suggestions from specialist ethnic minority organisations included more discreet services for South Asian women for example or ‘initiatives [that are] focused on physical activities, such as sport for Polish Men’ (Mental Health and Suicides amongst Polish Men in Scotland).

We heard that Eastern European people who have moved to Scotland in search of jobs and opportunities can experience significant levels of mental health issues. Some people feel the isolation of leaving behind family, friends and support networks and the difficulties around settling into a new culture.

Although Gypsy, Roma, Traveller (GRT) people have been recognised as an ethnic minority in law since 2008, they don’t always benefit from the protection which that should bring and can experience high levels of discrimination and persecution.

For example, we know from an EHRC report that GRT people are still refused registration with some GP practices even though proof of address is not essential. GRT people experience the poorest health outcomes of all minority ethnic groups.

This evidence highlights that additional intervention or effort is necessary for particular groups to ensure that there is equity for everyone in relation to services and treatment. This should be acted upon in accordance with the PSED which states that compliance with the duty may involve treating some people more favourably than others.

Challenges of a universal approach

We heard from organisations who told us that the way mental health services have tried to meet the needs of everyone with a universal approach leaves some groups having poorer outcomes. We repeatedly heard about how statutory services are not meeting the needs of a diverse population. Some respondents described the mental health system as being ‘institutionally racist’ because it consistently fails to meet the needs of marginalised people.

> ‘[F]air treatment does not mean that uniform treatment is positive. [To achieve this] we must recognise the intersectional dynamics of race, sex, gender and sexual orientation and how these may influence the prevalence and treatment of mental health.’ (GREC)

It is acknowledged that some individuals are affected differently as a result of discrimination and their intersectional identity and this was reflected in the feedback we received from the LGBT+ community.

> ‘LGBT people can have and do have other protected characteristics and therefore can be marginalised in multiple ways’ (Equality Network response to the SMHLR Consultation)

For example, an individual could be LGBT+ and disabled or LGBT+, disabled and from an ethnic minority. We heard from an ethnic minority LGBT woman about her experience of coming to the UK as a refugee. We heard about her intersecting experiences of marginalisation when seeking help from mental health services and how she was subjected to many layers of discrimination whilst trying to navigate what she described as complex systems. She described how she felt completely disempowered as a result of being dismissed by services that didn’t believe or take her seriously.

When considering services for people sharing protected characteristics it is important to ensure that there is adequate resourcing of community services as well as in-patient services (EHRC response to the consultation).

Rural living – isolation and other challenges

We heard about the additional barriers that people living in rural communities face, which feed into a sense of isolation. We know people living in remote and rural areas face unique barriers in accessing mental health support because fewer services are available or accessible for them and we know that suicide rates are a worrying feature.

We visited a mental health support group on the Isle of Mull who felt despair at the lack of continuity treatment. This was largely due to issues with attracting people to work somewhere so remote and meant that people were seeing locums and having to talk about often traumatic experiences over and over again. This was felt to exacerbate mental health issues. In addition to this there is a lack of affordable housing to accommodate professionals in many remote popular tourist destinations due to an increase in holiday rentals.

We heard troubling stories of individuals in crisis situations travelling to the mainland for treatment. The conditions for travel were inappropriate and not sufficient to support someone with this level of need. A therapist working in a remote part of the west coast told us that there are so few therapists to meet the needs of children and young people that siblings are having no choice but to see the same therapist.

There are additional barriers for people from particular groups living in remote and rural communities such as the added isolation they may face for being part of a minority, for example, being from an ethnic minority in a predominantly white community or being LGBT+ in a hetero-normative community.

The Equality Network undertook research in rural communities in Scotland which found that 86% of LGBT people who answered questions relating to mental health had experienced some kind of mental health issue (Equality Network Response to SMHLR consultation). This statistic is particularly worrying and is a good illustration of how layers of discrimination can reduce the chances of an individual receiving the support they need. The Equality Network reinforced concerns around the risk of isolation for LGBT+ people. It has been recognised that family support plays a major role in mitigating mental health stigma and resulting mental stress. We were told that [LGBT] people do not always have this familial support. This can be due to a number of factors including, but not limited to, ‘estrangement, neglect, losing touch, and for some….to not having a family.’ (The Equality Network). This is of particular concern given that LGBT+ people are more likely to develop problems like depression, anxiety, issues with food, dependence on drugs or alcohol, self-harm due to facing issues including discrimination, bullying, violence, and rejection and isolation. (Mind)

A holistic approach is required to understand the multifaceted needs of the individual so that services can be adapted to meet those needs and ensure that the right to health is afforded equally regardless of circumstances. Human rights enablement, as set out in chapter 8 can underpin and be the driver for this.

Additional attitudinal barriers

There are additional attitudinal barriers for other groups. We heard from people who were seeking support and treatment for their mental health issues but felt their sexuality, gender identity or trans status was made part of the issue when this wasn’t the case. They told us they felt medicalised, coerced, and traumatised by the mental health system when all they wanted was help and treatment. We also heard of people being further traumatised by accessing mental health services due to the ignorance and prejudice they encountered from staff and other patients. We were told about people being outed to other patients and trans patients placed on the wrong single sex ward or area.

People told us that they often felt disrespected, sometimes due to a lack of understanding about not being in touch with their biological families or difficult family dynamics. Even with progressive steps such as equal marriage, people spoke about their significant relationships not being recognised in the way they would be for heterosexual people. We also heard about people feeling they are teaching staff how to support them and that this is an additional burden on top of trying to get better. They also told us they only felt respected and listened to if they had an independent advocate present at meetings.

The deficiencies reported to us in relation to cultural awareness manifested in a lack of trust amongst ethnic minority communities and authorities. For ethnic minority children and young people there are particular difficulties. We heard of one example where a psychiatrist had admitted that they did not understand enough about the cultural contributions affecting young people such as extended families and community pressures. Also, people are often juggling issues of identity and belonging, dealing with racism and discrimination in parallel to issues about school, expectations of others, and the like.

Research indicates that mental ill health tends to affect women and men differently. This is illustrated, for example, in research findings from Germany, the Netherlands and France. It should also be noted that extensive research shows women are more likely to be living in poverty, more likely to be in low paid precarious employment, be unpaid carers and be more likely to experience sexual and domestic abuse. For ethnic minority women there is the added dimension of racist abuse and being seen as more of a threat to others. The Scottish Government's first Scottish Women's Health Plan does address mental health, but with focus only on one page of a 68 page document.

Diversity in the workforce

It was felt that the issues we have described are exacerbated by the lack of diversity in the workforce who provide mental health services and who developing mental health and capacity policy.

> 'The people making these decisions [about mental health policy] do not represent a diverse workforce and therefore are ill-equipped to understand what is happening on the ground.' (specialist ethnic minority third sector organisation)

Also on frontline services, the report by the Mental Welfare Commission on racial inequality surveyed 320 staff working in mental health services. 25% of staff felt that the team or ward in which they worked did not meet the needs of people from diverse backgrounds. When the same people were asked what could be done to help overcome barriers and make the team or ward more culturally competent, more diversity in the mental health workforce was a common response. This feeling was echoed in the feedback we received from ethnic minority third sector organisations who told us that a diverse workforce means that people accessing mental health services are more likely to have a connection with staff and feel more comfortable talking about their experiences.

MWC's report on racial inequality found that 'differences in approaches taken by different health boards in providing data on ethnicity and the workforce made it difficult to build a national picture of the diversity of the mental health workforce in Scotland.' MWC reported that 30% of staff had experience of, or had witnessed, racist comments directed towards their colleagues.

MWC also reported data from the Royal College of Psychiatrists in 2020, which showed 16% of the Membership in Scotland is from a visible minority. One individual felt that a lack of access for ethnic minority people into professional roles within the mental health sector was a contributory factor to the lack of visible diversity within the mental health workforce. Suggestions to improve diversity in the workforce included: creating alternative pathways for ethnic minority people to access the workforce; and developing strategies to attract young ethnic minority people.. To ensure this is sustainable, a retention strategy would also need to be considered alongside this.

This also reflects the findings of the Independent Review of the Mental Health Act in England, which recommended seeking greater representation of people from ethnic minority backgrounds, especially those of black African and Caribbean heritage in key health and care professions to tackle the disproportionate number of people from ethnic minority communities detained under that Act.

The Public Sector Equality Duty imposes a duty on authorities to use data on the composition of the authority’s employees and the recruitment, development and retention of persons as employees to enable it to better perform the equality duty. Data presented in MWC’s Racial Inequality report suggests that this is not being adhered to. The reasons for this are unclear.

Similar concerns were raised by the deaf community acknowledging the lack of deaf people within the mental health workforce:

> ‘Employing deaf people [in frontline roles] would ensure understanding and empathy for the barriers that deaf BSL users face every day of their lives.’
> (British Deaf Association)

These experiences illustrate the importance of a diverse workforce that can ultimately speak with and listen to the diverse range of people who experience the mental health system and get a better idea of how to make it more accessible and effective for everyone. This would help to design a system where people are afforded their rights equally.

We also heard about people’s experiences of racism and discrimination within mental health settings from both people with lived experience and practitioners.

Negative experiences in relation to staff were described by LGBT+ people as:

> ‘…feeling like you are there to educate them whilst you are in an acute ward.’
> (Equality Network Response to Consultation)

Experiences of transphobia were also reported within the wards (Equality Network Response to Consultation).

Training and awareness raising

Inadequate training was also raised as a concern by a number of people whom we spoke with. MWC's Racial Inequality report indicated that 70% of respondents felt that there were gaps in training (Racial Inequality Report). This demonstrates the need for mandatory training on anti-discrimination and anti-racism.

Our discussions also highlighted the need for LGBT+ equality and awareness training. BDA Scotland proposed that 'BSL awareness should be included in training for any professional who may come across Deaf BSL users in their line of work' (BDA Scotland response to consultation).

For those people who had reported racism within mental health services, many felt that there were insufficient mechanisms for accountability and that complaint handling procedures were not clear. This exacerbated the issues around lack of trust within services. It was argued that statutory agencies should be held to account when they are not meeting the needs of the people that they serve.

More than one ethnic minority third sector organisation expressed concerns around the lack of awareness and incorporation of the Public Sector Equality Duty within mental health services. It was suggested that this should be strengthened to ensure that services were held accountable.

We heard a great deal from organisations working with ethnic minority women how their needs were not met by statutory services. Specialist third sector organisations working with ethnic minority women told us that the isolation, racism and intersectional discrimination faced by ethnic minority women was a huge factor in the development of mental health issues. The situation was made worse by mental health services not being aware of, or sensitive to, the barriers these women face on a daily basis. Services appeared to be ignorant of the intersectional nature of these barriers. Often assumptions were made that South Asian people will have family that can look after and support them. We also heard about the different ways South Asian women may speak about or articulate their experiences which might be difficult for services to understand. This highlighted the need for qualified and appropriately experienced interpreters and culturally competent services.

Accountability

People also voiced their frustration about the huge gaps between policy development and practice. It was felt that lack of robust accountability mechanisms also had a part to play in this. It was argued that strengthening links between self-standing policies would highlight the links between socio-economic factors and poor mental health outcomes for ethnic minority people and help in developing policy to prevent this.

> ‘We need to redefine prevention, this starts at policy level’ (ethnic minority third sector organisation)

It was also highlighted that policy and service development are currently hindered by ineffective mechanisms for collecting and analysing data due to the fact that data is currently collected under one umbrella and is not disaggregated by ethnicity. It was felt necessary that datasets should be disaggregated into nationality, asylum status, carers, disability, gender, intersectionality, socio-economic status, age: ‘It should also be gender sensitive and sex disaggregated’ (EHRC feedback). The current approach means that it is difficult to evidence how ethnic minority people are affected by specific issues, such as domestic abuse. This does not meaningfully inform decision-making and makes it difficult to develop services in a way which meets the needs of specific groups.

The Mental Welfare Comission report highlighted the problem of monitoring information not always being completed. Historically there have also been concerns expressed by mental health professionals about asking a person who is distressed about their ethnicity. We discovered that these concerns are further exacerbated when professionals may be uncomfortable about issues around race. This further underlines the need for anti-racism training in the context of data collection.

Providers and services

Ethnic minority third sector organisations felt strongly that services should be delivered by people who could relate to, and had a cultural awareness of, the individuals that they served and supported. This was seen as paramount to building trusting relationships. Organisations described what they felt were the barriers to delivering these services.

Participants at roundtable events pointed out that there is recognition for the specialist support provided by third sector LGBT+ organisations alongside generic services but that recognition doesn’t seem to apply to BAME organisations, where ethnic minority people are just expected to use mainstream services that don’t meet their needs. The lack of funds channelled to third sector organisations also stymies their ability to develop and work on solutions. The people we spoke to wanted to see money ring-fenced for services supporting ethnic minority people, which would enable them to provide training and employment opportunities for multi-lingual, culturally and religiously sensitive counselling. They felt that organisations should be funded to employ their own translators who can build an expertise in mental health and the issues people encounter.

> ‘The challenge is that systems and processes stop ethnic minority people from progressing, so services are left to firefight issues rather than working on solutions. Scottish Government have been doing work to remove these barriers for years and are yet to find solutions.’ (third sector organisation)

We heard often about the lack of specialist trauma informed mental health services for migrants, refugees, and asylum seekers. We know that people are often arriving in the UK from war torn countries where they have faced persecution, conflict, and torture. The Mental Health Foundation found “asylum seekers are five times more likely to have mental health needs than the general population and more than 61% will experience serious mental distress”. There are additional issues for unaccompanied children, lone women and LGBT+ people who face having to prove their sexuality to the Home Office. Often people have very little knowledge of their rights and have limited access to public services. An example of the effect this can have on a person can be found in this newspaper article by the CEO of the Scottish Refugee Council, Sabir Zazai.

Furthermore, people are often denied access to healthcare, and prevention or early intervention regarding mental health care is often not available to them. We heard an example of one individual not being believed when relating her experience of racism in the asylum process alongside health professionals who appeared to lack a clear understanding of the asylum system. This created a feeling of disempowerment which we know can cause further detriment to the mental and physical health of people. We also heard that a lack of culturally competent interpreters and translation services meant that people were often not able to articulate their needs and gain any benefit from their interaction with services.

In our engagement it was stressed to us that the trauma of the asylum process needs to also be acknowledged in the context of the impact it will have on mental health.

We heard that small specialist ethnic minority third sector organisations are often working to bridge the gap between services and ethnic minority people, and are often going beyond their remit to ensure people get the right support. These organisations are more likely to employ ethnic minority staff and volunteers who can win the trust of individuals and can relate to the experiences people have been through. These staff themselves experience hostility, dismissal and discrimination from statutory services not recognising the valuable role they play in helping people get the right support.

The feedback received and research outlined in this chapter lead us to the conclusion that an holistic approach is required to underpin a system which ensures that everyone is afforded their rights equally in accordance with the PSED.

Without a holistic approach we cannot begin to understand the multifaceted needs of the individual, particularly an individual with one or multiple protected characteristics. This approach needs to be adopted in tandem with a commitment to provide flexible, culturally appropriate services that meet individual needs. Systemic changes are required in how such services are designed and provided, including an inclusive workforce which is representative of modern society across Scotland, and systems that enable us better to understand the impact of these services on particular groups. This includes significant improvements around the collection and use of data and a joined up approach to policy making to enhance service delivery.

We make recommendations on how this work should develop. We hope that beyond the recommendations we have made, the Scottish Government will consider what additional steps need to be taken to ensure the delivery of culturally appropriate services that meet individual needs. This could include for example, the creation of a centre of excellence for race, health and wellbeing that could take forward this work.

In addition to our recommendations, there is need for clear acknowledgement by Scottish Government and all relevant public authorities that the Public Sector Equality Duty already exists in law and should be adhered to.

Chapter 1: recommendations

Recommendation 1.1: The Scottish Government in taking forward recommendations from this Report, should do so with the full and equal participation of persons with lived experience including unpaid carers with lived experience.

Recommendation 1.2: The Scottish Government should work with people with lived experience, including unpaid carers, to reach agreement as to how our recommendation for full and equal participation of people with lived experience, including unpaid carers, can be achieved in the future.

Recommendation 1.3: The Scottish Government should provide resource to ensure people with lived experience and unpaid carers with lived experience can participate in work to implement recommendations on an equal footing with others.

Recommendation 1.4: The Scottish Government should adopt a human rights-based approach to budgeting for mental health and capacity law and services.

Recommendation 1.5: The Scottish Government should ensure that all recommendations in this report be implemented in such a way as to protect, respect and fulfil the rights of those with protected characteristics equitably.

Recommendation 1.6: The Scottish Government should consider addressing racial discrimination in relation to coercion in mental health services through a targeted approach which develops the PCREF approach , with monitoring and enforcement through the Equality and Human Rights Commission, the Mental Welfare Commission, the Care Inspectorate and Healthcare Improvement Scotland.

Recommendation 1.7: The Scottish Government should consider legislation which requires public authorities to ensure that practitioners and paid carers are adequately trained to recognise and address racism, including structural racism.

Recommendation 1.8: The Scottish Government should promote the Equality Act and UNCRPD duties to collect data on protected characteristics and should ensure this data is disaggregated in a way which evidences the inequalities experienced by geographically and culturally distinct groups.

Recommendation 1.9: The Scottish Government should strengthen accountability for public bodies delivering mental health services where they fail to demonstrate progress in relation to equality outcomes in accordance with Regulation 4 of the Equality Act 2010 (specific duties) (Scotland) Regulations 2012.

Recommendation 1.10: The Scottish Government should consider steps to improve the recruitment and retention of ethnic minority staff, across different professions within mental health services.

Recommendation 1.11: The Scottish Government should consider the additional needs for remote and rural communities to enable delivery of mental health services on an equitable basis.

Recommendation 1.12: The Scottish Government should resource and empower leaders of Scotland’s minoritised ethnic communities to lead in finding, developing and implementing solutions which ensure access to mental or intellectual disability services for their communities.

Chapter 2: What is the purpose of the law and who is it for?

2.1: The purpose of the law

2.1.1: Where we started

The primary focus of mental health and incapacity law at the moment is on authorising and regulating actions which encroach on an individual's autonomy, such as detaining them for treatment, or appointing another person to make financial and welfare decisions on their behalf. It is generally not concerned with ensuring that wider human rights are met.

We believe this should change, to reflect Scotland's new approach to human rights, as described in the introduction to this report which, for the first time, puts in a single place the range of internationally recognised human rights-civil, political, economic, social, cultural and environmental.

Our consultation proposed a new purpose for mental health and capacity law: to ensure that all the human rights of people with mental or intellectual disability are respected, protected and fulfilled.

We suggested that this could not be done solely by general human rights or equality legislation, but required specific provision in law for people whose decision-making ability may be impaired. It should not apply only to people receiving care and treatment without their consent, and should encompass the full range of rights set out in applicable human rights treaties, including the UNCRPD, the UN Convention on the Rights of the Child (UNCRC) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

This is a radical change.

2.1.2: What people told us

Our consultation found almost universal support for a human rights approach to the law, and strong support for the proposed purpose.

The Scottish Human Rights Commission said:

> ‘The Commission has, for many years, advocated the reform of mental health and capacity law towards supporting and enabling legislation, focused on delivering access to human rights, as opposed to governing restrictions on them … In achieving that, we agree that the legislation must extend beyond a focus on compulsory treatment and should take into account the full range of human rights set out in international human rights treaties.’

The Mental Welfare Commission also supported broadening the purpose of mental health law (including capacity law) to protect all rights.

Social Work Scotland said:

> ‘Social Work Scotland supports the breadth of what the Review is hoping to achieve, and welcomes the lens of the social model of disability. We agree with the widening of the scope of the application of the law beyond people who receive care and treatment in a hospital setting and are heartened to see equal consideration of medical and social models of mental health, particularly in relation to non-discrimination and equality, and inclusion.’

The Scottish Social Services Council supported the purpose, saying:

> ‘Expanding the remit of mental health law to ensure that the wider needs of people with mental disorder are met is important for making sure people are given the right support to allow them to live with dignity and autonomy.’

Organisations representing service users were also supportive, including the Mental Health Network Greater Glasgow, the Health and Social Care Alliance, and See Me.

The Equality and Human Rights Commission welcomed the purpose but argued that it was important to frame equality in the same way as human rights.

The Challenging Behaviour Foundation commented that mental health law is currently used in order to make up for failures and deficiencies elsewhere. We believe that must change.

However, there were some wider concerns about the practicality of this approach, and a risk of legislative overreach, potentially leading to weaker protection for those most in need.

Some responses were concerned that such a wide purpose could be too aspirational and unrealistic, when the reality is that ‘currently those who are subject to compulsion do not have basic needs and rights met’ [Response 25].

Indeed, even some responses which were supportive of this wider purpose, like that of See Me, were concerned ‘around the possibility of an implementation gap between ideal and reality, due to the practical facts of limited budgeting and staffing for mental health services across Scotland’. Support in Mind stressed the importance of robust monitoring to ensure the purpose and principles are being met.

COSLA welcomed a human rights approach but argued that the proposal pre-empted the human rights framework to be brought about by implementation of the recommendations of the National Taskforce for Human Rights Leadership.

The Royal College of Psychiatrists welcomed an evolution in law to bring about a positive fulfilment of human rights going beyond current legislative safeguards, but urged the Review not to lose sight of (as they saw it) ‘the fundamental purpose of mental health legislation in providing essential safeguards around the provision of non-consensual treatment for those unable to consent’. They considered that ‘broadening the scope of the proposed legislation to encompass a wider societal change, while welcome in principle, extends beyond mental health law. The most ambitious aspects of Human Rights Enablement (HRE) would be best delivered through wider human rights legislation and applicable to all’.

The Law Society of Scotland highlighted that the focus of this chapter was on public law principles and duties, when the Adults with Incapacity (Scotland) Act (AWIA) in particular was also concerned with private law, for example in the relationships between an adult and a proxy decision maker such as a welfare attorney. They suggested that the proposed purpose ‘should be extended to apply to all people with impairments of relevant capabilities, however caused, and should include facilitating the effective exercise of legal capacity by all people who are capable of that if provided with necessary support, and for those who are not fully capable of acting and deciding for themselves, but doing so in full compliance with relevant human rights instruments’.

2.1.3: Our final recommendations

We have considered these comments carefully. We agree that our suggested purpose is ambitious, but we believe it is right to be so. It does not prevent us from ensuring that the specific provisions governing non-consensual care are robust and rights-respecting. The fact that there is a major ‘implementation gap’ between the stated aspirations for mental health services and the reality on the ground is, in our view, an argument for stronger legal duties, not the status quo. At the same time, we accept that securing the full range of human rights will not be achieved by law alone.

We have also reflected on the argument that legislation to secure wider human rights for people with mental or intellectual disability is unnecessary or even discriminatory when the Scottish Government has plans to secure human rights for everybody. This does raise complex issues both of principle and of practicality.

We do not know yet exactly how the proposed Human Rights Bill will work. It may be that some of the changes we want to see will be addressed by it. But we do not think that will be enough, for two reasons.

Firstly, we have received compelling evidence of the discrimination and unmet need affecting people with mental or intellectual disability. Even in access to health care, the longstanding commitment to ‘parity of esteem’ remains an ambition rather than a tangible reality.

Secondly, people with mental or intellectual disability face particular barriers in accessing their rights and, however the law is framed, are more likely than others to have decisions taken on their behalf. It is a core principle of human rights practice that human rights are indivisible, so we believe that any legal framework governing non-consensual care must accommodate wider human rights requirements.

> ‘The focus of the law and the mental health system on the medical aspects of care can mean that a person is pushed out of the system once their condition is judged stable, even where underlying issues have not been addressed. This can result in repeated and avoidable use of coercion.’ –SMHLR Consultation March 2020

So we believe mental health and capacity law will need explicitly to address and enshrine human rights – but the precise balance and relationship between the universal human rights framework to be developed in the proposed Human Rights Bill and the specific provisions of mental health and capacity law will need to be worked through over the next few years.

2.2: Who is the law for?

2.2.1: Where we started

This Review was established by Scottish Ministers with the principal aim of 'improving the rights and protections of persons who may be subject to mental health, incapacity or adult protection legislation as a consequence of having a mental disorder, and remove barriers to those caring for their health and welfare'.

From the outset this was a challenge for us as the legislation at present is predicated largely on the concept of 'mental disorder'. If you come within the definition of mental disorder the legislation may apply to you. If you do not, it does not. Mental disorder however is regarded by many as a stigmatising and offensive term. And the diagnostic criterion of mental disorder has been criticised as being a violation of the UNCRPD anti-discrimination requirements in relation to the right to exercise legal capacity (Article 12) and the right to liberty (Article 14). However for detention to be lawful under Article 5 of ECHR, it must fall within one of the specified categories where detention is allowable – in this case because of 'unsound mind' Winterwerp v Netherlands 6301/73 [1979] ECHR 4 (the Winterwerp ruling) has established that lawful psychiatric detention requires objective medical evidence of a 'true mental disorder'.

Current Law

The current definition of mental disorder is found at section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

‘Section 328

(1) Subject to subsection 2 below, in the Act ‘mental disorder’ means any

(a) Mental illness

(b) Personality disorder ;or

(c) Learning disability,

however caused or manifested and cognate expressions shall be construed accordingly .

(2) A person is not mentally disordered by reason only of any of the following –

(a) Sexual orientation

(b) Sexual deviancy

(c) Transsexualism

(d) Transvestism

(e) Dependence on, or use of, alcohol or drugs

(f) Behaviour that causes or is likely to cause harassment, alarm or distress to any other person;

(g) Acting as no prudent person would act. ‘

The concept of mental disorder also appears in Adults with Incapacity legislation. An intervention may be made in a person’s life under the Adults with Incapacity Act (AWIA) if that person is incapable due to a mental disorder as defined by the 2003 Act. A mental disorder is also one factor in considering whether a person comes within the Adult Support and Protection Act, but in that case, it is only one of a number of possible factors.

We have been looking at several issues with the term including the following :

- The offence caused by the term ‘mental disorder’ towards people with lived experience.

- The tension between the requirement for a mental disorder to justify detention under ECHR, and the more recent requirements from the UNCRPD to avoid disability discrimination in mental health detention.

- Links between ‘mental disorder’ and involuntary treatment.

- Links between ‘mental disorder’ and impaired mental capacity.

- ‘Mental disorder’, and autism and learning disability.

In considering whether the law can or should continue to have a diagnostic criteria, and if so whether that should be mental disorder, the Rome Review concluded that the UNCRPD requires Scots law to adopt the human rights model of disability, including the understanding of disability described within that convention, but also that ECHR requires Scots law to allow for the possibility of detention and compulsory treatment for the protection of human rights. Generally, detention requires a medical diagnosis.

Rome’s recommendation was to remove learning disability and autism from the definition of ‘mental disorder’ and to create a separate law to provide support and equity in law for these communities. If someone with learning disability or an autistic person nonetheless had a mental illness over and above their lifelong condition, which brought them within the remit of mental health law, then the law would apply to them in the same way as to any other person. We discuss the Rome recommendations below.

This Review will make recommendations for changes to the law which are aimed at increasing the compliance of Scots law with both ECHR and UNCRPD. Significant proposals for change include those set out in this chapter around the purpose and principles of the law, and the approach set out in chapters 2 and 4 around Human Rights Enablement (HRE), Supported Decision Making (SDM) and Autonomous Decision Making (ADM).

These proposals seek to shift focus from a diagnosis of ‘mental disorder’ to a set of factors which may prevent ADM. Impaired judgement as a consequence of a mental or intellectual disability is likely to be one of the most frequent of these factors, but only when the disability in ADM cannot be reduced or removed through support for decision-making. Just as significant is the proposal for the HRE process which has the aim of enabling the person to access support and services they are entitled to.

Our thinking is that legislation that has at its heart the aim of enabling people’s rights rather than removing them, should be as inclusive as possible in its scope. As we have said we are proposing a change to mental health and capacity law that will seek to enable people’s human rights. Any restrictions on freedoms for the safety and wellbeing of individuals would start from the same base of looking at a person’s need for support in making decisions, regardless of which aspect of the current definition of mental disorder might apply to them.

However the starting point for this needs to be who the law should apply to, and whether the current definition of mental disorder is fit for purpose.

2.2.2: What people told us

In our March consultation we asked whether there still needs to be a gateway to mental health and capacity law that reflects a diagnostic criterion. In essence who should the law be for? By ‘law’ we mean the current mental health, incapacity and adult support and protection law and any future law which may replace them.

Responses were overwhelmingly in favour of there being some form of diagnostic criteria, but views differed as to what that should be or what it should be used for. There was an acknowledgement that ECHR requires there to be a medical diagnosis to permit detention to proceed, however our intention is that the law is wider than just considering compulsory measures.

> ‘ECHR requires there to be a genuine mental disorder of some kind before deprivation of liberty/ detention can be authorised. Hard to see how we can move from that sort of test for that kind of order. But as review goes wider than just compulsion should we distinguish between a gateway to law generally and a gateway to specific convention rights interference?’ – Faculty of Advocates

As already mentioned, beyond the majority view that diagnostic criteria are required, there was little consensus as to what that should be. Many commented that it was not the language around mental disorder that was the issue but the stigma around mental health. A significant number of responses were in favour of removing learning disability from the definition of mental disorder. Many learning disability groups reiterated what they told the Rome Review namely that the inclusion of learning disability in the definition of mental disorder meant they felt they were stuck in a system that was not designed to meet their needs.

A number of professional organisations spoke of the need to have a gateway with some form of diagnostic criteria linked to an inability to make an autonomous decision. Diagnosis itself should never be a reason to be subject to the law.

> ‘it is of fundamental importance to retain a gateway which as one component includes reference to diagnostic criteria. Someone should not be subject to the law simply due to a diagnosis. It is the effects of the condition on the person that which may make legal frame works necessary.' – Royal College of Psychiatrists’

> ‘We do not believe that the ECHR requires that a diagnosis of mental disorder be a component of other forms or support or intervention as envisioned across the proposals. We have also explained why we believe that UNCRPD requires disability-neutral criteria. Accordingly, we do not believe that new legislation should be confined to people with a diagnosed “mental disorder” or requires a specific gateway, and we consider that this is less contentious if the aims of the legislation are positive and supportive. The criteria identified for specific interventions elsewhere in the proposals appear to be adequate to address the human rights requirements involved in specific interventions including, in particular, detention.’ – Scottish Human Rights Commission

> ‘the term “mental disorder” or any similar barrier to accessing ways of meeting the particular needs of any and all people with relevant needs, is incompatible with a human rights-based approach and should be excluded from relevant legislation.’ – The Law Society of Scotland

Individual views were very much centred on the need for law to be non-discriminatory with one person saying - ‘Identifying individuals needing particular support would be person centred, not a range of people that fit a diagnosis. Not all people with personality disorders or autism would want to identify with a disability but anybody could recognise getting support at times’.

There was also a view that a number of the matters listed in the definition at present need to be removed simply because they are outdated.

In considering changes to our own legislation we have looked at other jurisdictions within the UK. The Mental Health Act 1983 in England and Wales defines ‘mental disorder’ as ‘any disorder or disability of the mind’. However, it goes on to exclude learning disability unless it is ‘associated with abnormally aggressive or seriously irresponsible conduct’.

The UK Government have proposed in their draft Mental Health Bill to change this definition so that autistic people or people with a learning disability cannot be detained under the Act unless they are suffering from another co-occurring mental disorder. It will still be possible to detain autistic people or people with intellectual disability if they are subject to criminal proceedings, or to use the Mental Capacity Act to authorise non-consenting care and treatment.

Northern Ireland’s Mental Capacity Act 2016 does not use the term ‘mental disorder’. It focuses on lacking capacity as the key gateway to interventions. Section 3 provides that the basis of that incapacity must be because of ‘an impairment of, or a disturbance in the functioning of, the mind or brain' – whatever the cause, whether permanent or temporary, and whether or not caused by a disorder or disability.

The place of learning disability and autism

One of the strongest challenges to our proposed purpose came from some organisations representing people with intellectual disability and disability autistic people.

People First argued that our purpose is misconceived as it is based on a grouping of people with 'mental disorder' (whether or not that term is used), which they do not see as the basis for a common set of needs and concerns. They note that the Scottish Government has promised separate legislation for learning disability and autism. They argue that:

> 'While it may be the case that not all groups have specific legal frameworks, some do and our argument for legislation covering people with intellectual impairment is to address the historical (and current) discrimination, abuse, denial of life opportunities and (apparently lawful) withholding of our human rights on the basis of having that characteristic alone.'

They go on to say that mental health law (and the Review) has tended to 'hit' those with mental illness and 'miss' those with intellectual impairments.

Similarly SCLD said:

> 'While SCLD completely supports the ultimate objective of respecting, protecting, and fulfilling human rights, we do not believe that mental health law should be the primary means of achieving this for people with learning

> disabilities. We believe that attempting to fulfil and protect the human rights through the prism of mental health legislation runs the risk of further entrenching underlying prejudices and social attitudes towards people with learning disabilities.’

ENABLE Scotland welcomed the purpose but they strongly supported removing learning disability from the 2003 Act.

We accept the force of these arguments, but have concluded that our proposed framework should apply to all forms of mental or intellectual disability. The point that mental health law has typically been shaped around the needs of people with a mental illness is a fair one, although it is not true of capacity law, which is also covered by the Review. We also accept that the priorities for securing ESC rights may be different for people with intellectual impairments than they are for people with mental illness – although it is also true that the needs of a young woman with an eating disorder may be completely different from a middle-aged man with a long-term diagnosis of schizophrenia.

In relation to the law regulating decision-making as detailed in chapter 4, we believe there should be a single framework applying to everyone whose decision-making is impaired. It is the impairment that requires a response, and the nature of the response depends on the individual needs of the person, not the diagnostic label.

In relation to ESC rights, we argue above that it is not enough for people with mental disabilities to be brought within a human rights framework applicable to all citizens. We think the strengthened rights we recommend to, for example, support for decision making, need to be linked to wider ESC rights, reflecting the indivisible nature of human rights overall.

Within that general approach, we accept that there will be particular needs for particular groups, and it may be right to legislate for those. The Rome Review (Rome et al, 2019) - made the case for specific legislation for particular groups. Rome recommended:

- the creation of a new law on support for people with intellectual disability (learning disability) and autistic people.
- that changes in law and improvements in services be put in place before autism and intellectual disability be removed from the definition of mental disorder in Scotland's Mental Health Act.
- that new law should also be created which aims to protect human rights on the same basis for everyone, to protect the rights of people who are at risk of serious adverse effects on their human rights.

On the first point, Scottish Government committed in its 2021-22 Programme for Government to take forward a Learning Disability, Autism and Neurodiversity Bill 'to uphold and protect the rights of autistic people or people with learning/intellectual disabilities' (Scottish Government, 2021). We do not yet know what that Bill will include.

On the second point, we recommend that the term 'mental disorder' should no longer be used. We recommend new language later in this chapter. There will still be occasions when it is necessary to act without a person's consent, to prevent harm, to act for someone's wellbeing, or to give effect to a person's will and preferences which they have previously stated. In contrast to the Mental Health Act and Adults with Incapacity Act, we are recommending that those decisions should not be made on the basis of 'mental disorder', but on the basis that a person does not have the ability to make a decision autonomously, even with full support for decision-making. Recommendations on this are discussed in chapter 8 on ADM.

On the third point, the Rome Review recommended that:

> '…decisions for detention and compulsory treatment should not be made on the basis of autism or intellectual disability, and should be made under future law that applies to people more generally.'

Rome acknowledged that it would be for the Scottish Mental Health Law Review to consider this. Rome suggested an approach of compliance with international human rights treaties to the greatest extent possible, limited only by unresolved areas of disagreement between some treaties. We believe that our recommendations achieve this. The Scottish Human Rights Commission responded to our consultation proposals as follows:

> '…we must make concerted efforts to move away from substitute decision-making and towards supported decision-making. We believe the work of the Review has tackled this challenge directly and provided a set of draft proposals that would set Scotland on a fundamentally new path in realising the human rights of people with mental health issues. The final goal must ultimately remain the removal of non-consensual treatment, however, we believe the proposals provide key elements of the roadmap towards that goal…'
>
> We are not of the view that mental health and incapacity law requires to be abolished in order to comply with UNCRPD, provided it is reformed as a supportive piece of legislation, and based on non-discriminatory grounds. General Comment No.1 of the Committee on the Rights of Persons with Disabilities, on the right to equal recognition before the law, requires that States 'must immediately begin taking steps towards the realization of the rights provided for in Article 12.

> Those steps must be deliberate, well-planned and include consultation with and meaningful participation of people with disabilities and their organizations' [United Nations, 2014; 30]. We consider that the proposals made here meet these requirements and represent a fundamental shift in the approach of mental health and incapacity law. They present a clear roadmap for achieving the end goal of eradicating non-consensual practices.
>
> UNCRPD, alongside ECHR, recognises that there may be duties on the state to intervene to protect a person, from abuse or inhuman or degrading treatment, or risks to their life. Our understanding of the requirements of Article 12 UNCRPD is that any intervention which overrides a person's will and preferences may be permissible but only on a non-discriminatory basis, not based on the person's disability. Accordingly, we believe the current capacity and Significantly Impaired Decision Making Ability (SIDMA) tests require to be replaced with a disability-neutral test.'

We recommend a test of ADM as that disability-neutral test. We also make a set of recommendations on reducing coercion across health and care services, in chapter 9. In developing our recommendations, we have involved and consulted people with disabilities and their organisations.

The Rome Review presented substantial evidence on harm which can and does arise for some autistic people and people with intellectual disability through compulsory care and treatment, even when that care and treatment complies with the law (Rome et at 2019, section 1.4). This is iatrogenic harm, which arises from care or treatment that has significant negative effects for the person. This harm may happen, for example, when a person is detained in an environment which fails to accommodate the person's communication or sensory needs, or when staff cannot fully understand, accept and support the person's individual needs.

In the future it may be that people with intellectual disability and autistic people would primarily receive support under the new specific legislation which is proposed by Scottish Government, which we understand will be informed by the Rome Review's recommendations. Some of those same individuals would require compulsory care and treatment. For those individuals, the specific legislation could set out how the needs of those individuals should be met, as autistic people and/or as people with intellectual disability. For those individuals, new legislation following the Scottish Mental Health Law Review would also apply across the range of measures which we recommend. Those measures include support for decision making, Human Rights Enablement, the Autonomous Decision Making test, and safeguards for coercion including compulsory care and treatment.

On the whole though, we are reluctant to focus rights too strongly on having a particular diagnosis or other label. That risks a bidding war between different groups, each seeking their own rights framework. Many people will have more than one condition, diagnosis in some cases will be uncertain, and diagnostic labels change over time.

The process of pro-active involvement of persons with mental and intellectual disabilities and their families and unpaid carers in the creation of the human rights framework should allow for consideration of how everyone's rights can be secured, including whether there are particular additional rights needed for particular groups such as have been highlighted by Deaf Scotland in response to our consultations.

2.2.3: Final recommendations

We agree that the current approach to mental health and incapacity legislation is not compatible with Article 12 UNCRPD. However, we are also mindful of the need to demonstrate a genuine medically diagnosed condition before some restrictions on autonomy can be authorised, to comply with Article 5 of ECHR.

We are recommending a move away, however, from the current primary focus of mental health and capacity law as being one of authorising and regulating actions which encroach on an individual’s autonomy, to a focus on ensuring that all the human rights of people to whom the law applies are respected, protected and fulfilled.

The gateway to access the rights anticipated to be provided by new legislation should be wide enough to ensure those in need of help and support can access it appropriately. Access to these rights and related support must not be conditional on an “incapacity test” or other similar threshold being met. We need to move away from a definition focussed on a diagnosis.

We considered an approach similar to that of Northern Ireland, which meets the requirements of ECHR without focusing on a diagnosis. However, their legislation is more limited than our proposals, which seek to ensure that all the human rights of everyone within the scope of the law are upheld. We have therefore adopted a different approach, drawing on the developing human rights landscape in Scotland.

We recommend a definition which draws on the approach of the UNCRPD. The UNCRPD stresses that ‘disability is an evolving concept’ and includes its own non-exhaustive definition in Article 1 –

> ‘Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. Disability is not therefore considered to be a medical condition but a result of the interaction between negative attitudes or an inaccessible environment with the condition of particular persons. By dismantling barriers, as opposed to treating persons with disabilities as problems to be fixed, those

> persons can participate as active members of society and enjoy the full range of their rights.’

We believe a similar approach should be adopted for our legislation, focusing on mental and intellectual impairments.

The focus on ‘long term’ impairment in Article 1 is not intended to exclude those who may have short term conditions, as the following extract from UN guidance shows. In the context of mental health law, it is vital that people with intermittent or short term mental health conditions are included in our definition.

> ‘The term ‘persons with disabilities’ applies to all persons who have long- term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles , may prevent those persons from participating full in society . However this is not an exhaustive definition of those who may claim protection under the Convention; nor does this definition exclude broader categories of persons with disabilities found in national law, including persons with short- term disabilities or persons who had disabilities in the past.’ (UN-DESA, OHCHR, IPU (2007))

It is suggested we follow this approach and that the gateway to legislation that includes support and other measures relating to persons with mental or intellectual disability should be something like :

A person with a mental or intellectual disability whether short or long term.

We intend this to be an inclusive definition. It could apply to anyone who needs support arising from any aspect of their mental health or cognitive functioning. This would include people with a diagnosis of mental illness (including dementia), personality disorder, or learning disability. It could potentially apply to an autistic person, or a person without a diagnosis who is experiencing an emotional crisis. Of course what help a person should receive under the legislation will depend on their individual needs and the barriers they face. Any diagnosis maybe highly relevant to determining that. We discuss this in relation to non consensual measures in Chapter 8.

There is an important respect in which the Adults with Incapacity Act goes beyond mental disorder. A person may be ‘incapable’ because of ‘inability to communicate because of physical disability’ if that inability to communicate cannot be made good by human or mechanical aid. This potentially applies to a small number of people with very severe physical disabilities such as ‘locked in syndrome’. We believe it will still be necessary to make provision for this small number of people within the new legal framework.

The statutory Code of Practice and related guidance can help to ensure that there is a clear understanding of the scope of mental and intellectual disability.

We do not believe it is necessary for the legislation to retain the three sub-categories of mental illness, learning disability and personality disorder. However, it will be important for monitoring purposes that any particular diagnosis is recorded when an intervention is made, particularly around non-consensual care. We would anticipate that ICD – 11 would be the basis for recording diagnosis . ICD-11 is the current version of the World Health Organization’s International Classification of Diseases.

Under our approach, we also believe it should not be necessary to retain a long list of exclusions from the definition, as appear at section 328(2). Some of these are now outdated – we believe no professional or judicial body would consider a particular sexual orientation to be a mental disorder, for example. And a list of exclusions creates uncertainty about conditions which are not included.

Some of the exclusions such as ‘acting as no prudent person would act’ could be accommodated in the provisions for Autonomous decision making, in the same way that the English Mental Capacity Act provides that ‘A person is not to be treated as unable to make a decision merely because he makes an unwise decision’. Anyone with a mental or intellectual disability may be entitled to access care and support as set out in the subsequent chapters to this report.

This will **not** however enable non-consensual interventions. In the event that non-consensual intervention in a person’s life is being considered, then a higher threshold, will require to be met, based on consideration of the person’s ability to make an autonomous decision and, after this, a diagnosis and the impact and risks associated with that. Details of this are set out in chapter 8 on Autonomous decision making. and deprivation of liberty. Chapter 13 considers how this change might impact on adult support and protection legislation.

We recognise that the definition of mental disorder in the 2003 Act is used in a wide range of other legislation for various purposes, beyond those set out in the current mental health and incapacity law . These would all need to be considered in consequence of any changes to the definition in due course.

Timing

These proposed changes cannot be taken forward in isolation. They are bound up with the wider proposals around the realisation of economic social and cultural rights, and Autonomous decision making and therefore would be part of the longer term changes we recommend.

Chapter 2: recommendations

Recommendation 2.1: The law should apply to persons with a mental or intellectual disability (and otherwise included under AWI) whether short or long term.

Recommendation 2.2: The new purpose for mental health and capacity law should be to ensure that all the human rights of people with mental and intellectual disability (and otherwise included under AWI) are respected, protected and fulfilled.

Chapter 3: What should the law look like ?

Principles and unified legislation

3.1: ‘Fusion’: unified legislation

3.1.1: This is where we started

The Review’s Terms of Reference asked us to consider ‘the need for convergence of mental health, incapacity and adult support and protection legislation’. This was prompted by developments concerning human rights in relation to interventions and non-consensual care, support and treatment of people with mental or intellectual disability. We mention those developments throughout this report. The Review was also prompted by a need for greater consistency and clarity relating to such interventions. We make recommendations which call for such consistency and clarity. Where no single piece of legislation meets the needs of an individual, it can be difficult for practitioners to establish how best to help the individual.

The most sweeping form of convergence is to replace these different Acts with a single Act – so-called ‘fusion’. To date, supporters of fused mental health and capacity legislation have adopted a capacity-based approach as the basis for all non-consensual intervention. They argue that an approach which adopts the same eligibility criteria for all people with physical and mental health conditions promotes fairness and respects non-discrimination (Dawson and Szmukler, 2006; Szmukler, Daw and Dawson, 2010; Gledhill, 2010; Harper, Davidson and McLelland, 2016). It is also argued that fused legislation offers greater consistency, clarity and coherency in service and professional approaches to people with mental or intellectual disability (Scottish Executive, 2001). The only existing example of fused legislation is the Mental Capacity Act (Northern Ireland) 2016 which adopts a capacity-based approach in relation to non-consensual interventions. This is only partially in force at present.

The 2018 Independent Review of the Mental Health Act 1983 considered whether fused mental health and capacity law was a viable proposition for England and Wales. In its final report it stated that five ‘confidence tests’ would need to be met before the time was right for the fusion process to be started (Department of Health and Social Care, 2018). These tests were whether there is overwhelming support from people with lived experience, an assessment of the impact of the Northern Ireland legislation in terms of detention levels, how it works in the criminal justice context, suicide rates and the impact on those with learning disability/autism (particularly in relation to length of stay in hospital). It concluded, amongst other things, that ‘Even if fusion currently looks like the most promising direction for future travel, things may well have moved on by the time our five tests can be delivered’.

Although we are not yet able to make an assessment of the impact of the operation of its Act, it is clear from the Northern Ireland experience that introducing fused, or unified, legislation would involve a major policy, legislative, financial and implementation exercise in Scotland. Wide-scale stakeholder support would be essential for the successful enactment and implementation of such legislation and the inevitable culture change it would bring in approaches to the care, support and treatment of people with mental or intellectual disability.

Fused legislation for Scotland was first considered by the Millan Review which recommended that there be consistency between mental health and incapacity legislation and that ‘In due course, mental health and incapacity legislation should be consolidated into a single Act’ (Recommendation 2.1; Scottish Executive, 2001). The 2017 report from the Mental Welfare Commission and the Centre for Mental Health and Capacity Law at Edinburgh Napier University, Scotland’s Mental Health and Capacity Law: the Case for Reform, concluded that, at that stage, ‘it was less clear whether there is an overall appetite for the immediate introduction of unified legislation amongst the stakeholders consulted.’ The report concluded that wholesale stakeholder support is vital for such an initiative to be effective (Mental Welfare Commission and Edinburgh Napier University, 2017). It suggested that such ambivalence was perhaps not surprising as a notable difference between Scotland

and Northern Ireland was that the 2016 Northern Ireland legislation arose from a much less developed mental health and capacity legislation landscape than that which existed in Scotland.

A key question for this Review has therefore been whether fused, or unified, legislation would be an improvement on the existing legislative framework. This involves considerations of: (a) which eligibility criteria (for example, a capacity-based or other approach) and underpinning principles would be adopted for such legislation; (b) whether it would provide a better way of resolving existing shortfalls relating to our current legislation and a framework that is most likely to achieve international human rights compatibility; and (c) whether it should include all areas currently covered by mental health, incapacity and adult support and protection legislation.

As will be explained later in this report, we are recommending a framework of a Human rights enablement, Supported decision making and Autonomous decision making. This framework provides a way of working which ensures that, irrespective of a person’s decision-making ability, their will and preferences are heard and respected on an equal basis with others and that the rights which support their specific needs at a given time are respected and given effect. It also ensures that the threshold for considering non-consensual measures cannot be justified by a diagnosis of ‘mental disorder’, although the presence of mental or intellectual disability may subsequently inform the type of measure or measures adopted. We propose this with a view to UNCRPD and ECHR compliance and see it as a way in which the approaches required by each treaty can be reconciled. This need to reconcile the different UNCRPD and ECHR approaches is important whether separate, separate but aligned, or fused mental health, capacity and adult support and protection legislation is adopted.

3.1.2: This is what people told us

In our March 2022 Consultation paper, we suggested that the new proposed approach of the Human rights enablement approach, Supported decision making and Autonomous decision making framework lent itself to a single system which would give the opportunity to create a consistent approach for people with mental or intellectual disability. In addition, by adopting the eligibility criteria for all people with mental health and physical health conditions equally, fairness and non-discrimination would be promoted.

In the consultation we asked if a single Act was the preferred way forward, given the proposed framework. We also asked if it would be better to align legislation instead and, if so, which pieces of legislation should be aligned. And we asked if there should be a single judicial forum, and if so, should this forum be a court or a tribunal.

Support and timing for fused legislation

Around 48% of those responding to this part of the consultation expressed a view about whether or not there should be fused legislation with half of these indicating their agreement and the other half not being in agreement. Third sector organisations and individuals were more in favour of fusion than others, citing the need to simplify the law, with one individual stating: ’The current plethora of laws makes it difficult to traverse the landscape with ease or speed’.

Several respondents felt that fused legislation should be a definite future goal with steps being taken towards this in the meantime. The Law Society of Scotland, for example, felt that fusion should be the long-term aim, noting that fused legislation within Northern Ireland took many years, although it cautioned that:

> ‘…reform should not be delayed pending the creation and drafting of a single piece of legislation...alignment of legislation is the preferred option initially and would allow time to see if fusion is necessary or optimal.’

Mental Health Rights Scotland stated that there should be :

> ‘…stepwise progress to fusion. Which needs to be planned properly before embarked upon.’

Those favouring fused legislation appeared to agree with mental health and capacity legislation being unified. However, there was a strong response against adult support and protection legislation being included within fused legislation, mainly because the scope of adult support and protection law is seen to be wider than mental health and capacity law and encompasses more than people with a mental disorder diagnosis and capacity issues. The view from social work practitioners is summed up in this response: ‘Combining the 3 pieces of legislation poses a significant risk of losing focus of the potential scope and reach of this legislation in helping people self-determine and take forward safeguarding with support’.

Alignment rather than fusion

Many consultees who did not express a strong preference for fusion tended to support greater alignment of the various pieces of existing legislation.

The Mental Welfare Commission supported alignment as the next best thing to ‘universalism informed fusion’. Others expressed concern over the risk that certain elements might fall through gaps in fused legislation.

A number of responses also requested that there be consistency of definitions and harmonised language across all mental health, capacity and adult support and protection legislation.

Single judicial forum

Respondents to the consultation were largely enthusiastic about a single forum for mental health, capacity and adult support and protection legislation with an overwhelming preference for the jurisdiction of the Mental Health Tribunal for

Scotland to be expanded to hear adults with incapacity and adult support and protection cases. It was felt by those responding to the consultation that the Tribunal lends itself better to participation by the adult, is more conducive to a person centred approach, and less intimidating that the sheriff court. AdvoCard said:

> ‘We have extensive experience of both the court and tribunal processes currently. Overwhelmingly the feedback we have from advocacy partners is that the Tribunal forum is preferred over the sheriff court. This is from people who have experienced both settings.’

Another individual said: ‘…it just makes sense. It’s easier for practitioners to work to one set of rule for a forum. The Tribunal is also better geared for adult/client/patient participation in a non-intimidating setting.’

And another said: ‘a single judicial forum will be better able to develop expertise across all the legislation and hopefully develop consistency of application of principles. Also it will make the logistics of collecting data easier and this can feed into future reviews and design of services and also can feed into training requirements.’

3.1.3: These are our final recommendations

In light of responses to the consultation and other relevant evidence obtained by the Review, we consider that the ultimate long-term goal should be one of fused mental health and capacity legislation. This would offer a single, consistent and non-discriminatory framework. We consider the arguments have not been made to include adult support and protection legislation at this time in fused legislation.

We note that strong support from stakeholders, as well as a robust evidence base about what works, is required to both bring about and successfully implement fusion. However, in the meantime, there is much that can be done to align these legislative areas to make them work better together and to prepare the way for future fusion. We therefore consider that steps should be taken to do this.

The HRE, SDM and ADM framework that we are proposing will, as we have already stated, provide a human rights-compatible structure within which to achieve such alignment.

However, the question arises as to which aspects of these different pieces of legislation should be initially aligned. There appears to be little argument that mental health and capacity legislation should be more closely aligned, and we consider that this should be undertaken incrementally.

We note the concerns expressed about including adult support and protection in such alignment given its wider remit and that the people who fall within it are not only those with mental or intellectual disability. However we believe that these is scope for a considerable degree of alignment. For people with mental or intellectual disability, adult support and protection procedures are often the gateway to actions under mental health or particularly capacity law, and it is important that these frameworks operate well together. Also, although our remit is mental and intellectual disability, many of the key recommendations we make, including around the HRE, SDM and ADM framework, and moving the definition away from a medical diagnosis, are potentially applicable to ASP law and practice. We discuss this further in Chapter 14 on Adult Support and Protection.

This structure will ensure the meeting of wider needs, irrespective of diagnosis and incapacity issues, and the tailoring of measures according to a person's specific requirements. It will allow for adult support and protection to retain its distinct identity.

This alignment across mental health, capacity and, where relevant, adult support and protection legislation will at the very least require:

1. A shared definition of who the law applies to.

2. Shared Principles (discussed in the next section)

3. The HRE, SDM and ADM framework to be applied across all the pieces of legislation.

4. The ability and duty to share information between those implementing the legislation

5. A shared judicial forum to decide cases arising under mental health and capacity legislation and, if considered appropriate, in due course adult support and protection legislation

We consider that achieving 1 to 3 above will need to be fully achieved incrementally, through legislative and operational changes, in the next three to five years.

We discuss in chapter 11 current misunderstandings over information sharing in health and social care between services and professionals and the existing cultural and IT obstacles to this. However, there is no reason why immediate steps to address and overcome these misunderstandings and cultural obstacles cannot be taken.

We note and agree with the considerable stakeholder support for the Mental Health Tribunal for Scotland to be the single judicial forum for all mental health, capacity and, if considered appropriate in due course, adult support and protection legislation cases. At the same time, we are acutely aware of the issue of resources and the extreme pressure that the Mental Health Tribunal is already under. There has been a lengthy delay in bringing the Tribunal into the First-tier Tribunal and Upper Tribunal for Scotland. If the Tribunal’s role is to be expanded then it must be appropriately resourced at all levels. Subject to this, however, we are recommending that the role of the Tribunal is expanded to include capacity and adult support and protection cases as an early step in aligning the legislation.

We therefore recommend the following:

Fused, or unified, mental health and capacity legislation should be the ultimate long term goal in Scotland.

In the meantime, active steps should be taken to align existing mental health, capacity and adult support and protection law. Such alignment will require:

- Immediate and ongoing work with professionals and people with lived experience, including unpaid carers, to overcome barriers and misunderstanding regarding information sharing.
- In the medium term:
    - A move towards a joint set of principles across all 3 Acts; and
    - Development of the HRE, SDM and ADM framework across all 3 Acts; and
    - Expansion of the jurisdiction of the Mental Health Tribunal for Scotland to include capacity cases; and
    - Sustained appropriate resourcing to accompany this extended remit of the Mental Health Tribunal for Scotland.

3.2: Principles

3.2.1: Where we started

The Mental Health Act, the Adults with Incapacity Act and the Adult Support and Protection Act each include a set of principles to govern how people should exercise powers and duties under that legislation. These are set out below.

Principles in legislation

Adults with Incapacity (Scotland) Act 2000	Mental Health (Care and Treatment) (Scotland) Act 2003	Adult Support and Protection (Scotland) Act 2007
• Any action or decisions taken must **benefit** the adult and only be taken when that benefit cannot reasonably be achieved without it. • Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that **restricts the person's freedom as little as possible.** • In deciding if an action or decision is to be made, and what that should be, **account shall be taken of the present and past wishes and feelings of the adult** as far as they can be ascertained. The adult should be offered appropriate assistance	• The present and past **wishes and feelings** of the patient must be considered. • The **views** of the patient's Named Person, carer and any guardian or welfare attorney must be taken into account. • The patient should be assisted to **participate** as fully as possible. • The patient should be provided with **support** e.g. Access to a solicitor and Advocacy services. • It is important to consider the **full range** of treatment options available. • Treatment must provide maximum **benefit** to the patient. • The Act must impose **minimum restriction** of	Must take into account: • The **wishes and feelings** of the adult at risk – past and present. • The **views** of other significant individuals, like the adult's nearest relative, primary carer, guardian or attorney, or any other person with an interest in the adult's wellbeing or property. • The importance of the adult **participating** as much as possible in the performance of functions under the Act. • Providing the adult with the relevant **information** and support to enable them to participate as fully as possible.

to communicate his or her views. • **Account shall be taken of the views** of the nearest relative and the primary carer of the adult, the adult’s named person, any guardian or attorney with powers relating to the proposed intervention. • **Encourage the adult to exercise whatever skills** he or she has concerning property, financial affairs or personal welfare as the case may be and to develop new such skills.	the freedom of the person, which appears to be necessary under the circumstances. • The person’s **background and characteristics**, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group must be considered. • It is important to provide **appropriate services** and continuing care to the patient. • The needs and circumstances of the person’s **carer** should be considered, providing such information as might be necessary for the ongoing care of the patient. • Where society imposes an obligation on an individual to comply	• The importance of ensuring that the adult is **not treated less favourably** than another adult in a comparable situation. • The adult's **abilities, background and characteristics**, including their age, gender, sexual orientation, religious persuasion, racial origin, ethnic group, and cultural and linguistic heritage.

	with a programme of treatment and care, it should impose a **parallel obligation** on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsory treatment (**reciprocity**).	

The principles overlap to a considerable extent. The provisions in the Mental Health Act are based on ten principles recommended by the Millan Committee:

> Non-discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, least restrictive alternative, benefit, and child welfare.

We suggested in our consultation that a new approach to the principles may be required. The current law is mainly about protecting people from undue interference in their lives. For that reason, principles like ‘least restrictive alternative’ and ‘no intervention without benefit’ set out an expectation that non-consensual care and treatment should be used as little as possible.

We want future legislation to be more about helping people with mental or intellectual disability to live well and enjoy their lives without stigma or prejudice. We proposed that the principles of the new framework need to reflect this wider aim.

We therefore suggested a new set of principles, based on principles already established in human rights instruments, particularly Article 3 of the UNCRPD.

The four core principles we suggested were:

- **Respect for dignity**. This is an important statement about the inherent human worth of any individual. It is linked in Article 3 with autonomy, but is a wider concept, which we believe should be separately stated. The National Taskforce for Human Rights Leadership stated that: ‘human dignity is the value which underpins all human rights’.

Academic work done for the Taskforce makes clear that the concept of human dignity is important in international human rights, and familiar in domestic law. Although it is difficult to spell out in legislation precisely what it covers, it has a strong resonance, which may assist in understanding the aims of the law. It is flexible enough to be applied and developed in different contexts. Respect for dignity provides an intuitive framework to help assess whether particular actions are consistent with human dignity.

It provides a basis for claims of economic, social and cultural rights, such as rights to health, housing, employment and social security to be taken into account. It also provides a lens to assess whether interventions in someone’s life are justified or necessary. Ultimately, this principle highlights the need always to keep the unique individual affected by the law at the centre of the law and its application.

- **Respect for autonomy.** This principle is fundamental to the UNCRPD with respect to legal capacity and respect for rights, will and preferences. It is also a core value of the European Convention on Human Rights, particularly Article 8. It relates to the freedom to make your own decision and / or be supported to make your own decision.

- **Non-discrimination and equality**. Non-discrimination and equality are central to the UNCRPD, and it is important to understand what they mean. For people with disabilities, it does not mean treating everyone the same. This principle requires us to remove the barriers that prevent disabled people from participating as equal citizens in society and having control over their own lives. Barriers can be removed through providing access to appropriate support, through reasonable adjustments (‘reasonable accommodation’), and creating conducive environments, for example. We have highlighted this in the first chapter of this report.

- **Inclusion**. This principle affirms the right of people with mental disorder to participate not just in their care and treatment, but in wider society: to have meaningful access to independent living, to fulfilling work, to friendships and social connections, to culture and creativity. Inclusion can also be about promoting our own sense of belonging and connection within a community with a common bond of impairment. This principle, in particular, reflects the shift to the incorporation of economic, social and cultural (ESC) rights, and the paradigm shift of the UNCRPD, which is the first international treaty explicitly to require inclusion.

As with the principles which currently operate, none of these on their own can provide an all-encompassing guide to what needs to happen in an individual situation. They need to be considered together, recognising that in some situations principles will pull in different directions and will need to be balanced against each other.

We anticipated that the legislation and Codes of Practice would set out in more detail how these principles should be given effect.

We suggested that the proposed principles encompass and expand most, if not all, of the Millan principles in the Mental Health Act and were also more easily able to accommodate the incorporation of economic, social and cultural rights.

We also consulted on retaining the principles of respect for carers, reciprocity, and a specific principle concerning the rights of children.

3.2.2: What people told us

There was considerable support for the general intent behind the proposed principles. SASW commented that: ‘Respect for dignity and autonomy and supporting the right for inclusion and equality are all fundamental values in social work practice.’ The Royal Society of Edinburgh praised ‘the intention to adopt the four core principles from the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) within the legislation’.

ENABLE said: ‘We agree with the four core principles set out within the consultation, and the ambition to incorporate international human rights treaties including UNCRPD into Scots law. ENABLE has a particular interest in the principle of Inclusion, and notes that significant progress remains to be made in delivering the right to independent living.’

Mental Health Network Greater Glasgow gave a detailed response on the four principles which included the following points:

Dignity: ‘being treated with ‘dignity and respect’ is critical to a positive experience of receiving mental health treatment and support and…is central to more effective engagement in the care process which then better reflects the care needs of the person receiving care…a framework that explores this dimension of the care process should be a central part of how we evaluate our mental health services’

Autonomy: ‘the treatment and support offered by our mental health services is often provided by staff who either do not know the person being treated or who don’t have any knowledge of them as a well person…the people receiving treatment often have strong opinions about their experiences of mental health care and their treatment…we have people who have no personal knowledge of a person, treating a person who lacks capacity and without any prior relationship or systematic support to assist the process. This happens every day…and we cannot help but wonder how many negative experiences within our mental health system could have been avoided by recording a patient's opinions about their care and enabling a dialogue with them.'

Inclusion: 'we absolutely agree with the right "to be included regardless of a label.' We feel that it is absolutely necessary that people have the right "to participate not just in their care and treatment, but in wider society – to have meaningful access to independent living, to fulfilling work, to friendships and social connections, to culture and creativity.'

Several responses were supportive but highlighted that principles on their own were insufficient. Support in Mind 'particularly welcomes enshrining the principles for reformed mental health law on principles already established in the UNCRPD… however, it must be ensured that people coming into contact with reformed mental health law know exactly what their rights are, what they mean for them, and how to use them.'

Age Concern commented: 'The principles in themselves are clear and focussed on a person's human rights so that they can be supported to live well and enjoy their lives without stigma or prejudice. We agree that with these changes the human rights of people with mental or intellectual disability will be better protected, respected and fulfilled. There is a question, though, about how this can all be properly and effectively resourced.'

At the same time, there was widespread support for the current principles – and several responses felt that these were easier to understand and apply in practice than the proposed new principles.

A local authority said: 'Removing the current principles e.g. benefit and least restrictive could result in individuals rights being infringed. The proposed principles seem more generic and less clear than existing principles.' Glasgow City Council said: ‘Some respondents were concerned that there was a lack of clarity in the 4 proposed principles contained within the Review Paper as compared to those within the 2003 Act.’

The MWC ‘welcomes the principles described- we particularly note a principle of inclusion. There are some questions however as to how these broad principles might be evaluated. We are aware of the widespread support and clarity that the current “Millan principles” retain within the landscape even though our own work shows that these are not always fulfilled.’

Individual 15 said: ‘I agree that there are benefits to including non-discrimination, dignity and respect more specifically - to do so also aligns law more with the professional value base of social work which in my view are excellent and of benefit to service users. However, I have been a Mental Health Officer since 2001 and have always felt that the principle of reciprocity is extremely helpful when considering interventions particularly. I am also against reducing the existing principles of the 2003 Act as set out. I have always felt that they provide excellent guidance. Furthermore, having worked as a Mental Health Officer under the 1984 Act too when there were no principles, I am against the proposal that principles should form guidance. They must remain enshrined in law.’

COSLA were sceptical of the value of seeking to summarise principles from human rights instruments, saying: ‘As there is already the intention to incorporate internationally recognised human rights directly into domestic law it is unclear whether these additional principles add value or cause confusion.’ In contrast, SHRC commented: ‘…the Human Rights Bill may seek to explore the concept of “dignity” as a founding principle to the delivery of human rights. The principles of both pieces of legislation should be developed in tandem to ensure cohesion. With regard to mental health law, dignity could be developed to encompass the protective aspects of CRPD, where, for example, positive action is required to prevent a person from suffering ill-treatment.’

The Law Society of Scotland highlighted the need to address the private law aspects of capacity law: '…complementing these essentially public law principles should be retention and enhancement of existing principles applicable to private law aspects of the relevant statutes, updated to comply with the recommendations of the Three Jurisdictions Report and our previous recommendations.'

We discuss below responses to our question about retaining the existing principles of reciprocity, respect for carers and child welfare. All of these attracted widespread support.

Reciprocity

In our consultation we said we were also considering whether **reciprocity** should remain as a feature of mental health law. The Millan report (chapter 3) defined this principle as follows:

> 'Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.'

There was widespread and strong support for the retention of the principle, from the MWC, professional groupings including the Royal College of Psychiatrists, the Forensic Network, the British Psychological Society and the Scottish Association of Social Workers, and user led groups such as the Greater Glasgow Mental Health Network who said:

> 'We feel that the retention and strengthening of this principle is hugely important. We would advocate for an explicit recognition that for every restriction there has to be a system to scrutinise, manage and minimise the restriction whilst it is in effect, promote engagement throughout the period but also ensure that the person subsequently becomes entitled to supported

> decision making support to manage and minimise any future restriction, i.e. learning from an episode of ill-health with support to plan preventatively against any future episode of mental ill-health and/or loss of capacity.'

Several respondents argued that principles from Millan such as reciprocity and 'least restrictive alternative' were clearer and more specific than the four new duties we proposed. 12 out of the 14 respondents who expressed a view were in favour of its retention.

The British Psychological Society highlighted the evidence base for the psychological treatment of psychosis spectrum disorders. This implies that, for example, long-term use of community-based compulsion for individuals who receive depot injections may not be reciprocal without access to psychological therapy if this would benefit the individual.

There was however criticism from two respondents that the principle was of limited value. People First said that the principle of reciprocity has never been properly applied to people with intellectual impairments, because there was no 'treatment' to cure intellectual impairment and therefore the object of detention was not a benefit to the person but to limit the perceived threat to the community.

Thrive Edinburgh said: 'One group member criticised the concept of "reciprocity", with its central idea of restricting people's liberty and human rights, but them at least getting something in return, as a sort of unwelcome "bargain" and bonus prize. It arguably creates a perverse incentive to detain and coerce, because that is what is seen to unlock help and support in the current system.'

We understand the concern but are doubtful that reciprocity as it is currently provided for in the Mental Health Act creates an incentive to detain. We are aware of concerns in England and Wales that detention is sometimes used to ensure a person receives treatment which otherwise would not be provided, but we do not believe that this risk in itself is a compelling argument against a principle of reciprocity.

We have concluded that we should include a principle of reciprocity in the new law. The Code of Practice should give guidance on how the principle should be interpreted and applied, including the need to minimise any harm to human rights, remove barriers and reflect to the maximum possible degree with the will and preferences of the individual.

However, given the proposals we make in this report to ensure that **everyone** has access to the support they need, through the Human rights enablement approach, it is legitimate to ask: what more do we owe to people subject to compulsion, and why?

Part of the answer can be found in the 2019 ECHR case of Rooman v Belgium which stressed that the lawfulness of detention on the grounds of mental disorder depended on the availability of suitable care and treatment:

> ‘Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition.’ (para 208)

As we set out in chapter 11, we propose that the Mental Health Tribunal should have stronger powers to ensure that anyone subject to compulsion is getting the support they need – and to ensure that compulsion is not being sought because of a failure to provide support which could have avoided it. We also believe a duty of reciprocity should apply directly to the public bodies which are (or should be) providing care and support during and after compulsion. The HRE framework set out in chapter 8 should facilitate that.

Although the current principle of reciprocity is widely supported, it is striking that there is little in either the Mental Health Act or the Code of Practice to define what the duty is. The Millan Report talked of ‘an obligation to provide safe and appropriate services, including ongoing care following discharge from compulsion’. We think this could be updated and expanded.

One response from a mental health officer highlighted the social work value base ‘centred around citizenship and reciprocity and which is relationship based as opposed to treatment based’. In line with our wider principles of dignity and autonomy, we believe the duty should not just be about services, but about understanding what the person values most and prioritising that for them.

There are complexities in considering reciprocity within capacity law, since attorneys and guardians (or decision-making representatives) are often private citizens, not part of the State, and so it is not clear how duties to provide support could be imposed on them. However, we do believe that any deprivation of liberty involving the State, including paying for private residential care, should attract the reciprocity duty.

Respect for carers

In the 2003 Act, section 1(6) provides that anyone discharging functions under the Act (other than making a decision about medical treatment) shall have regard to the relevant needs and circumstances of any unpaid carer and the importance of providing information to the carer to assist the carer to care for the person in need of care.

The four new principles we proposed did not specifically address unpaid carers, and we asked if we needed to include a specific principle regarding them. We found very strong support for this.

The Carers Trust, on behalf of the National Carer Organisations were supportive of the approach of the new principles, saying:

> ‘Moving away from the current paternalistic approach taken around mental disorder/disability can only be a good thing and moves Scotland into new era of human rights-based services which enable rather than disable people. Taking such approach can be of great benefit to unpaid carers, as it puts them as part

> of the team around the person that they care for, rather than someone who picks up the pieces once services withdraw or when the cared for person is discharged from a service.'

But they argued very strongly that it was also important to retain a specific principle of respect for carers:

> 'Without this it was felt that those working under the auspices of the pieces of law being discussed could simply overlook unpaid carers and have no regard to their views. One comment provided but echoed throughout our consultation exercises was: "without recognition at the outset of the law we are just consigned to the background. This would be a disastrous step back at a time when we are, to some extent, given a voice when the person being cared for is under the Act."'

There was similar strong support from other groups including VOCAL and SCLD.

It was suggested that the link should be made with the Carers (Scotland) Act 2016, which places a statutory duty on local authorities, NHS and other agencies to involve unpaid carers and respect their views. The Mental Health Workers Forum suggested that, instead of just talking about 'respect' for carers, wording such as 'engagement' or 'involvement' should be used to align with the Carers (Scotland) Act.

Children

We discuss in Chapter 12 the 'child welfare' principle, and set out our view that we should retain such a principle, linked to the requirements of the UN Convention on the Rights of the Child.

3.2.3: Our final recommendations

We have concluded that we should retain a detailed set of principles drawing on the existing principles of mental health, capacity and adult support and protection law, including autonomy, respect for carers and a principle reflecting children’s rights. These should be updated to give a stronger focus on respect for the autonomy of the individual, and to include principles of dignity and inclusion which should guide the positive duties we propose for public bodies.

We have recommended a set of principles which could be applied across mental health and capacity law, and could inform aligned or unified legislation. These draw on the existing principles and the wording of the principles in the UNCRPD. Some of these principles are intended to apply to any actions taken under the Act, including the duties of public bodies to respect Economic, Social and Cultural Rights. Others are specifically directed at situations where it may be felt that the person lacks Autonomous decision making ability, and some kind of intervention may be required.

In the recommendations below we suggest draft wording, but the final wording should be agreed following full engagement with people with lived experience including unpaid carers and those who would be required to have regard to the principles.

Adult Support and Protection (Scotland) Act 2007

There was broad agreement on the desirability of generally consistent principles across mental health, capacity and adult support and protection law, but there are particular nuances that have to be considered with the ASP Act, We consider these in more detail in Chapter 14 but overall we recommend a move towards consistency of principles.

AWI Act – intermediate recommendation

We anticipate that our complete agenda for legislative reforms legislation will take several years to develop. In the meantime, urgent reforms are needed to the AWI

Act. If these are brought forward ahead of any more radical alignment, we propose some updating of the AWI principles, drawing on the recommendations of the Three Jurisdictions Report, highlighted by the Law Society of Scotland. Detail on this and additional proposals for reform of AWI are provided in Chapter 13.

Chapter 3: recommendations

3.2.4: Fusion or unified legislation

Recommendation 3.1: Fused, or unified, mental health and capacity legislation should be the ultimate long term goal in Scotland.

Recommendation 3.2: To support the above recommendation, active steps should be taken to align existing mental health, capacity and adult support and protection law. Such alignment will require the Scottish Government to:

- **work with professionals and people with lived experience, including unpaid carers, to overcome barriers and misunderstanding regarding information sharing.**

- **move towards a joint set of principles across all 3 Acts.**

- **develop the Human rights enablement approach, Supported decision making and Autonomous decision making systems across all 3 Acts.**

- **expand the jurisdiction of the Mental Health Tribunal for Scotland to include capacity cases, including sustained and appropriate resourcing to accompany this extended remit of the Mental Health Tribunal for Scotland.**

3.2.5: Principles

Recommendation 3.3: Future mental health, capacity and adult support and protection law should expressly provide that anyone discharging a function under it should have regard to the following principles:

1. **Dignity: The importance of respecting the inherent dignity of any individual who may seek or be offered support for a mental or intellectual disability.**

2. **Inclusion: The importance of facilitating full and effective participation and inclusion of people with a mental or intellectual disability in society and in all decisions affecting them individually and collectively.**

3. **Autonomy: Respect for the individual autonomy of people with a mental or intellectual disability, and their will and preferences including past and present wishes. This should include the freedom to make one's own choices.**

4. **Equality: Respect for difference, and acceptance of people with a mental or intellectual disability as part of human diversity and humanity who retain the same rights and entitlements as those with other health needs.**

5. **Non-discrimination: The need to avoid discrimination on the basis of disability or any other characteristic, including age, gender, sex, sexual orientation, religious persuasion, racial origin, ethnic group and cultural and linguistic heritage.**

6. **Respect for carers: Consider the needs of anyone who is a carer (as defined in the Carers (Scotland) Act 2016 and the importance of providing them with such information as may assist them to care for the individual and engaging with any unpaid carer in the care planning process, where this is practicable to do so.**

7. **Respect for the rights of the child: Any interventions concerning a person aged under 18 shall respect the rights of that person under the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities. (see also chapter 12)**

For non-consensual treatment

Anyone considering or making an intervention with a person who has not consented or may be unable to autonomously consent to that intervention shall have regard to the following principles:

8. **Benefit: The intervention must provide benefit to the person which could not reasonably be provided otherwise and which can be justified with respect to the human rights of the person overall.**

9. **Least restrictive alternative: The intervention is the least restrictive alternative of the options likely to fulfil the aims of the intervention.**

In addition, the following principle shall apply to the NHS and any local authority or other agency defined in regulations who may have powers or responsibilities to provide care, treatment or support to the person:

10. **Reciprocity: Where an individual is required under the legislation to comply with a programme of treatment and care, there shall be a parallel obligation on health and social care authorities to provide suitable care and support, including, but not restricted to, after compulsion.**

Chapter 4: Supported decision making

4.1:Introduction

As has already been stated, the aim of this Review is to recommend changes to mental health and capacity legislation that will embed human rights and the rights set out in UNCRPD.

Traditionally these laws have turned on the basis of whether a person has the capacity to make decisions or not, with decisions for persons found to lack capacity made by others, sometimes without reference to the person.

The UNCRPD has provided an impetus for a shift in how states respond to disability rights. Fundamental to this is Article 12 UNCRPD which asserts the right of disabled people to equal recognition before the law and requires states to take appropriate steps to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

In the UNCRPD context, support for the exercise of legal capacity means providing support for a person to put their decisions into effect and can include support to challenge barriers that disable the person. The term ‘supported decision making’ (SDM) has been interpreted in different ways (Martin et al, 2016). However, for the purposes of this report, we shall refer to ‘supported decision making’ as including support for the exercise of legal capacity. This therefore encompasses support that helps a person to form a view about what they want to happen and how to make that happen so that it has legal effect. This is vital if people are to participate on an equal footing with others, in decisions about their lives.

Supported decision making starts from the premise that everyone, including those who may have decision-making challenges, has a right to make decisions for themselves. The decision maker should be at the centre of the process, with respect given for their autonomy.

The current framework in mental health and incapacity law in Scotland focuses in the main on protecting individuals with mental disorder from unnecessary intrusions in their life. However, there is sometimes limited acknowledgment of the need to recognise a person's rights, will and preferences. This needs to change and a fundamental part of that change is the development of a comprehensive regime of Supported decision making which should apply in all situations.

To date, there have been a number of initiatives established within Scotland to support greater autonomy for people using health and care services, including the Realistic Medicine initiative, legislation for self-directed support, anticipatory care planning, recognition of advance statements, powers of attorney and independent advocacy provision.

These approaches have had significant benefits but are sometimes limited in scope and not always successful. We are aware of a willingness on the part of many to develop these schemes. Engagement and participation are essential approaches that give effect to human rights and create genuine partnerships between people with lived experience, unpaid carers and practitioners that can lead to the best outcomes for people. Without proper resourcing and support however, it becomes an almost impossible challenge.

Research and evaluation of various forms of Supported decision making is also developing but is currently far from comprehensive.

4.1.1: Position of UNCRPD

The Committee on the Rights of Persons with Disabilities has made it clear that they consider Supported decision making should replace substitute decision making arrangements as these are discriminatory and deny the equal enjoyment of the right of persons to exercise legal capacity (Committee on the Rights of Persons with Disabilities, 2014). The Committee has indicated that this is because the basis upon which substituted decision-making is permitted is often based on biases and misconceptions about a person’s ability to make valid decisions because they have a diagnosis of mental disability and/or actual or perceived related impairment.

We have noted the Committee’s position and consider that for now, in Scotland, there remains a need for non-consensual interventions and treatment and these should be provided in law. However, we consider that it is imperative that the person’s voice is heard even in those situations. This position is considered in detail in Chapter 9 of this report. It is informed by consideration of a range of views including the voices of lived experience, which are far from unanimous on this issue.

4.2: Will and preferences

The use of SDM allows for the individual's views to be given effect to the extent that this would occur with others without disabilities. Where meaningful communication is genuinely impossible the UNCRPD Committee recognises that SDM does include the ability for others to make a non-discriminatory best interpretation of the person's will and preferences (Committee on the Rights of Persons with Disabilities, 2014).

It is important to understand that this interpretation is something which is different to a “best interests” decision. A best interests approach can be seen as paternalistic, with a sense of someone else knowing what is better for an individual than they do themselves. A best interpretation of a person’s will and preferences is an attempt to reflect what that person would actually want themselves in those circumstances.

A best interpretation of a person’s will and preferences should be based on information gathered from those known to the individual and should consider the person's values, beliefs and past expressions of will and preferences. Consideration also needs to be given to how the views of others impacted by the decisions taken can and/or should be taken into account. As is the case for everyone, rarely is a decision made that only impacts one person.

A person’s will and preferences combine a longer-term sense of what a person is trying to achieve in their life with what they prefer to happen more immediately. For example, a young person may want to live independently. This is their will for the long term, their immediate preference is to move out of their parents’ house.

However, will and preferences may not always be the same, in which case judgement would need to be exercised in the supported decision-making process as to which should be given priority. Whilst there is inevitably some debate about whether this in effect amounts to substitute decision making by another name, this does potentially allow for decisions to be made in many challenging situations.

In crisis situations it might also include taking steps to provide a “breathing” or safe space in which to address the causes of a person's mental distress and to ascertain their genuine will and preferences. This to some extent should address anxieties around having to give effect to an individual's wishes expressed in times of acute emergency.

This is the kind of tricky balancing act that can sometimes be required in SDM, which is why it can be time consuming and resource intensive. But if the Scottish Government is truly committed to developing a human rights-based system placing a person’s rights at the centre then resource is needed to develop Supported decision making and embed it fully in mental health , capacity and adult support and protection law and practice.

4.3: Existing practice

It is important to remember that much of what we are thinking of when we refer to SDM is not some new special thing which is different from everything done before, but an approach which encompasses a whole range of ways of operating, some of which are well established and some of which are newer. SDM can start with just the way a conversation is conducted, taking down barriers to ensure all parties are comfortable and can understand the discussion.

We have heard from many in our consultation that Supported decision making is already built into their work. Powers of Attorney, advocacy, advance statements all contribute to enabling people to have their voices heard and it is undoubtedly the case that part of the focus on a supported decision scheme must be aimed at improving existing practices, making them easier to engage with. But in its response to our March 2022 consultation the Mental Welfare Commission indicated that data it has collected demonstrated that the current legislation's promise regarding advocacy and advance statements has not delivered and there is a need for change to ensure that options are offered and acted on.

The UNCRPD Committee in its General Comment Number 1 refers to Supported decision making in relation to the legal right of persons with mental disabilities to access support for the exercise of their legal agency (Committee on the Rights of Persons with Disabilities, 2014). It sets out some informal and formal means by which support may be provided.

These include:

- Support from one or more trusted persons, peer support and independent advocacy

- Assistance with communication as appropriate to the needs of the individual, particularly for those who use non-verbal forms of communication to express their will and preferences

- Advance care planning – including providing support to a person to complete an advance planning process.

- Specialist support in legal and administrative proceedings

- Communities and support (collective advocacy)

We think there needs to be a common understanding of Supported decision making (SDM) rights and principles. It is a relatively new field of international practice which is not always done in the same way in different countries. The way ahead is considered in the reminder of this chapter.

We are proposing a new framework which includes enabling respect for human rights, Human Rights Enablement (HRE) (see Chapter 8). This framework will also include Supported Decision Making (SDM) to ensure focus on respect for the will and preferences of people with mental or intellectual disability. It will also include an Autonomous Decision Making (ADM) test to allow for non – consensual intervention in situations when this is necessary to protect the person's or others' rights.

Collectively these elements of the framework will:

- Ensure and protect the rights of persons with mental or intellectual disability; and
- Ensure that persons with mental or intellectual disability receive appropriate support at the right time (whether in an emergency or non-emergency); and
- Ensure that the rights of others are also protected.

Chapter 8 of this report details the recommendations for the HRE and ADM in detail but central to this is the SDM regime which will keep the focus on respect for the will and preferences of people with mental or intellectual disability in ways that are not done at present. Its purpose is to ensure that the person's will and preferences are heard and given effect on an equal basis with others even at times when the person is unable to express such will and preferences. The intention is that a finding of incapacity or SIDMA will no longer potentially result in the person's will and preferences being disregarded.

4.3.1: What people told us

In our March 2022 consultation, we asked for views on a wide-ranging supported decision-making scheme, based on the model proposed by UNCRPD, how it might be taken forward, including whether a Centre of Excellence might be an option, what the barriers would be to such a scheme, and how we might mitigate against undue pressure. We also asked if there should be legal duties on public bodies to secure SDM for people who need it.

In a smaller consultation in May 2022, we asked about independent advocacy and advance statements. We have also carried out work around named persons and had the benefit of research conducted by Edinburgh Napier University and Queen's University Belfast on the views and experiences of patients, named persons, practitioners and Mental Health Tribunal for Scotland panel members of the Mental Health Tribunal for Scotland (Stavert, Brown and McDonald, 2022).

As mentioned earlier in this chapter, responses to the consultations were very much in favour of a wide-ranging supported decision-making scheme.

The Scottish Human Rights Commission told us, echoing the views of many,

> 'The realisation of supported decision making is at the centre of compliance with Article 12 of CRPD. We agree that what is required is the development of a comprehensive regime of supported decision making, which should apply in all situations and especially where non-consensual interventions and treatment are being considered.'

There was a general feeling that a focus on SDM should be fundamental. There was a wide consensus that we need to find better ways to support people to make decisions.' -VOX

Individuals spoke of feeling powerless. One individual summed up the feelings of many saying ‘there were lots of conversations about me, but not with me’. Proper Supported decision making should stop this happening.

The challenges lie not in the concept of a SDM scheme, but how it might be carried out and resourced. There were concerns that, in the current constrained times, SDM is seen as aspirational. We heard from many that individuals' views can get lost amongst the need to prioritise limited resources. Comments were made by several individuals that there was a lack of accessible information available to enable them to make informed choices about their care and treatment, particularly under the 2003 Act.

Many expressed concerns about the practicalities of the scheme. There was a sense that an evolutionary rather than a revolutionary approach was needed, building on existing good practice, with core tools, a consistency of approach, provision of adequate resources, and clarity as to who would lead on this.

The main concern lay around resourcing – people, time and training and funds all need to be in place to progress this.

> ‘There is widespread support across the sector for mechanisms to increase an individual’s voice…..however this can take time to invest in relationships and there is often a lack of resource to ensure that options are available.’ Mental Welfare Commission

> ‘The benefits of these recommendations can only be fully realised if services are sufficiently funded to meet the needs of all service users.’ - Equality and Human Rights Commission

In addition, however, a substantial number of responses mentioned the need for culture change. It was striking how many of the user led organisations said that misplaced perceptions about their ability to make decisions would be a barrier to a successful scheme:

> ‘[another barrier is] the widely held belief that we are, by virtue of our intellectual impairment incapable of making our own decisions.’ - People First Scotland

Practitioners too spoke of the need for a shift in culture and approach:

> ‘Group members also recognised the cultural shift towards viewing decision making as being located with the person regardless of their autonomy as being necessary and substantial.’- Midlothian Health and Social Care Partnership

The challenges around the actual delivery of Supported decision making were addressed by many too. Consideration therefore needs to be given as to how to address the common situations where a person’s will and preferences are highly variable or inconsistent. And the need for adaptability was highlighted:

> ‘If the SDM model is to be utilised as part of a revised legal framework in Scotland then careful consideration needs to be given to its applicability to all areas of clinical practice and to a broad range of clinical scenarios. Due attention should be given to disadvantages as well as advantages, and consideration of potential modifications and refinements in certain situations.’
> - Royal College of Psychiatrists

4.4: How do we take Supported decision making forward?

We asked how SDM should be taken forward, what needs to be in place to make it happen. We also asked if there was a need for some form of centre of excellence to promote and develop SDM.

Many recommended clear commitment on the part of government and leadership at a national level:

> ‘Changes in law must be accompanied by strong rights and attributable duties. This means the Scottish Government must make it clear which bodies have oversight and responsibility for this scheme.’ - the Challenging Behaviour Foundation.

> ‘Supported decision making needs to be explicitly built into processes, with duties attached and the scrutiny of the performance of those duties made more robust… It must be clear where accountability lies for ensuring that an appropriate level of supported decision making has been provided.. the intention to provide SDM requires to be backed up by an attributable duty and to require evidence of it being performed.’ - Individual response

As well as a robust evidence base of what works with SDM for different people at different times training is also essential in order for SDM to be taken forward. Across all professions, this needs to be embedded from the outset and to sit alongside HRE. To ensure that rights are protected, it is essential that we have a workforce equipped to recognise changes in a person’s ability to make decisions and at which point additional support may be needed to enable a person to be involved in decisions about their lives.

As already mentioned, the need for adequate resourcing was highlighted by many. There were concerns that, as there is not enough resource in the current system to enable practitioners to engage in a human rights approach across existing legal frameworks, how can additional expectations be implemented unless significant additional resource is provided.

There was limited enthusiasm for a Centre of Excellence to develop and promote SDM. It was, however, considered by many that someone does need to hold this leadership role and the Scottish Government must give consideration to this. Without a central point of development, promotion and oversight, the practice will be left to services to develop, as is currently the case. This has led to patchy implementation and lack of awareness of the range of help available by both persons needing support and potential supporters.

Most importantly, however, is the need for SDM to be developed in true partnership with those who will use and benefit from the SDM scheme at all levels:

> ‘The scheme should be taken forward with involvement of people with lived experience and their carers and supporters. It should be reviewed in a year to establish what has been working on the ground and what has not.’ - Support in Mind Scotland.
>
> ‘The SDM scheme must be taken forward in partnership with those of us who will benefit from the scheme. We cannot emphasise enough the importance of lived experience participation, ideally in a leading role’ - People First .

4.4.1: Undue influence

This concept goes to the heart of the authenticity and voluntariness of a person’s ability to make decisions. When making decisions, we are all influenced to a certain extent by the views of others and by our circumstances. The influence of others can often be positive and facilitate decision-making but we need to be alert to occasions when a boundary has been crossed and the influence has become malign - overbearing, interfering, or even bullying. The identification of undue influence and managing situations where this might, and does, arise is important. Codes of practice and guidance must cover this.

One may consider influence “undue” when it mainly, or entirely, benefits the person providing the support and not the person being supported.

We asked for views on how to mitigate against the risk of this in SDM generally. It was pointed out by many that adult support and protection considers undue influence in practice and there is much to learn from social work in this area.

> ‘The reflective skills and self-management expertise of social workers are hugely important in supporting and understanding individuals within their own context. Expectations exist within other legislation…that require social workers to assess for undue pressure on an individual.’ - Scottish Association of Social Work

People also mentioned the need for independent provision of support and appropriate guidance for all those taking on a supporter role. Many mentioned the need to distinguish between an individual unduly pressurising someone and the situation where a practitioners or systems might unduly influence a person’s choices and decisions.

Respondents also mentioned the need to support communication, and make reasonable adjustments to ensure effective communication, so that undue influence can be identified in situations where there are difficulties in communication. It is clear that the skills of speech and language therapists cannot be underestimated here.

It was also suggested that the support of an independent advocate would help to mitigate against undue influence.

4.4.2: Conflicts of interest

Similarly, conflicts of interest may adversely impact on the authenticity and voluntariness of a person's ability to make decisions. In general, the existence of a conflict of interest is not necessarily harmful to a person but where it is clear that it will, or is likely to, influence a person to their detriment then it is harmful. A person may, for example, ask a family member, to assist them with their decision-making but that family member is a beneficiary in the person's Will. That family member may be best placed to support the person to make a decision and give it effect, and indeed has been chosen by the person to do so, and will do so with the predominant intention of giving supporting to give effect to the person's rights, will and preferences in the matter, although they may also benefit from the decision. This would only be of concern where only the family member is likely to benefit or benefit far more than the person from the decision.

It would be unrealistic to require that SDM can only be delivered in the absence of conflicts of interest. Indeed, Article 12(4) UNCRPD does not require this. However, it is vital, if SDM is to result in a genuine reflection of the person's rights, will and preferences, to provide that safeguards are in place to identify and manage conflicts of interest.

4.4.3: What types of support are needed ?

We asked in the Consultation about several types of support broadly based on the framework set out by the UNCRPD and how these might be developed. These are advance statements, powers of attorney, decision-making supporters, independent advocacy, specialist support in legal settings, named persons, curators and safeguarders and assistance in communication.

4.5: Advance statements

4.5.1: Mental Health Law

Advance statements (AS) in sections 275-276C of the Mental Health (Care and Treatment) (Scotland) Act 2003 are a means by which a patient may set out the way in which they wish to be treated, or treatment they do not want, for their mental health condition. In our consultations we proposed that it should be made easier to make an advance statement and that they should be integrated with other forms of advance planning.

The current system of advance statements has been criticised for a number of reasons including:

- AS remain relatively little used: MWC research in 2021 found that only 6.6% of patients whose T3 certificate (involuntary treatment under a Compulsory Treatment Order (CTO)), was reviewed had an advance statement.
- There is a lack of awareness. Although Health Boards were given a new duty in 2015 to promote Advance Statements, this appears to have had limited impact. There is, however, a much higher uptake of AS in forensic mental health services, according to MWC research.
- AS have legal status but may not be regarded as having sufficient weight. They can be overridden by a doctor or Mental Health Tribunal. The reasons for doing so must be recorded and can be reviewed by the MWC but this may be seen as of limited value, particularly if the person wants to make an advance statement because they are not confident the doctor will pay sufficient regard to their wishes. The Act does not specify the grounds on which it would be reasonable to override an AS.
- Despite this limited effect, making an advance statement is a relatively formal process. It must be signed and witnessed by a qualified person who certifies that the signer had capacity to make the statement.
- An AS is limited in its application. It only operates in respect of treatment under the 2003 Act – i.e. treatment for mental disorder when the patient is subject to compulsion under that Act (e.g. subject to a CTO or Short-term Detention Certificate). It does not apply to treatment as an informal patient, treatment under the Adults with Incapacity Act, or any wider issues which a person may wish to make provision for.
- Sometimes practitioners don’t know an AS exists, despite the existence since 2015 of a statutory register.

- The quality of an AS is perceived to have a bearing on how mental health professionals respond to it. But there are few templates or systematic processes within health and social care to support people to make an effective advance statement.

- People may be anxious that past wishes, expressed in an AS may overrule current wishes, when their current view on the care and treatment proposed is the more relevant.

People told us in our May 2022 Consultation that the current system is not working well. Comments from individuals included 'the current system is a farce and needs up dating ' and 'I am not surprised advance statements are not widely used because they can be overridden with little justification or challenge'.

The Equality and Human Rights Commission said:

> 'Our concerns …– low prevalence stemming from lack of awareness and understanding of the process, confusion over what should be included, lack of belief that the advance statement will be upheld., and difficulty in contemplating being unwell once in recovery .. we also share the Review's concerns around the ease of overriding and limited application'.

4.5.2: Incapacity law

The AWI Act makes no reference to advance choices. The Scottish Law Commission's 1995 report on Incapable Adults recommended provision for advance directives in relation to medical treatment, but this was not taken forwarded in the 2000 Act.

This has left considerable uncertainty in the law – many commentators believe that an advance directive in relation to medical treatment may have legal effect in Scotland, but no-one can be sure. Subsequently England and Wales legislated for Advance Decisions to Refuse Treatment (ADRTs) in the Mental Capacity Act 2005.

In 2009, the Council of Europe agreed ‘Principles concerning continuing powers of attorney and advance directives for incapacity’ which recommends that ‘States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives.’

The Law Society of Scotland recently reviewed the law in this area and concluded that the Scottish Parliament should make ‘clear and comprehensive legislative provision’ in respect of advance choices.

The independent review of learning disability and autism in the Mental Health Act (Rome Review) recommended that a statement of rights, will and preferences should replace the advance statement in the 2003 Act for persons with learning disabilities or autistic persons. We believe this should apply to all persons who wish to make provision for their futures involving mental health or capacity legislation.

4.5.3: Proposed changes

Our May 2022 Consultation suggested that we follow the Rome proposals and replace advance statements with a Statement of Rights, Will and Preference (SWAP). This would be a new model to address the limitations of the current system. We suggested that there should be consistency between advance decision-making in relation to treatment for mental illness and other medical decisions and the proposed SWAP could extend to all forms of advance choice. But this is a complex, sensitive, area and detailed consultation would be required to progress this.

We proposed that a SWAP

- could have wider application than medical treatment ,
- should apply to any support , care or treatment the person may need across all areas of their life
- could be varied in the extent to which advance choices could be binding

- would have more ‘teeth’ than the current ‘advance statement’, in terms of its legal effect.

However, we did not propose that a SWAP should be legally binding in every case. We are mindful that situations can be complex and that there will be situations where a SWAP should not be followed. Clarity would be needed about the justifications for not following a SWAP and who should decide if one of those justifications has been made out. Such decisions must be informed by the principles of law and the person’s human rights. It should not be the case that the clinician’s view on what is best for the person receiving care and treatment is the most important factor.

We also proposed that:

- a SWAP should be authenticated by someone qualified to certify that the person was able to make an autonomous decision in respect of the SWAP;

- the Mental Welfare Commission should retain a register of SWAPs and hold monitoring and reporting duties;

- SWAPs should be developed with care and time, and support given by advocacy workers, lawyers, peer support workers etc;

- if given authority by the person, unpaid carers, family members, trusted people and clinicians should have input into the SWAP;

- the SWAP could be in audio, video or written form , should be regularly updated, and a person could have more than one.

In response to concerns about the way an advance statement can be overridden at present we proposed the following circumstances in which a SWAP could not be followed:

- the person has acted in a way which is inconsistent with their SWAP.

- the person’s will and preferences seems to be more pertinent than those expressed in an earlier SWAP.
- a position on the person’s will and preferences on a given matter cannot reasonably be concluded from matters included in the SWAP.
- there are reasonable grounds for believing that the person did not anticipate the circumstances at the time of making the SWAP which could have affected their decision.
- there is evidence the person’s Autonomous decision making was compromised when they made the SWAP.
- treatment which is inconsistent with the SWAP is necessary to save the life of the person who is receiving treatment or to prevent serious suffering on their part.

We also consider that the SWAP should remain valid even if an attorney is appointed with relevant powers but the granter of the SWAP or a judicial body may give the attorney express power to act in ways which may contradict the SWAP where they believe that to do so would better protect the person’s human rights overall.

If the model were to be extended to physical conditions, it would be necessary to decide if there are any kind of treatments which cannot be refused in advance, for example hydration, nutrition or pain relief.

Consideration also needs to be given to whether a SWAP can give advance consent to a treatment the individual may have refused at the time. The concept of advance consent has been advocated for people with conditions such as bipolar disorder, who may have an idea when they are becoming ill and would want early intervention to prevent their condition deteriorating.

We did not propose that an advance consent in a SWAP be legally binding but should be regarded as significant evidence which may support a decision that a person’s stated wishes at the time of treatment do not reflect a fully autonomous decision and might be overruled.

4.5.4: What people thought about our proposals

With wide acknowledgement that advance statements are not working as well as intended, individuals and organisations were broadly in favour of extending a new type of advance statement that would reach beyond the current model. However, there was concern that the proposed name and acronym ‘SWAP’ was not easy to understand and could be seen as simply rebadging. A number of people commented that it would have no more ‘teeth’ than the current anticipatory care planning process. The Royal College of Psychiatrists suggested that it may be preferable to strengthen the current anticipatory care planning process as an alternative. This view was also supported by the Royal College of Physicians.

The Law Society of Scotland commented:

> ‘“Advance choices” is a more accurate term for what sometimes otherwise described as advance directions. This chapter is too narrowly focused on healthcare matters, rather than addressing the Review’s full remit. Too narrowly focused on “wishes and feelings”, rather than the broader purposes of advance choices. Need to ‘future proof’ recommendations to take account of predictable developments over the minimum period of 2 decades which has hitherto separated comprehensive reforms of this area of law.’

Overall their response to our proposals was to go further and to link this work to their recommendations around advance choices and medical decision-making in intensive care situations.

Other mental health practitioners felt that although SWAP seems like a new process, it is not markedly different from advance statement processes and will not increase uptake unless fundamental issues around completion are addressed.

See Me however felt the new proposals were an improvement:

> ‘Currently, advance statements act as a guarantor for all other rights and we support the plans to improve these and increase their use. The SWAP proposed appears to be an improvement, in that it is wider ranging than just medical treatment. This could allow people to have meaningful input in a range of areas, preventing discrimination in areas people may currently experience it….In having more than one for different areas of life is also a proposal we support, as it can encourage a more person centred approach to health care.’

That the SWAP is informed by human rights, not just clinicians view is also important in protecting people from discrimination.’

The clarity around when a SWAP could be overruled was welcomed, but it was noted that,if a SWAP were to cover a wider area, other disciplines may need to be involved in decision-making.

Responses suggest that what is critical to making this work in practice is that SWAPs are updated frequently to capture any changes to a person’s views. It needs to be borne in mind that as well as people’s views changing over time medical treatment changes too .

The need to provide clarity around ‘advance consent’ was noted.

> ‘Need to preserve clarity around non-consensual interventions – In providing care for someone with impaired decision-making or incapacity, mental health care and treatment is fundamentally non-consensual, regardless of whether the person ‘consented’ prior to that situation. Rights and safeguards still need

> to be in place. If a barrier statement of will and preferences was considered advance consent then the person's rights may not receive appropriate scrutiny.' - Royal College of Psychiatrists

The need for the person making the statement to be fully informed about the circumstances in which it could be overruled was highlighted, as was the need for full support, time and space in which to make the SWAP in the first place. This in particular needs to be carefully considered to avoid current issues around low uptake and lack of understanding about advance statements .

The need for clarity as to who has oversight for setting up a SWAP was also pointed out, particularly if there is to be an option for more than one SWAP to be made by a person.

The need for the SWAP process to be accessible to all was also highlighted. In particular the British Deaf Association Scotland raised concerns about ensuring that barriers for deaf people have been considered.

The proposal for the Mental Welfare Commission to deal with conflicts arising from the use and interpretation of SWAPs was broadly welcomed although it was queried whether this would be appropriate if SWAPs extended beyond the area of mental health .

Overall, we conclude that there is a strong case for a stronger, comprehensive and holistic model of advance choice, in anticipation of the possibility of being unable to make an autonomous decision in future. This should encompass both treatment for mental or intellectual disability and physical conditions, and potentially other aspects of a person's life. We set out in our recommendations below a tentative model for how this would operate. These draw on existing models, such as the Advance Decisions to Refuse Treatment (ADRT) in the Mental Capacity Act 2005.

Many of the most contentious issues, such as refusing life-saving treatment for a physical condition, require further detailed consideration and a wider engagement than has been possible within the remit of our Review. But we agree with the Law Society of Scotland that it is no longer acceptable to leave the law in this area to the common law, which is unclear and which has not become clearer in the two decades since the Adults with Incapacity Act.

4.6: Powers of attorney

A power of attorney is a well-established means of ensuring an adult's will and preferences will be followed in the event that the adult loses the ability to make decisions for themselves. Our proposals for amending the current power of attorney scheme can be found in Chapter 13 alongside other recommendations deriving from the Adults with Incapacity legislation.

4.6.1: Decision making supporter

In our March 2022 consultation we outlined a new decision-making model to replace the current guardianship system. This included the creation of a decision-making supporter, moving away from the substitute decision making role guardians currently generally adopt. Our final recommendations for change around this can also be found in Chapter 13.

4.7: Independent advocacy

Independent advocacy (IA) is one of the methods of SDM recommended by the UNCRPD. In Scotland, IA seeks to speak up for and stand alongside individuals or groups, to help ensure an individual's rights are recognised, respected and secured. The role of IA is to support people to understand and navigate complex systems.(www.siaa.org). It helps empower people so they can have more control over their lives and, ideally, are able to make their own decisions. Independent advocates only do what has been agreed with the person or persons they are supporting.

The right to independent advocacy (IA) was an important aspect of the 2003 Act and has resulted in the development of a range of valuable advocacy services. However, we have heard that services are increasingly required to operate more narrowly than the 2003 Act intended As noted in the report from the Mental Welfare Commission: The Right to Advocacy - a review of advocacy planning across Scotland focus is often on support for legal processes like tribunals . A more holistic and accessible service , which could help to prevent crises happening is rarely available to those who might benefit from it.

Unpaid carers have also spoken of their need for IA in their role as carer as carers often go unsupported by IA. Sometimes they are able to access independent advocacy for their own mental health needs. However, this might not be available to them in their unpaid carer role because the advocacy organisation might not be funded to work with unpaid carers and organisations report it is not appropriate for unpaid carers and the person they care for to be supported by the same organisation.

Only around 5% of people who have a right to independent advocacy actually access it. There are several reasons for this:

- the lack of knowledge amongst people about what independent advocacy is, how it can benefit them, how to access it,
- the very limited levels of funding most independent advocacy organisations (IAO) receive,
- the different ‘levels’ of access that each piece of legislation grants,
- the lack of awareness or understanding of IA amongst Health & Social Care staff.

In our May 2022 Consultation we asked a number of questions about independent advocacy and how it could be developed. We proposed that the Scottish Government should consolidate and align all the different pieces of legislation and policy to ensure consistency regarding the definition of independent advocacy, the right to access this and how it is commissioned and funded.

We also asked how access to independent advocacy should be improved and whether there should be an opt out system so people have to actively choose not to have support from an independent advocate.

We proposed a Scotland wide qualification for paid and voluntary advocacy workers and the creation of a national register for advocacy workers. We also recommended that resource is provided for equality and diversity training for all independent advocacy workers, and support for independent advocacy organisations to have dedicated staff to work with specific groups they share a background with, and to work with groups facing particular barriers in Scottish society.

We proposed that an independent body should be created to evaluate independent advocacy organisations, and resource provided to collect data in a uniform way across Scotland

As funding of IA varies across the country we suggested a national fund for the provision of IA covering different areas of work. Finally, we considered that there is a need for robust scrutiny of IA organisations.

4.7.1: What people told us about Independent Advocacy and our proposals for change

The vast majority of people who responded to the consultation on independent advocacy agreed that there was a need to consolidate and align all the different pieces of legislation and policy around IA to ensure consistency, improve understanding of the role of IA and enable greater accessibility. This should include ensuring greater access to IA within Adult Support and Protection legislation where at present there is only an obligation on local authorities to consider the provision of IA, in contrast with the right of access to advocacy under the Mental Health Act.

> ‘Welcome and positive proposal which will reduce variation of provision across Scotland and when supported by a Code of Practice will promote provision that has consistency and efficacy.’ - Scottish Learning Disabilities Lead Nurse Group

> ‘The complexities and the volume of the legislation governing the use of independent advocacy make it challenging for individuals to understand. Independent advocacy is used, and referred to, in many different settings but the interpretation of what it is and its purpose varies greatly across those different settings. An effort to rationalise the legislation around independent advocacy to make it easier to understand and, consequently, more accessible would be an approach welcomed by SDWG and NDCAN’. (Scottish Dementia Working Group (SDWG) & National Dementia Carers Action Network (NDCAN)

The majority of people who responded to the question asking if IA should be provided on an opt out basis, as recommended in the Rome report, agreed. As one advocacy group said if someone is struggling with their mental health they may not have the capacity to understand the role of an independent advocate. And another said that by making it ‘opt out ‘ it will give an indication of what the true need actually is.

Of those who were not in favour of an opt out system, concern was expressed about possible reduction of choice over which agency might provide an opt out service, and the prospect of repeated referrals to an advocacy service. And there was a comment that the focus should be on raising awareness of IA rather than creating a new system which may in reality limit choice. We think however this needs further discussion and that in looking at the way IA is delivered, the Scottish Government should give consideration to an opt out system for IA.

On improving access to IA more generally, there were suggestions of having roles and duties of independent advocates set out in law, as well as a general public awareness raising campaign. There was also strong support for training about the role of an independent advocate for practitioners, so there is a greater awareness of the benefits an independent advocate can bring for a person in need of support with decision-making.

4.7.2: Who can be an independent advocate ?

There was a variety of views about who should be an independent advocate. People recognised the need for training but this needs to be balanced against the against the risk that an overly academic and formalised route might dissuade some people who might otherwise be very well suited to this role, including those already in post, paid or voluntary. There was a general agreement that Scotland wide qualification would be a positive step. But the variety of the role of an independent advocate across different settings would mean tailoring would be necessary.

The Law Society of Scotland was concerned that being too prescriptive about training might deter people who would make excellent advocates. “ there should be clear standards of induction and training that should be mandatory and stated as minimum requirements, with further requirements for ongoing training, and shared learning arrangements in which less experienced advocates can learn from those with greater experience.”

The Mental Welfare Commission said that although qualification is a good way to measure quality and consistency it could put people off, and a peer support framework training may be a good model to adopt. Others proposed vocational training with the option to work towards qualifications.

It was felt however that human rights and equality training should form the basis of any training for independent advocates. with persons with lived experience being involved in the training programme along with organisations that have expertise in working with people with communication needs.

On the question of a national register there was again broad support. It was felt this would help with quality, monitoring and protection issues. Such a register will offer a degree of protection to vulnerable individuals.

> ‘This will also be useful for the purposes of planning ahead for future service delivery and to identify gaps in services. High quality data collection is also necessary to facilitate good governance and accountability.’ (Scottish Dementia Working Group (SDWG) & National Dementia Carers Action Network (NDCAN)

The details of how a register would operate and who would be responsible for it , transitional issues and other matters were subject to a lot of debate, but we consider these issues should be worked through with practitioners and persons with lived experience.

Along with the creation of a register, we asked about evaluation and scrutiny of Independent advocacy. We suggested that an independent body be created by the Scottish Government with a remit to evaluate IA organisations , or responsibility given to an existing organisation to do this as well as resourcing being given to collect data in a uniform way across Scotland to inform the development of the service.

The vast majority of respondents were in agreement with a form of evaluation.

‘an evaluation body would be helpful in this regard to potentially drive services to boost uptake. By evidencing the effectiveness of independent advocacy it would ensure there is a clear case for investment by services in their roles and development.’ - Royal College of Psychiatrists.

There was, however, a sense that the landscape is already quite cluttered and the forthcoming creation of the National Care Service will add to that. Rather than create a separate body, preference was for this role to be given to an existing body with the most common suggestions being the Mental Welfare Commission, or the Care Inspectorate. There was also concern that the creation of a new body to take on this role would delay implementation.

As to the collection of data, again this garnered broad support with the types of data collection needing careful consideration – this has to be done correctly to have any success.

And, as with every aspect of this report, resourcing is a huge issue. At present IA services cannot meet the demand placed upon them. If demand increases without changes to funding then the situation will simply get worse.

We asked questions about changes to funding IA. Currently IA under mental health legislation is funded by local authorities . This is in contrast to the right to IA under social security legislation where the duty to fund IA sits with the SG. A clear funding and resource commitment from the SG was considered vital by many respondents.

We proposed a national fund be created for the provision of independent advocacy. Whilst a majority of those who answered this question were in favour of such a fund, this question was left unanswered by over half of the respondents to the consultation.

Those in favour felt a centrally funded and commissioned service might remove unequal levels of access across Scotland.

> ‘National fund could be one of the methods to ensure equity of fund division and access to services… A national fund allocation will ensure that the necessary amount is allocated to each HSCP to ensure that advocacy is delivered well and IA providers are well resourced and supported to complete their task successfully’. (An Advocacy organisation)

However many expressed concerns about how this might impact across the country. ‘Useful but concerns around how this would be administered given variance across the country in terms of demographics, geography etc. How would assurance be provided that equitable access was being provided? What would role of local authorities be?' (response from local authority)

And there were concerns about the loss of the strategic link between Health and Social Care Partnerships and IA organisations. More detail was requested on how a national fund might operate in practice and how it might remove unequal levels of access. But SAMH captured the views of many in saying:

> 'These proposals won't work without national funding. Any national fund should also promote advocacy. Access is limited because of lack of understanding of who, how, why and when someone can access advocacy. Often opportunity is missed by the most vulnerable.' (SAMH)

We also asked how diversity, equality and inclusion could be improved in independent advocacy. We proposed that resource be provided for diversity and equality training for all IA workers and support for IA organisations to have dedicated staff to work with specific groups they share a background with and to work with groups facing particular barriers in Scottish society.

The vast majority agreed on the importance of diversity and equality .

> 'It was expressed by some participants that there were indeed particular barriers faced by people from certain groups, such as ethnic minority groups, and dedicated advocacy workers for those groups, where cultural competence, language and access are considered, were seen as an important need.' - Vox Scotland

How this might be achieved was less clear. There was a majority view that accurate data collection would be helpful in targeting areas of need but some concern that, by requiring data to be collected ,we may be setting up organisations to fail if service users are reluctant to agree to data collection.

> ‘Enhancing advocacy staff skills to provide culturally appropriate services is essential; also in supporting those who are neurodiverse. Training should be available to ensure needs are met in relation to inclusion (e.g. provision of British Sign Language (BSL) and Talking Mats). Welfare rights and benefits training is important to support financial inclusion.’ (Care Inspectorate)

> ‘Research has established that marginalised groups who would have greatly benefited from independent advocacy are least likely to access it. Recommend that data must be broken down in to type of ‘mental disorder’ and protected characteristics in order to determine if certain groups are more or less likely to access independent advocacy, and if not will make it easier to determine why they are not being met and how to move forward.’ (Support in Mind Scotland)

4.7.3: Collective advocacy

Collective advocacy groups are groups of people with shared experiences who come together to try and improve issues that affect their lives. They are run by and for their members and are independent. They are not like the other methods of Supported decision making we mention here in that they do not take on individuals’ issues but identify and seek remedies to issues that are affecting more than one person, including influencing policy and practice in their area.

These groups are really important and the UNCRPD committee has said that governments need to strengthen the capacity of these groups. However because of the type of collective support that they offer, findings and recommendations around collective advocacy can be found in Chapter 11 of this report

4.8: Aids to communication

Assistance with communication as appropriate to the needs of the individual should be a guaranteed right. This is particularly necessary for those who use non-verbal methods of communication to express their will and preferences. The British Deaf Association has emphasised the need for wider access to BSL interpreters who are culturally deaf aware. We discuss in Chapter 1 the challenges there are around accessing language interpreters timeously and appropriately. The duties under the British Sign Language (Sc) Act 2015, and the Equality Act 2010 need to be met .

4.9: What are our final recommendations?

We are aware of the challenges in the delivery of health and social care in Scotland at present. We know that people are struggling to provide people with the care and treatment needed and that the workforce across health and social care is under-resourced. The services needed to provide a range of care and support for people are simply not there in many cases.

However, we were tasked with making recommendations that will ensure mental health and incapacity law reflects human rights and UNCRPD requirements. The lynchpin of this is the development of a comprehensive regime of Supported decision making which should apply in all situations and especially where non-consensual interventions are needed.

Chapter 4: recommendations

Recommendation 4.1: The Scottish Government should develop a comprehensive scheme of Supported decision making (SDM) which should apply across mental health, capacity, and adult support and protection legislation, and especially where non-consensual interventions are needed. The scheme should build on existing good practices already in use across Scotland.

Recommendation 4.2: The Scottish Government should progress the SDM scheme with a central point for development, promotion and oversight

determined as the first step in this process. This could be developed as part of the new mental health model within the National Care Service .

Recommendation 4.3: The development of the SDM scheme must take place in with the full and equal participation of people with lived experience, including unpaid carers.

Recommendation 4.4: The SDM approach needs to be built into all training for practitioners at every level in the delivery of care, support and treatment in the field of mental health, capacity, and adult support and protection law.

4.9.2: Advance statements

Recommendation 4.5: The Scottish Government should change Advance Statements to a model of Advance Choices, reflecting an individual's will and preferences.

> **This new model should apply to any support , care or treatment the person may need across all areas of their life and should operate as follows:**
>
> **If a person, having been given appropriate support, is not able to make an autonomous decision and an Advance Choice exists, the Advance Choice should normally be respected. It should have the same status in law as a decision taken at the time by a competent adult, unless one of the following reasons justify it not being followed:**
>
> - **The person has acted in a way which is clearly inconsistent with the Advance Choice, which suggests it may no longer be their fixed view.**
> - **The person's current will and preferences seem to be more pertinent than those expressed in an earlier Advance Choice.**

- **A position on the person's will or preferences on a given matter cannot reasonably be concluded from matters included in the Advance Choice.**
- **There are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making the Advance Choice, which would have affected their decision had they anticipated them.**
- **There is evidence that the person's ability to make an autonomous decision at the time of the Advance Choice was compromised, for example because of significant illness or undue pressure being applied.**
- **Treatment which is inconsistent with the Advance Choice is necessary to save the patient's life or to prevent serious suffering on the part of the patient.**
- **It should not be possible to refuse normal hygiene, nutrition, hydration or the relief of severe pain.**
- **An Advance Choice refusing treatment is not applicable to life-sustaining treatment unless it makes clear that this is intended.**
- **An Advance Choice would not require a treatment to be offered where it isn't available or clinically justified but should be given significant weight as to the preferences of the granter.**
- **Except in an emergency, a clinician should not be able to overrule an Advance Choice at their own initiative. We propose a model based on s50 of the AWI Act, that an independent clinician be appointed by the MWC to review whether a ground for not following the Advance Choice has been made out. In addition to this, any interested party could seek a ruling from a judicial body (short to medium term)**
- **In advance of the introduction of this wider model, the Scottish Government should work with the Mental Welfare Commission, the NHS, local authorities and advocacy and peer support**

organisations to promote awareness of advance statements and to support people in making them.

The Mental Welfare Commission should issue further guidance on the circumstances in which it is acceptable not to follow an advance statement and should continue to monitor the system

4.9.3: Independent advocacy recommendations

Recommendation 4.6: The Scottish Government should align legislation and policy to ensure consistency regarding the definition of Independent Advocacy, the right to access it and how it is commissioned and funded for adults. This should include consideration of an opt-out service of independent advocacy. An equivalent process should take place for children and young people.

Recommendation 4.7: The Scottish Government should ensure independent individual and collective advocacy is sustainably funded. The Scottish Government must ensure culturally appropriate independent individual and collective advocacy provision.

Recommendation 4.8: The Scottish Government should consider a national advocacy service.

Recommendation 4.9: The Scottish Government and the Scottish Independent Advocacy Alliance, working with other independent individual advocacy groups should develop a national register of independent individual advocates.

Recommendation 4.10: The Scottish Government and the Scottish Independent Advocacy Alliance, working with other independent individual advocacy groups should develop a national training programme for independent individual advocates that recognises the need to ensure access to all those who would wish to work in this field.

Recommendation 4.11: The Scottish Government should assure an existing or new organisation should have responsibility for monitoring and continuing development of independent individual advocacy.

4.9.4: Aids to communication recommendations

Recommendation 4.12: Assistance with communication as appropriate to the needs of the individual should be a guaranteed right . This is particularly necessary for those who use non-verbal methods of communication to express their will and preferences. Work in developing this must be done in partnership with relevant sectors such as the deaf community

Chapter 5: Specialist support in legal and administrative proceedings

In addition to Supported decision making requirements as we detailed in the preceding chapter, there is a need to consider the requirement for specialist support for persons who may need it, in legal and administrative proceedings. By this we mean persons who may be appearing in both civil and criminal hearings and persons attending the Mental Health Tribunal for Scotland.

5.1:Criminal courts system

5.1.1: Intermediaries/Appropriate adult

This is where we started

The UNCRPD Committee has issued guidelines under Article 14 of the Convention. Article 14 is the right to liberty and security of persons with disabilities. These guidelines say that criminal defences based solely on the grounds of mental disability breach Article 14. The Committee states that this is because they deprive the accused of equal right to due process.

The independent review of learning disability and autism in the Mental Health Act (The Rome Review) and The independent review into the delivery of forensic mental health services (The Barron Review), both highlighted that some people who are in the forensic system because they were found unfit for trial, felt they could have participated in a trial if they had had better support. We were told the same thing.

In Scotland, anyone with a mental disorder is entitled to an appropriate adult on being interviewed by the police, but generally there is no formal scheme of support beyond this. We are looking to develop support for decision making across all the areas where people's rights may be affected. As part of this, we proposed the introduction of intermediaries for the accused and witnesses in criminal proceedings.

This is already happening in England and Northern Ireland. We thought this would support people who have communication difficulties.

This is what people told us

Responses to this question were all supportive of increased identification of, and support for, people who would benefit from such a service. Assessment and training were highlighted as key areas and some asked for clarity around who would be entitled to support.

A number of responses suggested extending the existing Scottish Appropriate Adult scheme as an alternative to introducing intermediaries. The Forensic Network explicitly preferred this to the system of intermediaries in England and Wales. The Royal College of Psychiatrists preferred the Northern Ireland model of intermediary support which provides a range of supports and extensive engagement to provide reports to the court. They said these were ‘resource intensive but are an ambitious delivery of their rights’.

The need for more support for people however was firmly endorsed:

> ‘This should be made available for all people with learning disability who come into the criminal justice system, both as suspects and defendants.’ (Scottish Commission for People with Learning Disabilities).
>
> ‘Absolutely every opportunity should be taken to afford persons involved in a trial with a mental disorder/disability the right to the correct support throughout.’ (Anonymous organisation).
>
> ‘Court processes can be complicated and stressful. People with a mental illness are dealing with the stress of an illness along with the court processes and would benefit from the support of an intermediary.’ (Scottish Association of Social Work)
>
> ‘Some people are currently unable to participate in the judicial process and find themselves on a very substantial order. Skilled support would increase

> participation to a greater extent. There is the potential for the system to do better at understanding a person’s situation/experiences and therefore removing/reducing current barriers to participation.’ (Edinburgh Health and Social Care Partnership)
>
> ‘As advocacy workers we have often been struck by how people can essentially be excluded due to current process, but would like to have had an input into proceedings.’ (AdvoCard)
>
> ‘Court processes can be complicated and stressful. People with a mental illness are dealing with the stress of an illness along with the court processes and would benefit from the support of an intermediary.’ (Scottish Association of Social Work)

Role of an intermediary:

Some responses set down the roles intermediaries should take on. The Scottish Association of Social Work said the role would need to be defined with guidance on roles and duties issued to the person and practitioners.

The Scottish Commission for People with Learning Disabilities (SCLD) wanted an intermediary to meet the person to assess ‘communication barriers and requirements for additional support, and then provide a report to the police and court’. They also saw their role as helping the person understand, support them to communicate and inform the court if the person is having difficulties understanding.

Some Mental Health Officers working in the NHS (explained how they currently feel excluded from the court processes, relying on solicitors or court staff which they feel ‘increased the vulnerability of adults involved’. They wanted the new support role to provide a direct link for MHOs to ensure their views and reports are understood, presented appropriately, and outcomes fed back.

Advocard said they would welcome intermediaries supporting people ‘with understanding the process, their options, and support their ability to take part’. One individual said intermediaries should not be provided without consent of the person.

They also wanted people who had been charged with an offence to be allowed to be supported by a willing friend or relative if they want.

Training/experience/time needed for the role:

The Law Society saw real benefit to having an intermediary ‘with specific training’ to support people. Support in Mind highlighted research that people with communication difficulties who are not supported by an intermediary, have their needs improperly met by police, lawyers, and judges. They therefore said intermediaries would need to be trained ‘on a wide range of mental health diagnoses and how these can limit communication skills’. One individual highlighted the need for experience in working with people with mental disorders and intellectual disabilities, and that this is currently the case for anyone who is an Appropriate Adult. The Scottish Commission for people with Learning Disabilities emphasised the right kind of support ‘requires time to prepare, an in-depth understanding of communication needs as well as mutual trust’. The British Deaf Association Scotland pointed out that Scotland, unlike England, have no Deaf BSL intermediary support. They want this gap rectified.

The Law Society also felt consideration would be needed as to how the role of intermediary and role of defence lawyer would interact, given it is normally only the latter who can communicate with the accused. There would also need to be clarity as to whether an intermediary could be called as a witness. The Mental Welfare Commission highlighted the implications for resources, training and standards.

Links with advocacy

A number of responses brought in how independent advocacy could support/work with intermediaries. The Mental Welfare Commission thought ‘enhanced advocacy services’ linked to criminal justice services in local authorities/HSCP could be used for this service. The Law Society felt ‘consideration could be given to extending the role of specialist independent advocacy workers’. Dunfermline Advocacy supports people in court. They said these people benefitted from having a ‘known face beside them’ who was able to access special measures or ask for breaks for them.

Links with Appropriate Adult scheme

The Forensic Network explicitly felt there was no need for a new intermediary system, but felt it could be done within the Appropriate Adult system ‘which is fully established and largely running through local authority social work departments’. They felt the advantage of this system over the intermediary one in England and Wales is that they are people with an understanding and training in mental disorders, ‘most commonly social workers’, while in E&W they can be relatives. They feel the existing system should be used, with the additional use of speech and language therapists when required. Others also made links to the existing scheme, One individual felt it should be an ‘evolution of the Appropriate Adult Scheme’, another that it was an ‘anomaly’ that the Appropriate Adult scheme did not extend to involvement in criminal proceedings after police interview. Another person who works for a local authority, suggested that once an Appropriate Adult case is picked up, then the ‘worker continues to carry this to see the role through to trial’. They feel the Appropriate Adults already specially trained in this area of support are a ‘greatly underutilised resource’.

NHS Greater Glasgow and Clyde MHOs felt an adult could support a person in court, ‘as an advance appropriate adult function’. Some at the Royal College felt the Appropriate Adult scheme ‘offered an initial basis to build on’. The Mental Welfare Commission felt the existing Appropriate Adult scheme ‘could be used as a basis to consider further extensions/developments’.

The Care Inspectorate highlighted itself as the body responsible for embedding a new quality assurance framework to support self-evaluation of Appropriate Adults services. They support the intention to expand mechanisms to support people to communicate and understand procedures in the criminal justice process.

Lack of clarity in the proposal

Some respondents supported the idea in principle however felt our proposals lacked clarity on what exactly we meant and how it would work, who would be entitled to the support, who would be doing this and what experience, training and ongoing support they would get.

These are our final recommendations

The role of the appropriate adult is confusing. An appropriate adult is supposed to be present whenever the police interview someone who appears to have a mental disorder. Their role is to ensure that the person being questioned is not unduly distressed, to assist communication and make sure the person understands questions from the police. In practice, the role of the appropriate adult is sometimes seen as supporting the investigation rather than the adult, and the role does not normally extend into any court hearing. In addition, the existence of the appropriate adult role predates the offer of mandatory legal advice/representation before or at an interview and does not always integrate well with this.

The challenge mentioned earlier about the lack of awareness and training in mental health law and issues for solicitors is clearly an issue here along with the effectiveness of appropriate adults in some cases. It is vital that a person suffering from a mental or intellectual receives the right support to enable them to understand what is being asked of them, and to give them the best chance of being able to be considered fit to plead.

The Rome Review suggested the creation of an intermediary in law. Autistic people and people with intellectual disability would have a right of access to such an intermediary to support them through the criminal process but such an intermediary would also be available to anyone who is charged with a crime or prosecuted for a crime and who needs helps with their communication.

The Barron Review said it was ‘likely that the Appropriate Adult or equivalent support will be required throughout the criminal justice system in order to allow people with a learning disability to fully participate’.

We think it is clear therefore that increased support is necessary and would be welcomed. The question is how best to do this. As in other areas, this should be addressed in incremental stages moving towards a comprehensive intermediaries scheme which will be able to address individuals who need support to help them to engage in all criminal proceedings. Full recommendations for change are at the end of this chapter.

5.2: Civil courts system and the Mental Health Tribunal for Scotland

5.2.1: Named persons

Throughout the Review we have heard many people's views on the role of named persons. This section takes account of these views. In addition we carried out a discrete piece of work looking at the role of the named person, curators ad litem, safeguarders and listed initiators. We have also benefitted from the recently published report The Mental Health Tribunal for Scotland: the views and experiences of Patients, Named Persons, Practitioners and Mental Health Tribunal. We particularly wanted to find out whether, taking into account changes made by the Mental Health (Scotland) Act 2015 Act to the way named persons are appointed, the law sufficiently protects people who lack capacity from discrimination and enables their views to be conveyed to the court or tribunal on an equal footing with those able to speak for themselves.

Named Persons/Listed Initiator

The Mental Health (Care and Treatment) (Scotland) Act 2003 Act does not define the role of the named person but generally it is to represent and safeguard the interests of the individual. The named person may be able to help the individual claim their rights by helping set out the individual's past and present wishes and feelings and by helping the individual to be involved in, and understand decisions about their care and treatment. The named person represents the interests of the individual but does not necessarily represent the individual and need not necessarily agree with the individual's views on what should happen.

The Mental Health (Scotland) Act 2015 made some changes to the named person provisions to the effect that a person will now only have a named person if they appoint one. Prior to this there was a default appointment of a named person. This was on the recommendation of the McManus report, which stated that, due to privacy and human rights implications, the former default appointment of the named person should be abolished. A new role of listed initiator was created.

A listed initiator can be any relevant welfare guardian or attorney or a individual’s primary carer or nearest relative. This role gives the person the ability to act in certain circumstances, namely that they can make an application or an appeal to the Tribunal. The listed initator however, is not a party to the Tribunal and does not receive papers or notifications and is not consulted before treatment in the way a named person must be notified.

We asked people what they thought about the abolition of the default named person, how the listed initiator role was working in practice and whether any improvements could be made to improve the rights and protections of people subject to the existing provisions in this area of the Mental Health Act, including removing barriers to those caring for their health and welfare.

What people told us

Whilst it was agreed that the former default appointment of the named person posed a great risk to individual choice and privacy, it was felt that abolishing this had removed a critical layer of protection for individuals. We were told that the number of named persons involved in Tribunal hearings has greatly reduced. The Tribunal told us that the named person served as an “important contradictor” which has been lost through this amendment to the law. One Mental Health Officer felt that the abolition of the default named person had been particularly detrimental to individuals affected by alcohol and drugs as a result of tendencies to ostracise themselves from family and friends, a situation that seems to have become more prevalent as a result of the covid pandemic.

When people were asked about their experiences of the listed initiator, responses reinforced the feeling that there is a general lack of awareness and understanding about the role. This would explain why there has been a low uptake. The listed initiator was created to replace the safeguards removed by the abolition of the default named person but, as a result of the issues outlined, it is not working in practice as intended.

Feedback to our consultation indicated that there is also a lack of awareness around the role of the named person, to the extent that:

> ‘The role of the named person is largely unknown in general medical clinical practice and overlaps with the role of POA or Guardian. Listed initiator, safeguarder and curator are also largely unknown’ (Royal College of Physicians)

This was reinforced by further comments around the lack of quality information and inconsistencies in guidance and training materials about the named person. Whilst it was acknowledged that Mental Health Officers play a significant part in making sure that people have all the necessary information to make an informed decision about committing to the role, it was suggested that improvements could be made to ensure that people are fully aware of what they are signing up to and are able to carry out the duties of the role effectively. For example, Community Psychiatric Nurses often see patients more frequently than a Mental Health Officer and whilst many already do provide support in consideration of whether a named person might help an individual, more could be done to develop this. Information should be as far reaching as possible to include psychiatric nursing, support staff and support agencies.

> ‘Improve guidance on the roles and responsibilities of the named person and ensure this guidance is widely available and accessible. Named persons should also be given a formal opportunity to ask questions.’ (Scottish Association of Social Work)

Evidence also suggested, that there needs to be improved governance as to what happens on the ground. Consistent guidance and training would go some way in resolving this issue but this should be done in tandem with monitoring and governance of the role.

We asked people whether individuals who lacked capacity and did not have a named person were sufficiently protected. Feedback indicated that those who did not have a named person to act in their best interests were not equally protected. Comments from the Equality and Human Rights Commission add poignancy to this issue. Within their own engagement at stage one of the review they were told that ‘very often the existence of a named person could be the reason for the release from compulsory detention. The change in law was described to them as a ‘‘no man’s land’ where families get shut out.’ (EHRC response to consultation)

We did hear evidence, however, indicating that there has been a positive shift in relation to the participation and contribution of primary carers over the last 3-4 years, particularly for individuals with dementia. Whilst carers are often best placed to ensure the voice of the person receiving care is heard, this may not always be the case and consideration needs to be given to whether more is needed here, especially in light of the comments heard from the EHRC.

It was suggested that where no named person has been appointed, the power to appoint should lie elsewhere. One proposal was that this power might naturally lie with the mental health officer given that they already have the power to take steps to remove a named person, however it was felt that there was too great a risk to the relationship of the mental health officer and the individual they were supporting. Taking this into account we recommend that this power would better sit with the Tribunal, but the practicalities of this would need to be explored in further detail.

The Carers Trust, on behalf of the National Carer Organisation suggested that the Tribunal:

> ‘should be able to approach an unpaid carer about the role, with the caveat that the carer should not be coerced into the role.’

Feedback from the LGBT+ community raised concerns in relation to familial structures and relationships which may vary depending on many factors such as cultural, social, environmental or gender identity.

In determining the most appropriate named person regard must be had to the evident importance of the supporter to the individual, taking into consideration the familial structures and relationships. Feedback from the Equality Network explained that, even where a named person had been chosen by an individual, it should be recognised that the named person may not be someone who respects the individual's gender identity or sexual orientation. Although this is less likely now that no adult will be assigned a default named person, this is still a concern for those under 16 who may have been allocated a default named person (Equality Network and Scottish Trans Alliance response to consultation).

Feedback from the consultation and discussion within our stakeholder engagement also revealed concerns around the safeguards for children who are deemed not to have capacity from birth. There was strong agreement that where a child has never had the capacity to appoint their own named person, the default named person should continue in the role when the child reaches 16. This would be a named person from birth, with the additional protection that the named person can be removed, should the role no longer be considered appropriate.

We have been told that the current situation, which involves the role of named person ceasing once the child reaches 16, is putting the individual at risk and resulting in "welfare guardianship being used as the back door" to ensure that the individuals interests can still be represented by someone who knows them well and has an understanding of their wills and preferences. We make a recommendation on this in Chapter 12.

It was also suggested that where an individual has previously appointed a power of attorney (POA) and loses capacity, the attorney should automatically be given the same powers as a named person. Similarly guardians should be given a named person role. This would provide better protections and safeguards for individuals who lose capacity through dementia for example. Rather than an automatic right however we consider that the potential need for an attorney or guardian to become a named person should be a point of discussion when drawing up a power of attorney, and when a guardianship application is made.

Similarly it was suggested that the potential need for a named person should form part of the discussion between an individual and practitioner when an advance statement is being prepared and should also be reinforced.

From an administrative perspective the Law Society of Scotland highlighted the need for a central register for named person nominations to alleviate issues with named person nominations not being included in case papers.

5.2.2: Curators ad litem

Where we started

The Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005 state that the curator ad litem is appointed to ‘represent the patients interests’. A curator ad litem is usually appointed where the individual is ‘incapable of understanding the proceedings’ and the individual does not have a representative to represent their interests, usually because the individual does not have the capacity to appoint a solicitor. Curators ad litem are not subject to a statutory duty to have regard to the principles of the 2003 Act but guidance on the Tribunals website suggests that a Curator ad litem should take account of the principles and should have regard to the overriding objective of the of the Rules of the Tribunal to secure that proceedings before the Tribunal are handled as ‘fairly, expeditiously and efficiently as possible.’

Curators ad litem can also be appointed by a Sheriff under the Adults with Incapacity Act. The appointment of curators ad litem has been revised in recent years for the MHTS and is a more transparent process now than was previously the case. Curators ad litem must now be legally qualified with an up to date knowledge of mental health legislation. No new process has been introduced for the appointment of curators in the Sheriff court, however, and generally the common law is relied upon.

What people told us

Feedback on the role of the curator ad litem was received through responses to our consultation and targeted stakeholder engagement. There were variances in the way that the role was described but we mostly heard that, where an individual has been assessed and deemed not to have capacity, a curator ad litem is appointed to 'step into the patient's shoes'. It was also recognised that they represented the best interests of the individual through an independent assessment. It was explained to the Review that this assessment involved speaking to a range of people involved with the care and treatment of the individual including, but not limited to: carers/unpaid carers, relatives, RMO and MHO.

Within our engagement we discussed the extent of the enquiries made by the curator ad litem to ascertain the will and preference of the individual. Responses to this generated the impression that the work undertaken by curators ad litem was of a high standard. It appeared that this was largely because of the small pool of curators ad litem held on the list by the Tribunal which meant that the same individuals were frequently appointed and therefore gained necessary knowledge and experience. We were told that in practice, curators ad litem did their best, to ascertain the will and preference of the individual, often within short timescales. There was recognition, however, that the requirement to ascertain the will and preferences of the individual was not formalised.

Furthermore, it was noted that curators ad litem did not have training in carrying out their duties. This was of particular concern where a curator ad litem was working with a neuro diverse person or someone with a sensory impairment who might need additional support to communicate. We consider there should be an obligation to require the curator ad litem to report on the actions taken to ascertain the will and preference of the individual.

It is also of note that there is no statutory obligation for the curator ad litem to produce a report. We were told that reports were rarely produced by curators ad litem and, of the reports that were presented to the tribunal, there were variances in the quality and detail of the reports. The omission to produce minimum standards and a lack of governance in relation to these duties could result in inequitable opportunities for individuals receiving outcomes that should reflect their will and preferences.

We know that trusting relationships between the person receiving care and treatment and professionals, looking after their welfare, leads to better outcomes for the person. It was recognised that curators ad litem are appointed on a case by case basis which limits the ability to develop such a relationship. We understand that the scheduling team for the Tribunal endeavour to match curators ad litem to individuals that they have worked with before. This goes some way to addressing this issue.

It is acknowledged that, on occasion, an individual will be assessed as having capacity but does not have the volition to appoint a solicitor or elects not to do so. We explored the safeguards in place to protect individuals in this situation. We were told that the tribunal is alert to this issue and, in such circumstances, an interim order will often be granted to allow the individual more time to appoint a solicitor. Whether the individual has capacity to do this will also be taken into account when assessing individual capacity. As one individual said:

> ‘Sometimes there may be dissent from the medical professional who says that there is no need for a curator as the patient has capacity but they will be asked to take into account whether the effects of their illness would mean that they would lack the volition to appoint a solicitor. In this instance a curator would be appointed.’

Feedback to the Review’s consultation highlighted that there are disparities between the roles in relation to rights of appeal. A curator ad litem only has right to appeal if they are party to the proceedings as is the case in AWI cases. Curators ad litem do not have a right of appeal in the MHTS – the Court of Session held in 2012 that the absence of an appeal right does not amount to a breach of article 5 of ECHR (Black v MHTS 2012 SC 251). In principle, a curator ad litem who considered the tribunal to have acted unfairly or wholly unreasonably could seek judicial review. And the curator ad litem can contact the Mental Welfare Commission if there are concerns about the operation of the tribunal or welfare of an individual. But perhaps the right of appeal for a curators ad litem in the MHTS may need to be considered again.

5.2.3: Safeguarders

Where we started

Section 3(4) of the Adults with Incapacity Act 2000 provides that the sheriff ‘should consider whether to appoint a person to safeguard the adult's interests in each case.’ This is notwithstanding that it is already possible to appoint a curator ad litem to represent the adult’s views to the court. Unlike proceedings under the Mental Health Act, under the Adults with Incapacity Act a curator ad litem will become a party to the proceedings.

There are concerns that the remit of safeguarders and the matters which they are required to investigate are not clearly understood. As a result there is a large variance of work undertaken by safeguarders. There is no formal structure around the appointment of safeguarders, and fees vary widely unlike the fees set out by the MHTS for curators ad litem.

What people told us

When people were asked to describe the roles of both the safeguarder and the curator ad litem, there were overlaps and not much distinction between the two roles. It was explained that the safeguarder represented the individual’s interests but it was clear that the remit of the safeguarder was not fully understood.

Mental Health, Incapacity and the Law in Scotland (Patrick and Stavert, 2006) describes the role of a curator ad litem as considering whether there is a legal case for the order and reports on the welfare and financial issues under consideration, whereas a safeguarder’ s role is to represent the interests of the adult. But this distinction was not well known or understood in practice and a number of individuals questioned the need for both roles and suggested consolidation.

Consolidating the role of the curator ad litem and safeguarder would serve to reduce confusion about the distinctions between the two roles and circumstances which give rise to the respective appointment of each role. There was support for this proposal and the Review feels that the practicalities of doing so should be explored in further detail. In doing so it would need to be clearly stated how the execution of the roles would be distinct depending on the setting, given that powers under the AWI Act are much broader, covering more aspects of a persons life.

Regard should also be had to potential conflicts of interest. Currently section 3(5) of the Adults with Incapacity Act gives the Sheriff power to appoint a ‘separate curator ad litem to convey the views of the adult [where] it is not possible to combine the functions of conveying views and safeguarding interests’

Common issues raised in relation to the curator ad litem and the safeguarder included a lack of common procedure for appointments of both curators ad litem and safeguarders across Scotland. We were told that some sheriffdoms appoint a safeguarder as a matter of course, whilst others will only appoint a safeguarder where there is a ‘particular bone of contention on a certain matter.’ In relation to pay we were told that councils were picking up the tab but there was ‘uncertainty as to the basis on how this should be charged.’

These concerns have been highlighted in other reports from as early as 2005 including the Adoption Policy Review Group Phase II Report , Adoption: better choices for our children, Scottish Executive; again in 2006 in the Report by the Research Working Group on the Legal Services Market in Scotland; the final report of the Scottish Civil Courts Review (2009); and in 2014 the Faculty of Advocates asked the Scottish Law Commission to consider a review on the law of curators ad litem appointed under common law powers. These concerns were echoed in the work we carried out through the consultation. Recommendations from these reports can be summarised as follows :

- uniform training programmes respectively with a requirement that the training is completed prior to being accepted as a curator ad litem/safeguarder.

- the training should provide a framework for the role, and set out minimum standards in respect of what is required. The training should take account of the principles and reinforce the duty of the curator ad litem to ascertain, as far as possible, the will and preferences of the individual.
- the APRG recommended, in relation to children's cases, that individual case appointments were to be made locally but remuneration should be paid centrally. The practicalities of doing so across the board should be explored further.
- the report also suggested a system of national standards for the work being done which would enable best practice to be shared across the country and that rates of remuneration should reflect this.

In discussions with practitioners, the potential for an Official Solicitor in Scotland was raised. In England the Official Solicitor acts for people who because they lack mental capacity and cannot manage their own affairs are unable to represent themselves and no other suitable person or agency is able or willing to act. We have not had time in this Review to consider this role for Scotland in any detail but it may be something the Scottish Government would wish to look into in the future.

Chapter 5: recommendations

5.2.4: Specialist support in legal and administrative meetings

Recommendation 5.1: The Scottish Government should introduce intermediaries. This should be subject to review and assessment of an expanded use of the Appropriate Adult scheme and independent advocacy

- **The use of the existing Appropriate Adult Scheme should be expanded to increase the support for individuals throughout current justice processes.**

- **Work should be done to explore the possibility of using independent advocates to assist in providing support for individuals going through justice processes.**

Subject to the review of whether the expanded use of appropriate adults and independent advocates set out above proves sufficient to provide the necessary support, a scheme for the use of intermediaries should be introduced to provide support from start to finish in justice processes

5.2.5: Named Person recommendations

Recommendation 5.2: Where no named person has been appointed the Scottish Government should consider allocating powers to the tribunal to appoint a named person.

Recommendation 5.3: Subject to changes above being carried out, the Scottish Government should abolish the role of the listed initiator

Recommendation 5.4: Scottish Government should ensure that that named persons have access to

- **independent advocacy and legal representation**
- **accessible guidance**

Recommendation 5.5: The process of appointing of Power of Attorney (POA) or guardian should include consideration of appointment of a named person, should that become necessary.

5.2.6: Curator ad litem recommendations

Recommendation 5.6: The Scottish Government should increase governance over the role of a curator ad litem. This should include:

- **a statutory duty on the curator ad litem to report the actions they have taken to ascertain the will and preference of the individuals**
- **mandatory training for curators**
- **establish a process for ensuring that there is no conflict of interest where a curator ad litem also acts as a solicitor**

5.2.7: Safeguarder recommendations

Recommendation 5.7: The Scottish Government should:

- **Review guidance to ensure that there is a consistent approach to appointing safeguarders between sheriffdoms**
- **Review guidance to ensure that the role of the safeguarder is unambiguous**
- **Create a uniform training programme with a requirement that the training is completed before being accepted as a safeguarder.**
- **Create a system of national standards for the work being done which would enable best practice to be shared across the country .**
- **Revise the payments system for safeguarders to place it on a more equitable footing.**

If the above changes have occurred, the Scottish Government should undertake a further review to consider if the combination of roles available meets the needs of mentally or intellectually disabled individuals appearing in court or before the MHTS.

Chapter 6: Economic, social and cultural rights

enabling people to live fulfilling lives

6.1:This is where we started

At the core of a human rights approach is the idea that the State is under an obligation to respect, protect and fulfil human rights; in other words, to enable people to live fulfilling lives.

Scotland's National Taskforce for Human Rights Leadership has recommended that, to do this, the Scottish Government should incorporate key UN Human Rights Conventions, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of Persons with Disabilities (UNCRPD) directly into Scots law (NTHRL, 2021).

The Taskforce proposed a 'maximalist' approach, aiming to secure the most effective promotion and protection of human rights within devolved competence' (NTHRL, 2021). This includes ultimately establishing specific duties on public bodies to comply with the new rights. The Scottish Government intends to propose a Bill to the Scottish Parliament to do this.

The Taskforce also recommended that there should be 'a participatory process to define the minimum core obligations of incorporated economic, social and cultural rights, and an explicit duty of progressive realisation to support the effective implementation of the framework, which takes into account the content of each right' (NTHRL, 2021).

Finally, the Taskforce were clear on the need to ensure that

> ‘adequate and effective remedies and routes to remedy exist within the national legal system. Under international human rights law, remedies and routes to remedy require to be accessible, affordable, timely, and effective. …. The effectiveness of a remedy not only takes into account the elements of access to justice, but also requires that an appropriate order is issued, and that such order is complied with by the competent public authority.’ (NTHRL, 2021 p48).

This implies that, where human rights duties, including in relation to economic, social and cultural rights, are not upheld, an affected person should be able to take this to court.

The Taskforce discussed a range of ways in which remedies could be pursued. In addition to individual legal action, they proposed that the statutory framework should allow for civil society organisations with “sufficient interest” to support victims or to bring systemic cases that are in the public interest. We discuss how this might apply to the Mental Welfare Commission and collective advocacy organisations in Chapter 11.

There is a well-developed framework for giving effect to economic, social and cultural (ESC) rights. ESC rights need to be **progressively realised** by States. This means that the State must take steps, to the **maximum of its available resources**, with a view to achieving progressively the full realisation of these rights, through all appropriate means, including legislation. Because each State’s available resources are different, States will make progress in realising these rights at different rates. However, there are **minimum core obligations** which apply to all States, for each ESC right. Several of the rights in the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) have a ‘minimum core’ obligation which States are expected to meet immediately, not (Cepeda, O'Regan & Scheinin, 2021).

Progressive realisation also requires that there should be no backwards steps by States - no regression - on ESC rights. In circumstances where regression is absolutely unavoidable - for example, after a major economic crash - the State will have to demonstrate that any regressive steps are necessary, and that the State's actions will not disproportionately affect any vulnerable groups in society.

At this stage, we do not have all of the detail on how the new duties and processes will operate under the proposed Human Rights Bill. We put forward in our consultation a set of proposals for how this might work in relation to the rights of people with mental or intellectual disabilities. We have closely followed the approach of the Taskforce in doing so.

6.1.1: Minimum core obligations, service standards and data

We proposed the following:

- A legal requirement for the Scottish Government to establish minimum core obligations to people with mental or intellectual disability to secure their human rights.

- A statutory responsibility on public bodies to secure those aspects of the minimum core obligations reflected in their statutory powers and duties.

- Duties to provide health and social care to be reframed in terms of human rights standards, including the AAAQ (availability, adequacy, acceptability and quality) framework.

- A systematic process of data monitoring to assess whether these obligations are being met.

- The development of these should be carried out with the full participation of people with mental or intellectual disability and their representative organisations.

We also made some suggestions regarding a revised Scottish Mental Health Strategy – that it should:

- Set out a clear framework for the progressive realisation of economic, social and cultural rights for people with mental or intellectual disability.

- This should not be confined to health and social care services, but address other relevant government policies and strategies, including housing, poverty, employment and community support.

This reflects guidance from the Committee on Economic, Social and Cultural Rights that (United Nations, 2000, para 53).

> '… the highest attainable standard of physical and mental health … requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy … '.

Since our consultation, the Government issued its own consultation on a new Mental Health and Wellbeing Strategy.

6.1.2: Requirements which follow from particular human rights

Our consultation highlighted specific human rights issues of concern to people with mental or intellectual disabilities.

- Stigma and attitudinal issues (CRPD Article 8)

Evidence from people with lived experience, including unpaid carers highlighted the harms caused by negative attitudes to mental health, including those of staff, wider society and self-stigma experienced by people with mental or intellectual disability. We sought views on a positive duty on Scottish Government to address stigma and discrimination against people with mental or intellectual disability, as a barrier to their full inclusion within society.

- Right to the highest attainable standard of physical and mental health (ICESCR Article 12, CRPD Article 25)

Sections 25-27 of the Mental Health (Care and Treatment) (Scotland) Act 2003 contain duties on local authorities to:

- Provide support to minimise the effect of mental disorder on all people – not just people who have been in hospital.
- Give people the opportunity to lead lives which are as ‘normal’ as possible; to provide services to promote wellbeing and social development.
- Provide assistance with travel.

However, we found little evidence that these duties directly influence what local authorities provide, and no mechanism to assess whether or not the duties are being adequately met. They also do not apply to the NHS.

We proposed that these provisions should be extended and reframed to set out clear and attributable duties on NHS Boards and local authorities to provide mental health support to individuals with significant levels of need, reflecting the minimum core obligations.

This proposal would not cover all of the obligations implied by the right to health. Other obligations include prevention of mental health problems, and addressing the social determinants of good and poor mental health. We proposed that that they be addressed in the wider proposals (above) for fulfilling the right to health through a reframed and human rights-based mental health strategy.

We also highlighted the need to ensure that Government actively addresses the physical health needs of people with mental or intellectual disability, given the huge health inequalities experienced by this group, and concerns about ‘diagnostic overshadowing’.

- Right to an adequate income (ICESCR Articles 9 and 11, CRPD Article 28)

Evidence to The Review highlighted a number of issues around poverty and access to employment. These issues may be common to a range of disadvantaged groups, but we proposed the Government’s approach to financial inclusion in its mental health strategy and more broadly should address particular issues, such as disruption to benefits when admitted to hospital, failure of benefits assessors to recognise mental health conditions as disabling, and the over-use of the sanctions regime when people struggle to keep appointments. Evidence reported in chapter 11 in relation to independent advocacy is also relevant, as is our recommendation for consistency in independent advocacy provision.

- Rights to housing and independent living (ICESCR Article 9, CRPD Article 19)

UNCRPD Article 19 sets out the right to choose where, how and with whom to live, the right to access individualised support services, and the right to access mainstream services. It is clear that this right is not being fully met for many people at the moment.

This may be particularly relevant for people with dementia, autism and learning disabilities, where financial constraints may lead to a regression of previous commitments to independent living and support in the community. But the lack of suitable housing is also often a problem for people with experience of mental illness.

We proposed a strengthening and broadening of the duties in section 25 of the 2003 Act, which mentions ‘residential accommodation’.

- Inclusion in society (ICESCR Article 15, CRPD Articles 19 and 30)

Evidence to The Review also highlighted issues of isolation and loneliness. At the moment, it is doubtful that any statutory agency feels under any obligation to address these. We suggested that Section 26 of the 2003 Act (services to promote wellbeing and social development) could be strengthened to address wider barriers to inclusion in society including people’s own communities.

- Accessible information (CRPD Article 9)

The lack of awareness of rights and options is a significant problem for many people with mental health problems, particularly at times of crisis. We proposed law reform to strengthen and broaden the existing duty under sections 260 and 261 of the 2003 Act to ensure that accessible information is available to people with mental or intellectual disability whenever they may need it, not just when they may be subject to detention/compulsion.

In line with the approach of the human rights taskforce, we believe there must be a route to legal enforcement of these duties.

6.1.3: System-wide changes including culture change

Economic, social and cultural rights – and the rights and duties discussed in other parts of this document - require some system-wide changes to culture, to training, and to the way services are commissioned and organised.

We suggested that system wide changes may need to include the following:

- Significant lived experience, including unpaid carers input at all levels of service delivery, and in the development of law, policy and practice. There may need to be stronger duties on bodies providing services, and to build on previous developments in collective advocacy. We consider this in chapters 1 and 11. Scotland needs to take account of the requirements of the UNCRPD in this area, as interpreted by the UN Committee on the Rights of Persons with Disabilities (United Nations, 2018) along with guidelines from the lived experience movement on best practice. Patient director posts are one example of good practice (Gilbert, 2021) but best practice should be defined by and with people with lived experience, including unpaid carers of mental or intellectual disability.

- Human rights budgeting: to ensure that budget decisions reflect human rights standards, that the process of formulating, approving, executing, and auditing budgets reflects human rights principles, and that the budget allocated to mental health is equitable in relation to the budget for physical (NTHRL, 2021)

- Community and inpatient services**:** both forms of services must be adequately resourced, not one at the expense of the other.

- Design: Design of spaces and buildings could combine safety with positivity, peace and relaxation. There is evidence that building design has an impact on the use of coercive practice, from the provision of safe and comfortable environments down to the culture that they promote.

- Co-ordinated professional training and development: This may be needed across health and social care services to develop a consistent understanding of a human rights-based approach to mental health care. Staff training should include lived experience led training. Developments might include multidisciplinary training, extensive changes to training within universities and colleges, and significant investment in retraining opportunities for current professionals. Training on human rights would need to include not only the “mechanics” of human rights but also training on human rights values. Lived experience training is developing and will require the right support in order to be an effective, high-quality experience.

- Addressing awareness with lived experience, including unpaid carers collaboration. In addition to professional training, there will be a need for awareness raising across and beyond health and social care services. Lived experience, including unpaid carers awareness training may need to be developed.

- Redefining culture: We think that culture in services for people with mental or intellectual disability may need to be addressed directly across developments, including a vision for services, with leadership from persons with disabilities including their organisations. Culture change will also require a coherent, dynamic and resourced national strategy which is driven by legislation.

- Professional roles: We think that Scotland may need to provide more support to professionals to ensure they have the knowledge, resources and authority to give full effect to the human rights of individuals. Implementing human rights treaties including the UNCRPD may require a different skills mix and different balance of specialisms, and a redistribution of responsibilities between professionals, to remove barriers which disable people and to empower them. We have not had the opportunity to consider in detail how best this should be done, so make no specific recommendation in this chapter, but this is a matter which we believe requires further consideration by the government and the professions, working with lived experience, including unpaid carers and human rights institutions.

6.2:This is what people told us

6.2.1: Government duties of progressive realisation and minimum core obligations

There was wide support for the creation of statutory duties relating to minimum core obligations and progressive realisation, including from Social Work Scotland, Scottish Association of Social Workers, See Me, SAMH, AdvoCard, Support in Mind, Sense Scotland and the Mental Health Network Greater Glasgow.

The Health and Social Care Alliance commented:

> ‘The ALLIANCE welcomes the proposal to ensure that future mental health law reflects economic, social, and cultural rights, and the approach set out by The Review for the Scottish Government to meet its minimum core obligations. … Mental health engages a wide range of human rights, which are indivisible, interdependent, and interrelated. Incorporating international economic, social, and cultural rights into mental health law – and mainstreaming them within practice – is key to promoting, protecting, and realising the rights of people with mental health conditions. … Embedding human rights explicitly within legislation, guidance and policy provides a powerful tool to drive improvement and mainstream human rights principles to ensure that people’s rights are respected, protected, and fulfilled.’

Edinburgh Community Voices response said:

> ‘The issue of attaining the right to the highest standard of physical health is one that is important to our members ...

Issues of accessibility in physical healthcare were raised here. Noisy, disorientating, overcrowded spaces, like those in places like the Emergency Department, can put people off getting care. Physical health care appointments can be traumatising for some people, for instance physiotherapy and female sexual health. People can be given appointments a large distance from their home, causing difficulties for people with agoraphobia or without access to a car.

It is important that people with lived experience, including unpaid carers have their rights supported across all health services, not just mental health. This should be included in the Scottish Mental Health Strategy.

Difficulties with housing and finances are often raised by our members as issues which affect their mental health and areas where they face discrimination. There was great support for widening the remit of the Scottish Mental Health Strategy, including housing as part of it, and setting out a clear framework for the progressive realisation of economic, social and cultural rights'.

There was concern in some responses that, although this aspiration was welcome, 'the ambition of some of this may out-reach its achievability' (Individual Response 5). In relation to minimum core obligations, several responses expressed concern that what is intended as a minimum could, at a time of constrained resources, be all that would be achieved. The Royal College of Psychiatrists and the Forensic Mental Health Services Network argued that an approach of continuous improvement and the development of quality standards offered a more dynamic approach to improving services. Glasgow City Council commented that it was difficult to shift cultural values based on a wholly legislative approach.

The Mental Welfare Commission broadly supported the proposals, but stressed the need to maintain a focus on those at the greatest risk of not having their needs met. They also stressed that it should not be necessary to wait for legislation:

> '…this may be an opportunity to ensure that the standards work that Scottish Government is currently consulting on and intends to use as a set for people with mental health conditions to be clear on expectations from services and reflect minimum core obligations.'

The Equality and Human Rights Commission proposed that 'The Core Minimum Obligations should be developed to ensure that not only are people able to secure their human rights, but the protections they enjoy under the Equality Act 2010 too'. They also highlighted their response to the Scottish Government's recent review of the Public Sector Equality Duty, as containing lessons in how to ensure that such public duties are effective.

6.2.2: Stronger duties on provision of services and information

Many user and third sector organisations, including See Me, SAMH and Inclusion Scotland, supported strengthening the duties currently in sections 25-27 of the 2003 Act. SCLD stressed the importance of ‘clear consequences for failure to comply both in terms of regulation and in an accessible enforcement route for people and their carers/families.’

The Scottish Human Rights Commission commented:

> ‘‘The proposals identify a series of human rights issues affecting people with mental health issues which may require specific duties or action. These reflect a range of CRPD obligations … which require concerted action and which we support. The proposals to strengthen sections of the 2003 Act are a practical way of building a broader understanding of human rights standards into existing duties.’

A number of organisations stressed the need for clarity as to the nature and extent of the proposed obligations. The Royal College of General Practitioners said that terms such as ‘significant levels of need’ and ‘mental health support’ needed a clear definition, and the Care Inspectorate said that articulating specific duties could assist scrutiny activity.

The MWC agreed that monitoring and awareness of the existing duties was inadequate. In relation to strengthening the duties, it highlighted the importance of being clear about whether this was part of or separate from the requirement to secure minimum core obligations, and whether there was a ‘threshold’ of severity when the duties kicked in. The Royal College of Psychiatrists felt it was important to prioritise those with defined mental health conditions and, in the context of mental health law, focus particularly on the right to health.

A number of respondents, including Social Work Scotland, Healthcare Improvement Scotland, and Families Outside, said it was important that the duties should extend to people who are or have been in prison.

Social Work Scotland, the membership body for social work leaders, supported expanding the ss25-27 duties and agreed in principle to extending them to the NHS as well as local authorities. They stressed the importance of aligning any new provision to plans to develop a National Care Service. They were concerned that current integration authorities are not sufficiently sighted on this aspect of the Act, instead focusing largely on the provision of clinical services. Considerable variation exists across Scotland in how mental health and social care services are delivered to people and their carers. We are interested in understanding the degree to which this variation is warranted by local circumstances and need, and to determine how unacceptable variation can be diminished in a way that respects local democracy.'

Other local authority bodies expressed concerns about the resource implications of expanded duties. COSLA stressed that any new guarantee of services without consideration of the resources needed to achieve this was setting reform up to fail, and highlighted particular pressures and finite supply of, for example, social housing. They also pointed out that some services which would be relevant to the duties are provided on a universal basis, so it would be difficult to identify what was being provided for people with mental or intellectual disabilities.

We accept that we are asking for more to be done, and make no apology for this. A key part of a human rights-based approach is to have clear attributable duties to provide such services as are necessary to secure rights such as the right to health and to independent living. This supports our proposals for Human Rights Enablement (see chapter 8).

The precise level and type of service would not be prescribed in primary legislation, but would be developed through the development of minimum core obligations, service standards set out by the Scottish Government, and the duty of progressive realisation.

In a world of integrated services, it is no longer appropriate that the duties to help people with experience of mental or intellectual disability live decent lives should be confined to local authority social work departments. They should be extended to cover housing and healthcare – including physical healthcare.

Importantly, we do not believe that it is enough to provide a level of support which may prevent a person from being readmitted to hospital, but leaves them leading an impoverished and isolated existence. There is much more that health and local authority services can do to remove the barriers preventing people with mental or intellectual disabilities from flourishing, and that should be the level of ambition we set.

We recognise that addressing wider social determinants of poor mental health requires a broader societal approach. We agree that it is not best dealt with in mental health law, even in the wider approach we suggest. We set out below how we think these should be addressed in a wider strategic response.

There was also support for stronger duties to ensure people have access to accessible information about their care and their rights. AdvoCard said: ‘We would welcome increased duties on all services to provide timely access to accessible information, translation, interpretation and advocacy. At times this is currently not possible under the 2003 Act’. The ALLIANCE said ‘Information should be provided in a range of accessible formats and should follow the Six Principles of Inclusive Communication'.

6.2.3: Stigma

There was strong support for continued positive action to reduce stigma, and considerable support for a positive duty to address stigma and discrimination.

The importance of this is reinforced by the wording of Article 8 of the CRPD which obliges States 'to adopt immediate, effective and appropriate measures … to foster respect for the rights and dignity of persons with disabilities [and] to combat stereotypes, prejudices and harmful practices relating to persons with disabilities.'

See Me said: 'We would therefore recommend that the "minimum core obligations" outlined include an explicit focus on eradicating the mental health stigma and discrimination experienced by individuals receiving care under mental health law, so that this aim is not deferred or reduced to a long-term ideal under the banner of "progressive realisation."' They felt the focus should address issues preventing people from seeking help, issues when people receive support, and barriers to full inclusion in society after receiving help – including prejudice and negative attitudes and practice of staff and wider society, as well as self-stigma.

Various suggestions were made in responses as to how stigma could be addressed, including greater support for people with mental or intellectual disabilities to be involved in directing how services and policy were developed, adopting measures outlined in Article 8 of the UNCRPD to increase awareness of the rights and dignity of people, developing education and training programmes, and enhancing the duties and powers of the Care Inspectorate and other scrutiny bodies to scrutinise, monitor and report on stigma and discrimination.

People First argued that negative and discriminatory attitudes are ‘helped by the way legislation refers to us and deals with us as different from other citizens.’

A number of respondents commented that stigma should be understood within the wider context of discrimination. COSLA pointed out that ‘Within the public sector, the public sector equality duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities: this includes making sure people with a protected characteristic have the same opportunities as others’. They said that ‘The benefit of legislating to reduce stigma is unclear and this may be best promoted by the support of this continued cultural shift rather than legislative change.’

We agree that legislation cannot end stigma and discrimination on its own, and action to address it should not await a new duty in law, but we have concluded that the legal obligations on Government should be strengthened. Article 8 of CRPD is clear and urgent in its terms, and the evidence we have received supports the view that current actions are insufficient; and that we need to go beyond the general obligations of the Public Sector Equality Duty, and ensure the full range of approaches recommended in Article 8 are put into effect.

6.2.4: Prevention and early intervention

We received many suggestions of ways in which society could do more to prevent mental ill-health. Some of these could be covered by the expanded duties we propose for mental health law.

The MWC suggested that strengthening the Mental Health Act duties could lead to ‘tertiary prevention’ in preventing relapse. The Royal College of Psychiatrists said that ‘support and care in community settings is missing or insufficient in many areas of Scotland, and the HRE framework and minimum obligations could provide opportunities to address deficits in preventative community care.'

See Me quoted focus group participants:

> '… we need better funding for early intervention to stop people reaching the point where they need coercive treatment…A lot of times it's: people trying to get help, being pushed back, trying to get help, being pushed back. And then whatever's going on is bubbling up and up and up and then they reach this crisis point where they can no longer autonomously decide what's best for their wellbeing. And it shouldn't get to that point.'

> 'A lot of it does really come down to accessible early intervention…they can't keep slapping Band-Aids on bullet wounds and shipping you out.'

One respondent suggested the introduction of 'community based mental wellbeing hubs with a common set of definitions and service specifications.'

The Health and Social Care Alliance cited the recommendations of the Independent Inquiry into Mental Health Services in Tayside: 'These include learning from events and listening to the feedback from people with lived experience, including unpaid carers and their families, in order to improve future practice; and ensuring that there are appropriate services in the community to support early intervention and prevention, particularly of more complex mental health conditions.'

Social Work Scotland highlighted the importance of public bodies working jointly to address issues such as poverty, discrimination and societal stress, and stressed that the prevention of mental health problems requires a whole system approach to policy design and service delivery. The legal framework should place the duty and expectation of public bodies working jointly.

We agree with this, although we accept that some preventive interventions should be seen in a wider context than mental health law. COSLA pointed out that the incoming mental health strategy provided an opportunity to embed mental health considerations across national policy in areas such as housing and green space.

Other broader interventions mentioned by respondents included tightening alcohol laws, trialling new approaches to illegal substances, reduction in the prison population and improvements to the benefit system, poverty reduction initiatives and addressing discrimination including racism, sexism, ableism, and homophobia.

6.2.5: Other ESC rights

Several respondents agreed that addressing poverty and access to employment were important elements of a human rights-based approach for people with mental or intellectual disabilities. SAMH said that social security policy needs to be aligned with this ambition, and SASW commented that the new Scottish benefit system offers an opportunity to create a fairer system that doesn’t penalise or allow people to fall through gaps in welfare support because of their mental health.

A range of other areas of focus was suggested. Support in Mind Scotland ‘supports efforts to prioritise digital inclusion to allow individuals experiencing loneliness to access online services and groups.’

The MWC said:

> ‘There is a growing body of evidence that ‘belonging’ … is important to maintain and to enable good mental health and recovery from mental illness. However there is little evidence that ‘belonging’ is measured for individuals using mental health services …. This does not just mean around vocational pursuits. Recent research conducted by the National Institute for Health

> Research (NIHR) published in the British Medical Journal … highlighted how systems consider mental and physical health for people with learning disabilities but with little emphasis on developing inter-personal relationships … this will require a significant change in culture, and services may need to be brought into existence/enhanced in order to make progress in this very important area.'

The Health and Social Care Alliance was supportive of the range of rights mentioned and highlighted the need to consider the rights of particular population groups, including people with sensory loss, people for whom English is not their first language, and people with learning disabilities.

Other suggestions included access to culture, leisure and sport, both because of their beneficial effects on mental health and because they are rights set out in Article 30 of the CRPD.

6.2.6: System-wide changes

There was almost universal support for the system-wide changes to mental health services which we suggested were necessary, although there were differences of view over the place of legislation in addressing them.

NHS Greater Glasgow & Clyde suggested that The Review was 'at times, excessively negative regarding the existing provisions and systems'. We agree that there are examples of excellent practice and a commitment to improvement in many parts of the mental health system, but the responses we received from user and professional groups nearly all suggested that more needed to be done.

SASW commented:

> ‘More support to professionals to ensure they have the knowledge, resources and skills to give full effect to the human rights of individuals is vitally important. … Social work education does not always cover a human rights approach in enough depth or detail, yet it is crucial to social work practice.’

The Care Inspectorate agreed with the system wide changes suggested, saying: ‘For system wide, and particularly upstream changes, to be achieved and sustained, there would require to be adequate and ongoing resources. This may include consideration of an asset-based community development model, a population health approach, extending an understanding of the role Adult Support and Protection can play and a greater focus of resources on preventative spend.’

The Royal College of Psychiatrists stressed that system change should encompass in-patient as well as community services:

> ‘Positive care settings should include in-patient settings (looking to the ‘Maggie’s Centres’ template for positive in-patient environments) and supported accommodation to enable community living. It is unacceptable that mental health in-patient services are sometimes inadequately maintained and do not always provide a welcoming and pleasant environment. We would also see this applying to those working to provide care for people with a learning disability, other relevant neurodevelopmental disorders, acquired brain injury and degenerative disorders such as dementia.’

Several respondents argued for a greater recognition of the role of trauma. We make a recommendation on this in chapter 9 on reduction of coercion. The Health and Social Care Alliance argued that we should: ‘Place greater emphasis on supporting the workforce to be trauma informed. Awareness of trauma and the barriers that those affected by trauma can experience when accessing care, support and treatment can help to reduce stigma and encourage the workforce to engage with people in a person centred way and in accordance with individual needs and circumstances.'

CRER pointed out that 'across all headings, specific attention is needed to ensure racial inequalities are addressed, particularly regarding cultural shifts and support to professionals (particularly for BME staff).'

Glasgow City Council said they would be 'would be concerned about further systemic change at this time, given current recovery status from the pandemic and the impact of cost of living'. We recognise this concern, and our view is that these systemic changes are not a standalone package, but need to be part of wider reforms, including the development of the National Care Service.

The Health and Social Care Alliance said:

'ALLIANCE members and partners have consistently highlighted the need for wider, systemic culture change to facilitate meaningful change in mental health services. We welcome the ambition set out in The Review's consultation document. However, during our engagement sessions it was recognised that there's often a disconnect between human rights rhetoric and implementation at ground level. If The Review proposals are taken forward, there needs to be a positive move towards human rights enablement at ground level.'

They suggested the following key elements to enabling system-wide and cultural change:

- Progressive economic systems
- Co-production and co-design

- Data and research
- Accountability
- Rights awareness and capacity building
- The role of duty bearers
- Investment and resources.

Specific proposals included an ongoing programme of longitudinal research to capture qualitative and quantitative data, framed within an equalities, human rights and intersectional lens, using ‘dignity language’ as a helpful tool for people to see the value in legal human rights frameworks, and the use of practical tools such as the PANEL principles and AAAQ framework.

Chapter 6: recommendations

Changes to mental health law including new duties

Recommendation 6.1: There should be a legal requirement for the Scottish Government to establish minimum core obligations to people with mental or intellectual disabilities to secure their human rights, including but not restricted to the right to the highest attainable standards of mental and physical health, and the right to independent living, alongside a framework for progressive realisation of those rights.

Recommendation 6.2: Sections 25 to 27 of the 2003 Act should be extended and reframed to set out clear and attributable duties on NHS Boards, local authorities and integration authorities to provide or secure support to individuals with past or present experience of mental or intellectual disability. The duties should include:

- **Personal care, support and treatment to maximise mental and physical health**
- **Housing which is appropriate for the person’s needs**
- **Provision to support living and inclusion in the community and prevent isolation or segregation**
- **Education, training and support for employment**
- **Assistance with travel to any of the above supports**

- **Access to financial advice and anti-poverty initiatives.**

Recommendation 6.3: NHS Boards, local authorities, integration authorities and the Scottish Prison Service should be under a duty to secure similar supports to people with mental or intellectual disabilities who are in prison or being discharged from prison.

Recommendation 6.4: There should be a systematic process of monitoring to assess whether these obligations are being met.

Recommendation 6.5: The duties under sections 260 and 261 of the Mental Health Act should be extended to ensure that people with mental or intellectual disabilities have effective access to information about their rights whenever they need it, including translation or interpretation where required.

Recommendation 6.6: There should be a legal duty on Scottish Ministers to adopt specific measures to address the requirements of Article 8 of CRPD (Awareness raising) in respect of people with mental or intellectual disabilities, including fostering respect for their rights and dignity and combating stereotypes, prejudices and harmful practice. The duty should be supported by specific actions in the minimum core obligations.

Recommendation 6.7: In line with the recommendations of the National Taskforce for Human Rights Leadership, there should be accessible, affordable, timely and effective remedies and routes to remedy where any of the above duties to provide services, support or information are not upheld. This should include the ability of individuals to raise a legal action in the civil courts.

Wider changes

Recommendation 6.8: The Scottish Mental Health Strategy should be recast to set out a clear human rights framework including the development of minimum core obligations and the progressive realisation of economic, social and cultural rights for people with mental or intellectual disabilities.

Recommendation 6.9: This should not be confined to health and social care services, but address other relevant government policies and strategies, including housing, poverty, social security, employment and community support.

Recommendation 6.10: The development of these minimum core obligations and the framework for progressive realisation should be carried out with the full participation of people with mental or intellectual disabilities and their representative organisations.

Recommendation 6.11: As the minimum core obligations are developed, the Scottish Government should identify any other public bodies who should be subject to a specific responsibility to fulfil the economic, social and cultural rights of people with mental or intellectual disabilities.

Recommendation 6.12: Duties to provide health and social care should be reframed in terms of human rights standards, including the AAAQ (availability, adequacy, acceptability and quality) framework set out at paragraph 12 of ICESCR General Comment Number 14 (United Nations, 2000). Since many of these duties apply more widely than to mental or intellectual disability, this may require to be considered as part of the general implementation of the proposed Human Rights Bill.

Chapter 7: The role and rights of unpaid carers

In our consultation paper in March, we made two proposals aimed specifically at promoting, protecting and realising the rights of unpaid carers. We proposed a framework for identifying, working with and improving communication with unpaid carers across the system. Part of this was the proposal for the development of Carer Awareness training for all staff working with people with mental or intellectual disabilities. We thought this training should be mandatory. Our proposals were based on what unpaid carers had already told us about their experiences of engaging with professionals, and a survey we had done with professionals.

The Carers (Scotland) Act 2016 (referred to as the Carers Act) sets down the rights of unpaid carers to involvement in the care and treatment of those they care for. This Act defines an unpaid carer as someone who provides care for another individual for which they are not paid. Neither do they provide this care as part of a contract or as voluntary work. It does not include people caring for young people under 18 (or 18 and still at school) if the reason they are being cared for is their age. It defines a young carer as someone who is under 18 (or 18 and still at school).

There are believed to be over 880,000 unpaid carers in Scotland (Carers Week Report 2020). Knowing how many of these people are providing care to people experiencing mental and/or intellectual disability is difficult. This is because there is stigma around this. Care may be provided for reasons in addition to mental and/or intellectual disability. And many people do not see themselves as being an unpaid carer. They see it instead as simply being part of what they do for a partner, sibling, mother, father, son or daughter.

7.1: This is where we started

In the first phase of the Review, we carried out targeted consultation work with unpaid carers of all ages. We spoke to a cross section of unpaid carers. We heard from people providing support to people with intellectual disabilities. Some were caring for people experiencing mental and/or intellectual disabilities. Others were caring for autistic members of their family. People were caring for their parents, siblings or children and young people.

Due to there being Covid restrictions in place, this engagement all took place either over the telephone or online. Unpaid carers also responded to our first consultation paper in 2020. Common themes emerged.

The first common theme to emerge from our engagement with unpaid carers was around the communication between people with lived experience, unpaid carers and practitioners in services for mental health, intellectual disabilities, autism and dementia. We reported in our interim report in 2020 that many unpaid carers felt ‘left-out’, ‘ignored’, and ‘under-valued’.

One unpaid carer commented that, ‘unless people had the courage to challenge professionals, they will act according to what they, as professionals, consider is best, and this is not necessarily in the adult’s interests’. Many reported that they were not kept informed about their family member’s admission, progress or discharge and were not given any support for themselves. Indeed, concerns about communication were raised in almost all responses received from unpaid carers to our first consultation. Few practitioners raised the issue.

The Communication and Engagement Advisory Group of the Review was concerned that these responses indicated poor levels of awareness and engagement between practitioners and unpaid carers. This was because, in many situations, the unpaid carer is the only or most constant person in someone’s life. It is the unpaid carer who knows that person when they are free from a mental or intellectual disability. They are the person who can best tell when the person starts to show signs of deteriorating health or distress. But it was also disappointing because of the existing laws which are meant to ensure unpaid carers are appropriately involved.

The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 require that regard is given to the views of unpaid carers. The Carers Act sets out that unpaid carers should receive appropriate information and support to continue with a caring role. They should have their views and needs taken into account. They should also receive respect for their role and experience. And there is a duty on health boards to involve unpaid carers in hospital discharge, where appropriate. These statutory protections are also underpinned by the best practice guidance, Triangle of Care: A Guide to Best Practice in Mental Health Care in Scotland (Triangle of Care). The responses to the Review in this first phase indicated that, in many instances, these rights in law are not yet resulting in a better experience for unpaid carers.

This links to the second common theme that was raised by unpaid carers. Many people with lived experience, and their unpaid carers, are not being made aware of their rights. This includes their rights under current mental health and incapacity law, the Carers Act or more broadly within a human rights context. Many people also specifically raised concerns about access to advocacy.

The Communication and Engagement Advisory Group first wanted to check what resources or tools were available to help practitioners working in the fields of mental or intellectual disabilities identify and engage with people with lived experience and unpaid carers in more substantial ways. Second, it wanted to send out a survey to such practitioners to gain a greater understanding of their perspectives around engagement with unpaid carers.

7.1.1: Resources to support engagement with unpaid carers

There are two main resources available to support practitioners working in services for mental health, intellectual disability, autism and dementia to work alongside people with lived experience and unpaid carers in meaningful ways.

Equal Partners in Care is an online training course. It was designed, with input from unpaid carers, for practitioners to raise awareness of unpaid carers of all ages. The

Triangle of Care mentioned above was developed by mental health carers in England. It has now been adapted for use within mental health services in Scotland. Although initially developed for use within mental health services, the Triangle of Care can be adapted and used within a wide variety of settings, including intellectual disability, autism, and acute care. There are already Triangle of Care resources for use in dementia settings and Child and Adolescent Mental Health Services.

The Triangle of Care is a therapeutic alliance between service user, unpaid carer and practitioner. It is based on six standards.

The six standards are:

1. Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.
2. Staff are ‘carer aware’ and trained in carer engagement strategies.
3. Policy and practice protocols on confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, along with a relevant range of information across the care pathway.
6. A range of carer support services is available.

Services are able to assess how they engage with unpaid carers using a self-assessment tool. Where there are gaps in such engagement (identified by the self-assessment process), an action plan is created to detail ways of filling such gaps.

7.1.2: Survey of practitioners' views

To understand more about how practitioners viewed their engagement with unpaid carers a short survey was developed. It was sent out to practitioners within services for mental health, intellectual disability, autism and dementia. The Review published this survey and a summary of the responses we received in 2021 (Scottish Mental Health Law Review 2021)

The survey asked about practitioners' confidence in identifying unpaid carers of all ages and the frequency of their interaction with unpaid carers. There were also questions about their awareness of the rights of unpaid carers, awareness of the Carers Act, involving unpaid carers in care plans, and sharing information.

It is recognised that the size and self-selecting nature of the survey's sample had its limitations. However, it was felt the results did highlight that significant work remains to be done around the role of unpaid carers. The survey responses raised concerns about a lack of awareness and training of unpaid carers and their rights among practitioners. Set alongside the experiences we heard from unpaid carers, they also indicated that practitioners' perspectives on their confidence in identifying unpaid carers and involving them in care and decision-making may be different from the perspectives of unpaid carers.

We asked practitioners what barriers they felt prevented them engaging with unpaid carers effectively. We also asked them what they thought they could do to support unpaid carers more effectively. The responses are summarised under key themes in Tables 1 and 2.

7.1.3: Table 1: Barriers to engaging with unpaid carers of all ages

Barriers to engaging with carers	
Theme	**Barriers**
Sharing information	• Patient withholding consent. • Poor relationship between patient and unpaid carer. • Poor relationships between staff and unpaid carers. • Not understanding the role of unpaid carer. • Differing patient and unpaid carer views. • Fear of saying wrong thing.
Identifying carers	• Short stays can limit time to identify or involve unpaid carers • People not seeing themselves as unpaid carers. • Dealing with misconceptions of unpaid carers held by other team members. • No thought to whether any children or young people could be providing unpaid care
Involving carers/ seeking carer views	• Overbearing unpaid carers who do not follow care plans. • Unpaid carers obstructing clinical decisions or not being on board with them. • Unrealistic expectations of the care that can be provided. • Unpaid carers’ loss of faith in services. • COVID restricted unpaid carers visiting wards, removing this chance to talk with them. • Other professionals’ discriminatory attitudes towards unpaid carers. • Poor experiences of working with unpaid carers in past.

7.1.4: Table 2: How mental health professionals could support carers more effectively

How mental health professionals could support unpaid carers more effectively	
Theme	**Suggestions**
Sharing information	• Identify when individual is well and ask about sharing information. • Helpful to begin these discussions at the admission stage. • Ensure unpaid carers know their rights. • Ensure unpaid carers have opportunities to be involved in Multi-Disciplinary Meeting (MDT) meetings. • Find out if unpaid carer is also guardian/power of attorney and what they specify. • Ensure policies and procedures are in place for confidentiality and sharing information. • Explain to unpaid carers that some information cannot be shared.
Identifying, involving and supporting carers	• Raising awareness of unpaid carers of all ages. • Listen and respect the views of unpaid carers. • Treat unpaid carers with respect and acknowledge their expertise. • Have more time in appointments to speak with unpaid carers. • Have more discussions with individuals around the support they need. • More training about unpaid carers and how to involve them. • Keep up to date with unpaid carer networks.

	- Signpost to local carer organisations. - Awareness of Carer Advocacy. - Awareness of role of young and young adult carers

The findings from this survey were discussed with the Lived Experience Reference Group of the Review. They helped consolidate ideas for recommendations around ensuring that unpaid carers are meaningfully identified and engaged with.

These recommendations formed part of the consultation chapter on Roles and Rights of Unpaid Carers carried out in 2022. We had two main proposals:

> To develop a framework which encompasses best practice in identifying and working with unpaid carers of all ages and in improving communication in general.
>
> To make Carer Awareness Training mandatory for all staff.

- This training to be ongoing to keep staff working within mental health services up to date with the rights of unpaid carers.
- That awareness raising of Carers (Scotland) Act 2016 and rights should be included within this, especially the right to involvement in discharge planning and processes.

We asked people what they thought about these ideas. We also asked some additional questions. One was about people’s thoughts and experiences of the sharing of information between unpaid carers and mental health practitioners. Another asked what needed to happen to ensure unpaid carers of all ages are respected and valued. We specifically wanted to know how young carers could be better identified and involved. We also wanted to know people’s views on the right within the Carers Act for unpaid carers to be involved in discharge planning.

A number of responses pointed to the need for our proposals to extend beyond unpaid carers in mental health services. We have always intended our proposals to expand beyond mental health services to all the services within the scope of the Review. This was made clear when working with our focus groups. We heard from unpaid carers and organisations who supported people with intellectual disability, dementia, and autism and their responses are reflected in our work.

In the rest of this chapter, we summarise the responses we received under themed headings and present our final recommendations aimed at promoting, protecting and realising the rights of unpaid carers.

7.2:Carer Awareness Training

7.2.1: This is what people told us

We asked people for their view on our idea that Carer Awareness Training should be mandatory for all mental health staff. We had suggested this training be ongoing to keep mental health staff up to date with rights of unpaid carers. And that the training should include raising awareness of the rights of unpaid carers in the Carers Act, especially around discharge.

The majority of people and organisations agreed with the need for mandatory carer awareness training. Many felt it should be extended to more than just mental health staff. Others included recommendations for what that training should look like and when it should be done. A smaller number of responses did not support this proposal or had concerns about it. Concerns included the resource implications of mandatory training and the need to legislate for this was questioned. An underpinning theme was that working to increase the realisation of existing legislative rights for unpaid carers should be prioritised over new legislative measures.

In support of the proposal: The proposal was supported by the majority of responses. Support in Mind Scotland felt it was ‘overdue’. Age Scotland felt if this was not already happening it was an omission. Thrive Edinburgh said that ‘it should align with priorities in the Carers Act, and while recognising that “mandatory” was a “strong term” … it was necessary’. The Health and Social Care Alliance supported targeted training on this. Scottish Social Services Council welcomed the proposal and opportunity to work closely with the Scottish Government to support its implementation. NHS Education for Scotland said they could provide this training.

A number of respondents suggested that the mandatory training should be for more than just mental health staff. The Law Society of Scotland said ‘it should be mandatory and should not be limited to staff in any one particular service’. There were specific calls for it extend to: social work and social care staff (Social Work Scotland); all professionals involved in the care and treatment of people in community and hospital settings (Moray Council); all staff supporting adults across the three pieces of legislation (An adult support and protection committee, Scottish Commission for People with Learning Disabilities (SCLD), staff in the Scottish Prison Service (Families Outside), people working with people with dementia (Parkinson’s UK), staff in the third sector (Support in Mind), and staff working with young carers (Thrive Edinburgh).

Requirement for carer awareness training: Those in support of our proposals were also clear about what would be needed if such training was to be worthwhile and meaningful. One of the most commonly stated requirements was that unpaid carers needed to be involved in both its design and delivery (Carers Trust Scotland , SASW, AdvoCard, Challenging Behaviour Foundation, Scottish Commission for People with Learning Disabilities (SCLD). SCLD specifically stated that PAMIS, who support people with profound and multiple learning disabilities need to be involved.

Another key requirement was that the training should recognise that unpaid carers are not ‘a homogenous group and have many intersecting characteristics’(SCLD). It needs to ‘respect and value the group’s diversity’ and take account of the cultural backgrounds of unpaid carers’ (Royal Society of Edinburgh). ‘It must specifically include carers of ethnic minority people as well as mandatory cultural awareness'(anonymous organisation). It must also reflect the needs of Deaf Carers and unpaid carers of autistic people, as well as other neurodevelopmental differences. The Forensic Network warned it would need to be tailored to the different clinical and social care settings if it is to avoid being too generic to use.

Staff awareness of training was seen as critical to prevent young carers being overlooked (COSLA, Glasgow City Council, Scottish Social Services Council). Raising awareness of young carers, including sibling carers, was seen particularly important in ensuring this group received the support they needed, and which was age and stage of development appropriate for them. Cultural awareness was again emphasised, e.g. the concept of 'young carer is not understood in many ethnic minority communities (Royal Society of Edinburgh).

People emphasised that this needed to be adequately funded (Royal Society of Edinburgh). 'The resource burden for any such training should not be met by unpaid carers or their organisations' (SCLD).

Responses also spoke to how it may work in practice and gave suggestions of when it should happen. e.g., to have this as part of pre-qualification training, induction, refresher or accreditation, or academic training programmes (Carers Trust Scotland , Social Work Service Dumfries and Galloway, MWC, Thrive, COSLA). Edinburgh's Carers Council suggested it could be part of recruitment and induction processes.

Lack of support or concerns about the proposal: A smaller number of responses did not support the proposal or had concerns about it. People pointed to existing training already available but were concerned about the amount of time and cost involved in making it mandatory (Anonymous organisation, COSLA, Glasgow City Council). This included cover to allow staff to do the training.

Others felt it was more important to ensure unpaid carers are involved in wider service design and keep training less fixed and mandated (Royal College of Psychiatrists, Social Work Service, Dumfries & Galloway). The Mental Welfare

Commission, while supporting the proposal, was also looking for the unpaid carer voice to be more embedded within the governance structures at all levels of health and social care services. They felt this approach ‘can often orient services towards these issues more meaningfully.’

Prioritisation of realising existing unpaid carers’ rights: A key theme underpinning a number of responses was that the realisation of unpaid carers’ existing rights should take priority over new legislation or rights. Many responses felt the necessary rights already existed, but more needed to be done to recognise them, as well as to recognise the status and critical contribution unpaid carers make to supporting the people they care for in our communities.

The Carers (Scotland) Act 2016 put in place a welcome set of rights for carers, but the experience of some of the family carers in ENABLE’s membership is that the objectives of the Act are not reflected in their experience with public bodies in their area. Ensuring the rights of carers already legislated for are being realised in practice is as much a priority as considering further legislative measures. (ENABLE Scotland)

> ‘Many of the problems in mental health services are related to the poor practice of the law and not necessarily inadequate protection within the law itself.’ (The Royal Society of Edinburgh).

As such, the need to legislate in this area was questioned. COSLA felt it would be ‘heavy handed’ and could become out of date quickly and preferred taking an improvement approach to the existing legislation to reduce additional complexity. This linked to responses that felt any unpaid carer awareness training needed to align with the priorities of the Carers Act (Thrive Edinburgh), and cover information, training and recognition of carers rights (Edinburgh Carers Council).

As well as more awareness of the rights of unpaid carers , more also needs to be done to ensure services know the statutory duties placed on them by the Carers Act.

> ‘It was especially noted that involvement of carers at discharge planning stages was poor in most mental health services and workers wondered whether mental health services, from NHS, knew there was a legal duty in place to ensure carers were involved in such discussions where practicable.’(Mental Health Workers Forum c/o Carers Trust Scotland and Coalition of Carers)

The Health and Social Care Alliance also noted that unpaid carers should be involved in discharge conversations and stated, ‘We know many unpaid carers can face challenges during hospital discharge process and are often left with a lack of support’. They suggested that an increased awareness of the rights of unpaid carers as set out in the Carers Act and the Carers’ Charter was needed.

Not involving unpaid carers in discharge planning was viewed by SCLD as ‘de-valuing their role’. They noted the significant contribution unpaid carers make in helping the cared for remain in the community and the carer has to be seen as part of the post hospital team.

One voluntary organisation raised the issue of unpaid carers receiving culturally appropriate support, such as help with language, during planning of discharge. They further noted that, where English is not the first language of the carer, they can struggle to understand what is being discussed and this can lead to a situation where the carer cannot provide the appropriate care at home.

7.2.2: Our final recommendations

Responses have shown that there is support and a need for Carer Awareness Training. While there was support for this to be mandatory there were also concerns about the impact this could have.

To be meaningful and effective we were told this training needs to accurately reflect the diversity of experiences, cultural backgrounds and ages of unpaid carers across Scotland, We feel therefore that cultural awareness needs to be a part of the training, as does raising awareness of young carers, including sibling carers. To achieve this it is critical that a cross section of unpaid carers are involved in the development and delivery of this training.

However, the responses highlighted that making it a legal requirement may not be helpful as it would make it more difficult to respond to changes in policy areas. It also does not feel in the spirit of encouraging partnership. And, without the need for legislation, the changes we would like to see happen could start within a relatively short time following any acceptance of the recommendation.

We think that the awareness of the rights of unpaid carers requires to be addressed. We think Carer Awareness training is essential in helping staff understand the role and rights of unpaid carers. We do not think this needs to be set down in legislation. We also have listened to the concerns about making this mandatory.

We recommend:

Recommendation 7.1: NHS Education for Scotland in partnership with unpaid carers and National Carers’ Organisations should develop Carer Awareness Training for all staff working with people with mental or intellectual disability across health and social care settings.

This training should:

- **Cover the rights of all unpaid carers as enshrined in legislation.**
- **Have local unpaid carers and carer services involved in its delivery at local levels where this is possible.**
- **Become best practice within pre-registration requirements for professionals across health and social care settings.**

- **Become best practice in the induction process for staff in third sector organisations.**

- **Become best practice in continuing professional development**

- **Respect and value the diversity and intersecting characteristics of unpaid carers, including cultural differences and the needs of young carers.**

- **Be supported by the development of measures to monitor and assess its effectiveness in improving outcomes for carers and staff, including levels of staff awareness, knowledge and confidence in protecting, promoting and fulfilling the rights of unpaid cares of all ages, and the difference it makes to the experience of unpaid carers.**

7.3: Best practice engagement framework

7.3.1: This is what people told us

As well as the Carers' Awareness Training, we proposed that a framework be developed to encompass best practice in identifying and working with unpaid carers of all ages. It would also cover improving communication.

There was support for a framework of best practice for practitioners.

Supporting the framework, organisations pointed to existing models that could be used or built upon for this. These included the Triangle of Care, the Somerset Model and the family psychoeducation model. (Carers Trust Scotland, Scottish Association of Social Work). The Triangle of Care was mentioned most. 100% of responses to a poll by the Mental Health Workers Forum c/o Carers Trust Scotland and Coalition of Carers approved of such a framework, suggesting the Triangle of Care as the 'best guidance to use'. They wanted the Scottish Government to support its implementation across all services supporting people with mental or intellectual disability, dementia, autism and other neurodevelopmental conditions within Scotland to ensure a consistent approach. Currently, it is very much a 'game of chance' whether unpaid carers were identified and offered support.

> 'Thus, whilst carer awareness training is welcome, there needs to be organisational and professional guidance and policies developed to back this up. This necessitates the adoption of an approach such as the Triangle of Care across Scotland so that public sector organisations and professional groups can work consistently and to the same standards.' (Mental Health Network Greater Glasgow).

> 'Triangle of Care could also be used as a quality assurance mark to indicate to carers and people with lived experience, that the service was carer aware […] The issue is that carer involvement and engagement is different in different parts of Scotland, there is no consistent approach and some carers get great support from mental health staff whilst others don't. Having a standardised best practice guide could reduce this happening.' (Mental Health Workers Forum c/o Carers Trust Scotland and Coalition of Carers).

Some responses indicated specific aspects that they would want such a framework to cover. It is critical that it can address the stigma that mental health has in specific communities (Anonymous organisation, Royal Society of Edinburgh). SCLD felt the 'framework within the Triangle of Care is an excellent starting point' as it already takes account of transcultural issues. However, they want more recognition for people with intellectual disabilities who are unpaid carers and how to engage effectively with them. They also wanted it to specifically cover the inclusion of unpaid carers involvement in discharge planning. Families Outside wanted any framework to include and reflect the needs of unpaid carers for people in custody.

In response to our specific question about information sharing, people suggested the need for a framework to support doing this better. Support in Mind wanted best practice guidelines and a toolkit for staff involved in information sharing. Many responses called for specific guidance or greater clarity on Data Protection and consent issues, with good practice examples. Edinburgh Carers Council felt staff needed more training on the General Data Protection Regulation (GDPR) and confidentiality in relation to unpaid carers, and a clearer framework for what can and cannot be shared: They asked 'who is making the decisions around what information can be shared?'. Mental Health Network Greater Glasgow felt that there needs to be more confidence in sharing information – there is a need for training but guidance and policies are also required to back it up. The Forensic Network wanted to strengthen the existing duties on the Mental Health Officer to gather information from unpaid carers and be a conduit in absence of consent. Midlothian Health and Social Care Partnership felt it would be helpful to have clarification about the rights of the person not to involve their family members and the rights of the unpaid carer to be involved. Social Work Scotland specifically felt that there was no need for any change in legislation around this. They felt the Data Protection Act and guidance from the Mental Welfare Commission's Good Practice Guide on Carers and Confidentiality were already sufficient.

The Royal Society of Edinburgh pointed out that section 27 of the Carers (Scotland) Act 2016 states 'unpaid carers should be involved in carer services' but felt this was not adequately understood by many statutory services. They felt a framework was needed to ensure that this legal requirement is met. The Carers Trust Scotland (on behalf of National Carer Organisations) highlighted concerns around inconsistency of approach in identifying and engaging with unpaid carers. They suggested the use of a framework similar to the Triangle of Care. They felt it could be adapted to relevant settings and should include arrangements made to involve unpaid carers in the discharge process as well as in overall care planning, with consent of the person being cared for.

COSLA felt that it would not be necessary to set any framework in legislation as there are many areas where frameworks exist. They gave Getting It Right For Every Child (GIRFEC) as an example.

7.3.2: Identifying and engaging with young carers

In our discussions with young carers during the final consultation phase we heard that services involved with the person they provide care for do not take the time to identify or listen to them. We also specifically asked what people thought was needed to ensure mental health services identified and engaged with young carers in our consultation paper in March 2022.

People recognised the challenges around the identification of, and engagement with, young carers, with most explicitly voicing the need for proactive steps.

> ‘Firstly there needs to be a proactive recognition of young carers and then a duty to support them.’ (Royal College of Physicians)
>
> ‘Young carers are still the most misunderstood and down-trodden of all carers. They ought to have special protection and support in the process.’ (Individual)

Identifying and supporting young carers was seen as essential to ensuring that their own health and wellbeing needs were addressed alongside rights enshrined under UNCRC. Young carers were viewed as being the last person professionals think about when asking about anyone providing unpaid care, highlighting the need to identify and support a young carer.

Some called for a statutory requirement to offer support to young carers. Others said that sufficient legislation existed, but resources had prevented it being embedded. The Law Society framed a focus on young carers and their identification as ‘a preventative strategy to support their mental health and avoid further issues into adulthood’.

The importance of asking the right questions in order to identify young carers was noted by the Carers Trust Scotland . They suggested that specific Young Carer Awareness Training should be offered to education services and health and social care services. They also pointed out how the Young Carers identification card scheme was helping young carers engage with services. One voluntary association amongst others explained young carers may first need reassurance that they will not be separated from the person they care for and, if this is to happen, be given information on timescales and support to deal with it.

To assist with identification, the Mental Welfare Commission and the Royal College of GPs highlighted that GPs often have a code for carers so that they can proactively provide support. Thrive Edinburgh suggested training for staff and a notification system for Social Workers and Mental Health Officers. The SCLD suggested engaging with young carer organisations as they will be aware of young carers in their area.

People said young carers need more intensive engagement and support to allow them to fulfil their role. They said that staff need to know how to engage effectively with the young person. This is about knowing the young carer’s preferences in terms of communicating, as well as engaging age appropriately. All unpaid carers need to be given the right information at the right time. But this was seen to be especially important for young carers as oversharing information can be inappropriate and lead to distress (Thrive). Social Work Scotland also cautioned against inappropriate information being given to young carers and the need to be careful to maintain the relationship between the young person and the person being cared for.

Responses emphasised the need to move the system to suit the young carer’s needs. For example, offering flexibility around meeting times so they do not clash with school/university or work. Renfrewshire Young Carers stated that ‘the needs of the young carer had to be taken into account when making decisions around any hospital interventions’.

The Law Society spoke of the need for a holistic overview of the needs of all carers which would include, for example, how young carers may need the support of specialist aspects of education. Thrive said it was ‘everyone’s job’ to engage with young carers, with schools being vital. SCLD suggested acceptable support organisations should be contacted to provide additional emotional support. Salvensen Mindroom highlighted greater understanding was required of the needs of sibling carers. Edinburgh Young Carers conducted research specifically into the specific needs of sibling young carers. This found that some sibling young carers struggled to get sufficient attention from parents resulting in them learning coping strategies which affected their mental wellbeing. Common amongst sibling young carers in this research was the loss of identity as decisions are made around the needs of the person with disability or illness.

Some suggested that training for staff with an element specifically focused on young carers is key. Salvensen Mindroom wanted a framework or relevant processes and designated time to engage with young carers and suggested that local authority Young Carers’ Statements could be shared, with permission, with relevant services who are supporting the cared for person. NHS Greater Glasgow and Clyde advocated greater engagement with wider community partners, ‘Triangle of Care’ assessments and the use of Carer Coordinators to improve communication with young/all unpaid carers. The Forensic Network also felt that, once identified, there is a need to explore why the young carer is fulfilling that role. Glasgow City Council felt that one of the aims of engagement should be alleviating caring roles where possible.

The Health and Social Care Alliance was looking for a ‘rights-based approach, through the lens of the UNCRC’ to ensure young carers rights are adequately respected, protected and fulfilled. They said young carers’ voices must be at the forefront of change, system design and implementation.

7.3.3: Our final recommendations

There was support for a framework for identifying and improving engagement with unpaid carers of all ages.

We think the Triangle of Care is the best fit to ensure as many of the asks made by the people who responded as possible can be met. The framework, if following the Triangle of Care structure, would allow services to identify unpaid carers, including young carers. It would record any health or disabilities the unpaid carer may have which may impact on them fulfilling their caring role, and how they may interact with services, and vice versa. It also has a standard around protocols for confidentiality and information sharing. This should address the concerns that many people raised around these issues. There is also a standard relating to staff being ‘Carer Aware’ which is achieved by Carer Awareness training as outlined in our earlier recommendation. However, we feel it is important to have Carer Awareness as a separate recommendation as this type of training should be provided for all staff working in mental or intellectual disability services, those training to work in such services including third sector and independent services. We note that some of these would not necessarily implement a Triangle of Care type of framework, so our earlier recommendation still means staff receive Carer Awareness training.

Triangle of Care is already used by some mental health services. It is also currently being implemented in areas including NHS Tayside, NHS Dumfries & Galloway, NHS Lanarkshire and the State Hospital. Both NHS Tayside and NHS Lanarkshire plan to implement it across mental health and learning disability services and there is potential for expanding this into physical health settings.

We do not recommend that this becomes legislation but it should be seen as best practice and fully supported by the Scottish Government. It will need to be accompanied by robust guidelines to ensure consistency of approach.

We recommend:

Recommendation 7.2: The Scottish Government should support the development of a national framework to ensure the identification and meaningful engagement of unpaid carers to be used in all services supporting people with mental or intellectual disability, including Child and Adolescent Mental Health Services. Its development and implementation should be coordinated by Carers Trust Scotland with support from National Carer Organisations, including Scottish Young Carers Services Alliance.

The framework should:

- **adopt and extend the Triangle of Care.**
- **include quality indicators for monitoring impact, compliance and criteria which reflect the rights of unpaid carers, enshrined in the Carers (Scotland) Act and human rights entitlements. Healthcare Improvement Scotland should be involved in the development of these quality indicators in partnership with Carers Trust Scotland and inform an improvement approach to implementation.**

7.4: Involving, valuing and supporting unpaid carers

7.4.1: This is what people told us

We asked people to tell us their views on information sharing between unpaid carers and professionals. We also asked what needs to happen to ensure that unpaid carers of all ages are respected, valued and supported. These questions linked to issues raised during our first consultation in 2020.

Sharing information

In relation to the sharing of information, a consistent response was that information sharing was ‘highly desirable’ if the person gave consent. The importance of both the involvement of an unpaid carer and the importance of consent were repeatedly highlighted, as was the need for it to be a two-way process, and how the voice of unpaid carers is often not sought or is ignored or marginalised. There was a clear and repeated underlining of the need to balance the right to private life and respect for confidentiality, with protection and respect for family and friends, highlighting the ethical challenges, legal obligations and complexities around information sharing. Even if consent is not available, people spoke of the need for unpaid carers’ views still to be heard to give a picture of how the person was ‘when well or, for example, before dementia developed’ (Thrive) and to be heard as part of the care provided (COSLA). The Health and Social Care Alliance want information to be shared with unpaid carers of all ages. VOCAL is looking for professionals to pay closer attention to the need to obtain information from unpaid carers and to provide them with information to help them care more effectively.

> ‘Information sharing should be in the context of a human rights-based approach which balances the rights of the person with lived experience and the rights of the unpaid carers.’(Salvensen Mindroom Centre)

Of the 70 unpaid carers VOCAL spoke to, two thirds were not offered opportunities to be involved in the care planning of the person they cared for. They felt this was down to confidentiality, the person receiving treatment being the primary focus and a lack of awareness of the role of the unpaid carer . Many also spoke of the need for accessible information and to be able to sit down and speak to someone when entering services for the first time, from a place of staff understanding how ‘daunting, distressing and scary’ it can be.

People spoke about what was ‘appropriate’ to share, and highlighted that information should be shared ‘mindfully’, taking into consideration what information was needed to allow unpaid carers to do their caring role, but also the impact or unintended harm sharing of some information may cause to the unpaid carer, the person receiving treatment and their relationship or the therapeutic relationship. The Care Inspectorate highlighted the ‘value the sharing of the information would bring to the adult at the centre’. The Royal College of Psychiatrists spoke of what was needed for ‘optimal care’. The Law Society felt limitations on sharing information should be ‘strictly drawn’ and based on demonstrable and real concerns/harm, rather than progressing on a ‘need to know basis’. They felt safeguards were also needed to ensure any such limitations were not driven by the convenience of providers. Scottish Social Services Council felt it was essential that unpaid carers are given the opportunity to be involved in decision-making and are supported as necessary to provide any required information, Edinburgh Carers Council felt that unpaid carers should be entitled to more, not less information.

Social Work Services in Dumfries and Galloway felt the individual should be prioritised, suggesting a scheme similar to the named person.

> ‘Each caring situation will be unique, and a personalised response applied. Consent and data protection has its own legislative basis that cannot be ignored. There are too many situations in which a vulnerable adult may not want certain information to be shared to make an overall commitment to this.’(Glasgow City Council).

COSLA listed a number of considerations across this ‘complex’ area, including consideration of what to do when a relationship breaks down and management of coercive control within a carer/cared for relationship. A local authority also highlighted negative relationship dynamics/undue influence and for legislation to have safeguards for such situations. People First, while supporting appropriate information sharing, spoke of still experiencing ‘carers and family members having more information, and in many cases, more say over our lives than we do ourselves’, leading at times to greater restrictions than services may have suggested otherwise.

Sharing information was noted as an issue by the young carers that we spoke to. Their support worker also commented that this is particularly concerning for those young carers who are the sole person providing care and support. The information sharing was seen as essential during transitions between services and when planning for discharges. However, it was noted by this group of young carers, their worker and other organisations that planning meetings tend to happen during the day, when young carers may be in school, further education or working. It can be difficult for a young carer to secure the time away to attend such planning meetings either because they have not disclosed they are a young carer or because they have to take time out due to other aspects of their caring situation. The young carers in the focus group were able to tell of other young carers who simply returned from school and realised that their parent had been discharged from psychiatric hospital that day. No one had prepared the young carer (the sole carer) for this happening. (Renfrewshire Young Carers).

As in earlier responses, it was clear that engagement must be tailored to the specific needs of different groups of unpaid carers. Carers Trust Scotland spoke of the need for greater transcultural awareness of how different groups construct mental illness. Deaf Scotland felt Deaf carers looking after Deaf people are going ‘under the radar’ due to lack of information and engagement; they are unlikely to accept help from hearing organisations due to lack of understanding of their language or preference to engage with another Deaf person. The Royal College also raised specific issues around what and when to share information when a person had neurodegenerative conditions.

Organisations who support ethnic minority people commented that there exists a lack of recognition of unpaid carers in general, but the lack of awareness tended to be higher in ethnic minority communities. It was felt that there were expectations from services that family members provide unpaid care. Organisations such as MECCOP (National Carer Organisation for Black and Minority Ethnic Carers) wanted to see independent, culturally appropriate advocacy available for unpaid carers and to raise the profile of unpaid carers from ethnic minority communities amongst professionals.

Responses highlighted the need for unpaid carers to have their own advocate and highlighted how important advocacy is in the area of carers' rights; acknowledging that unpaid carers have needs that are separate and can be different from the cared for person. SHRC felt advocacy and training could be needed to assist unpaid carers to play their roles. One organisation felt unpaid carers should be allowed to take part in tribunals, 'to ensure their rights are considered'. Several responses asked for a dedicated advocacy service to be developed for unpaid carers (SASW, Support in Mind, SHRC). There was a general consensus that a designated carer advocacy service was needed, and the use of advance statements could assist unpaid carers around sharing information. COSLA felt there was a need for advocacy particularly for young carers to ensure their rights are protected.

One individual felt that the system of sharing information worked well if the unpaid carer was also a power of attorney holder. Another felt that the unpaid carer was the best person to inform professionals about the will and preferences of the person and should be involved in the assessment process. Thrive suggested unpaid carers may need information to carry out their role as Named Person or Initiator.

Valuing and supporting unpaid carers

Valuing and respecting unpaid carers is key to providing a therapeutic relationship between professionals, unpaid carers and those experiencing mental or intellectual disability. Many unpaid carers talk about not feeling valued by services through lack of inclusion in care and treatment or decisions made around the person they care for.

Support for unpaid carers can offer the chance for unpaid carers to maintain the caring role and have a life for themselves as well. Support, however, cannot be a one size fits all approach, it has to be what is needed by the unpaid carer, which includes ensuring information, communication and support respects the cultural background of the unpaid carer as well as age and any illness, disability or condition the unpaid carer may have.

Organisations who support ethnic minority carers and individuals stated that support is needed to assist unpaid carers in accessing financial benefits such as Carers Allowance. For people with language barriers this can be extremely complex which means people are often left in dire circumstances. It was stated that often people don’t know what benefits they are entitled to.

One individual noted that the HRE process should be available for unpaid carers especially where they provide substantial care. This could affect their financial situation and economic status. This individual also commented,

> ‘Caring can be relentless and tiring, support services need to be in place to enable them to live as normal a life as possible.’

Another individual noted that,

> ‘The role of carer itself can be quite traumatising. Most people are not equipped with the skills necessary to carry out the tasks required of them. They end up isolated and overwhelmed.’

It was further pointed out that there is a lack of culturally appropriate options available for unpaid carers of ethnic minority people requiring respite. Examples given include dietary requirements not being met and a lack of culturally appropriate activities, especially for young people, being offered. We were also told that while the Self-Directed Support Act was brought in to resolve these issues, this is not working as intended, mainly due to lack of funding to deliver it.

Parkinson’s UK Scotland also highlighted that there can be significant issues for unpaid carers of people experiencing Parkinson’s who also experience mental health or cognitive symptoms. They go on to say that services, for instance, day care, respite or befriending, which can provide support to people with Parkinson's and a break for unpaid carers, can be harder to access when the person also has complex mental health issues alongside complex physical health problems. This can also be an issue when looking for appropriate residential placements.

Consideration of the needs of older unpaid carers was mentioned by the Challenging Behaviour Foundation. They noted that people with complex intellectual disabilities are now living longer lives, which means they are often outliving their parents who may have provided the main care for most of their lives. It was suggested that more support was needed to help older unpaid carers and their families prepare for the transition to alternative care arrangements when an older unpaid carer is no longer able to provide that care. People with intellectual disabilities must also be supported to deal with such transitions. The Challenging Behaviour Foundation also noted,

> 'We know that family carers of individuals with severe learning disabilities can often suffer from mental health issues due to their experiences of advocating and supporting their relative. There needs to be effective services to help such carers.'

British Deaf Association UK Scotland also raised the issue of services needing to assess the needs of unpaid carers. They suggest that services should be aware of relevant services to which to refer carers for further support for their own needs. They also suggested setting up a carer support group specifically for Deaf carers where they can meet with others and share information.

7.4.2: This is what we are recommending

The majority of responses were supportive of information sharing, but also stated that this had to be an appropriate level of information and with the consent of the person cared for. Where consent was not given, or the person was unable to consent, safeguards were in place to avoid any breaches of confidentiality. It was felt though that safeguards may need to be improved and unpaid carers supported more to help them understand the process of sharing information. Our proposal for a national framework for identifying and engaging with unpaid carers will cover information sharing protocols.

To further enable to the voice of unpaid carers to be heard, responses indicated the need for a dedicated advocacy service for unpaid carers. This was felt to be especially necessary for ethnic minnority carers to ensure that they had access to information and to share it in a way that was appropriate for them as well as in the language used by carer. For many, the existence of carer advocacy was seen as a way of protecting carer rights, especially for young and ethnic minority carers .

We think there should be a dedicated national independent advocacy service for unpaid carers. This would not provide the type of support normally provided in carer centres. It would exist solely to provide independent advocacy to unpaid carers. This is the model of service provided by the Edinburgh Carer's Council. Keeping such a service separate from a carer centre or service ensures the independence of the advocacy provision. We appreciate, however, that a local carer service may wish to also provide a service offering independent advocacy (such as a carer service for ethnic minority carers) and it is recommended that, in doing so, regard is paid to the Scottish Government's Guidance for Unpaid Carer Advocacy in Scotland.

We also support the call to ensure Scotland has culturally appropriate respite services for people.

We recommend:

Recommendation 7.3: The Scottish Government should create a national dedicated independent advocacy service should be developed for unpaid carers. This service should include culturally accessible advocacy for carers.of ethnic minority people.

Recommendation 7.4: The Scottish Government must ensure the development of culturally appropriate respite services.

Chapter 7: recommendations

Carer Awareness Training

Recommendation 7.1: NHS Education for Scotland in partnership with unpaid carers and National Carers' Organisations should develop Carer Awareness Training for all staff working with people with mental or intellectual disability across health and social care settings.

This training should:

- **Cover the rights of all unpaid carers as enshrined in legislation.**
- **Have local unpaid carers and carer services involved in its delivery at local levels where this is possible.**
- **Become best practice within pre-registration requirements for professionals across health and social care settings.**
- **Become best practice in the induction process for staff in third sector organisations.**
- **Become best practice in continuing professional development**
- **Respect and value the diversity and intersecting characteristics of unpaid carers, including cultural differences and the needs of young carers.**
- **Be supported by the development of measures to monitor and assess its effectiveness in improving outcomes for carers and staff, including levels of staff awareness, knowledge and confidence in protecting, promoting and fulfilling the rights of**

unpaid cares of all ages, and the difference it makes to the experience of unpaid carers.

Best practice engagement framework

Recommendation 7.2: The Scottish Government should support the development of a national framework to ensure the identification and meaningful engagement of unpaid carers to be used in all services supporting people with a mental or intellectual disability, including Child and Adolescent Mental Health Services. Its development and implementation should be coordinated by Carers Trust Scotland with support from National Carer Organisations, including Scottish Young Carers Services Alliance.

The framework should:

- **adopt and extend the Triangle of Care.**

- **include quality indicators for monitoring impact, compliance and criteria which reflect the rights of unpaid carers, enshrined in the Carers (Scotland) Act and human rights entitlements. Healthcare Improvement Scotland should be involved in the development of these quality indicators in partnership with Carers Trust Scotland and inform an improvement approach to implementation.**

Involving, valuing and supporting unpaid carers

Recommendation 7.3: The Scottish Government should support the development of a national dedicated independent advocacy service for unpaid carers. This service should include culturally accessible advocacy for carers of ethnic minority people.

The Scottish Government must ensure the development of culturally appropriate respite services.

Chapter 8: Human rights enablement, Autonomous decision making and Deprivation of liberty

8.1: Human Rights Enablement (HRE)

8.1.1: Where we started

The focus of existing mental health and capacity law in Scotland is primarily on authorising non-consensual interventions in relation to psychiatric treatment and other health, welfare, financial and property matters. It also contains various human rights-based safeguards against the unnecessary use of these. However, it does not go much further than this. It does not proactively ensure that a person's wider needs are respected, for example those which enable a person to live independently and fully participate in society. If this is to be achieved then the law needs to reflect the rights that entitle a person to have these needs met.

At the time The Review commenced there was growing concern across stakeholder groups that mental health and capacity legislation in Scotland, and its implementation, was failing to fully meet the needs of persons with mental or intellectual disabilities (McKay and Stavert, 2003).

As stated in Chapter Two of this report, we consider that the purpose of mental health and capacity law should be wider than simply regulating non-consensual interventions and should ensure respect for the whole range of rights for persons with mental or intellectual disabilities, including economic, social and cultural rights.

The limited human rights reach of Scotland's current mental health law is perhaps understandable. At the time the legislation was enacted there was only a legally binding duty on the Scottish Parliament to give effect to ECHR rights. ECHR rights are mainly concerned with preventing unwarranted intrusions into a person's life and autonomy. However, with the growing influence of the CRPD has come the realisation that the whole range of a person with mental or intellectual disability's rights must be considered and respected on an equal basis with others. The law therefore needs to address both this and the requirement that active support is made available to overcome inequalities in rights enjoyment.

The proposed approach

Throughout The Review we have consistently been told by persons with lived experience, including unpaid carers that their overriding wish is to be responded to with compassion, to feel respected, cared for and to receive the appropriate support and protection at the right time. This is not necessarily expressed in terms of ‘human rights’ but there are human rights that, if respected, will ensure that these wishes are respected. It is therefore clear that a legal framework must be in place that both allows for such human rights to be identified and actively put into effect.

In our March 2022 consultation, we proposed therefore that the law puts in place a mechanism, or approach, that actively enables respect for human rights: Human Rights Enablement (HRE). This will work within a framework which also includes :

(a) A Supported decision making (SDM) regime to ensure a focus on respect for the will and preferences of people with mental or intellectual disabilities; [see Chapter 4] and

(b) An Autonomous decision making (ADM) test to allow for non-consensual intervention in situations when this is necessary to protect the person’s or others’ rights. [see the following section for more information on ADM]

Collectively these elements of the framework will:

(a) Ensure and protect the rights of persons with mental or intellectual disabilities;

(b) Ensure that persons with mental or intellectual disabilities receive appropriate support at the right time (whether an emergency or non-emergency);

(c) Ensure that the rights of others are also protected.

We proposed that the framework should apply irrespective of diagnosis, and without the necessity for any capacity/SIDMA tests, see Chapter 13, or ADM test, see below. It would be applied in situations currently covered by mental health, adults with incapacity and adult support legislation.

We see the role of HRE as being the means by which to determine the most appropriate strategy of overall care and support for an individual. It will provide a framework within which to make decisions with and concerning persons with mental or intellectual disabilities that best ensures that the whole range of the person's rights are respected and therefore enjoyed to the same extent as others.

Essential components of HRE

1. Maximising a person's ability to make an autonomous decision and thereby ensuring that priority or 'special regard' is given to a person's will and preferences. This involves:
    - Making all efforts to best understand the person's will and preferences and giving effect to these;
    - Only limiting the person's rights if this will demonstrably lead to more respect, protection, and fulfilment of the person's rights overall; and
    - Only limiting rights to the extent required to achieve these protections.
2. Protecting the rights of others. This appreciates that sometimes decisions will be necessary to protect the human rights of other people thus recognising that rights must be enjoyed by everyone on an equal basis.
3. Clearly identifying relevant human rights which are considered on an individual basis.
4. Covering all a person's needs, including economic and social as well as clinical needs, and will normally require input from a number of persons, for example, the person, their family and/or carers, independent advocates and various practitioners.

5. Having a right to refuse or decline an HRE. This should normally be respected unless it is an involuntary decision of the person in which case an HRE should be completed. Voluntary decision-making is discussed in more detail in ADM below. However, a person’s decision to decline a HRE is distinct from any decision they may wish to make, or ongoing engagement, about the proposed care, treatment, support or protection. That being said, such a refusal on one occasion does not preclude completion of an evaluation at any other time, or later stage. A record should be made of the refusal and on a later occasion, when an HRE review would otherwise be due, a check should be made that the decision to refuse remains.
6. Being an ongoing approach, HRE is not a discrete or one-off process and should offer a structure for continuous review by way of regular engagement. However, there should also be formal updating at certain ‘trigger points’.

   Examples of ‘trigger points’ for a review of a person’s HRE, or relevant aspects of it, are:

   a) A request from the person or an interested party, for example their unpaid carer.
   b) An application for compulsory care and treatment.
   c) An application to authorise restrictive measures outside care and treatment such as where a person is to live, who they live with, what they wear, who they meet, control over their own finances, etc.
   d) A newly identified vulnerability.
   e) A new episode of care.
   f) A referral to a new/different service or delayed discharge situation.
   g) A formal review of the treatment plan.
   h) A change to the personal situation, for example, a change of accommodation, a change of financial circumstances, the change of a

carer’s status, or even a change of mind by the person on their preferences.

i) If none of these events has arisen, a formal review should occur annually unless a less frequent review has been agreed.

7. Having a route of appeal against the outcome of the HRE and a route to remedy, for example, because there is a failure to deliver rights to which a person is entitled where it is reasonable that these could be met. We propose that there is an escalating process, commencing with an internal review, followed by review by a body responsible for protecting rights such as The Mental Welfare Commission (MWC).
8. Making and maintaining a record of HRE, including the process and a record of the person’s will and preferences, or refusal of the evaluation, and this being easily accessible for ease of later review. Until a cross-service IT system is established there should be a statutory requirement to ensure that, with consent, or where it is legitimate to protect the person’s or others’ rights: (a) the record is placed in all relevant health and social care files and (b) a duty is placed on those who have made or been involved with the assessment to inform others. We appreciate the practical challenges with this and recognise that it will require lateral thinking and potentially creative solutions.

We do not consider that there be a specific HRE template form as this may result in the process becoming merely a ‘tick box exercise’, not allowing for a full consideration of the person’s rights, but the record must be clearly marked ‘HRE’ so that it is easily identifiable.

Essential components of HRE approach

An HRE approach must embody an evaluation that:

a) Ensures that the person’s will and preferences are known in respect of the given issue;

b) Identifies what rights, if any, are in need of protection, including the rights of others or another;

c) Considers whether all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment;

d) Weighs advantages to human rights against harms to human rights. Significant harms to certain human rights would be justifiable only exceptionally, on the basis of very significant advantages in the respect, protection and fulfilment of the person's human rights overall;

e) Provides a plan of action for giving effect to such identified right or rights in order to meet the person's needs at that time.

We mention above that significant harms, or restrictions, to certain human rights would only exceptionally be justified on the basis of very significant advantages in the respect, protection and fulfilment of the person's human rights overall. This is a different approach to that of protecting someone by limiting their freedoms. Currently our mental health and incapacity law focuses on protecting the health, safety or welfare of the person, and the Mental Health Act also on the safety of any other person. However, we consider that it is possible that all of these concepts can instead be thought of in relation to harms to human rights, which is indeed what the UNCRPD requires us to do. For example, protecting health can be interpreted in terms of giving effect to the person's right to health, right to habilitation and rehabilitation, protecting safety in terms of the right to life, freedom from torture or cruel, inhuman or degrading treatment or punishment and protecting welfare in terms of freedom from exploitation, violence and abuse.

In terms of clarity as to when and by whom HRE must take place, we consider that this can be achieved by direction in legislation with accompanying guidance and Codes of Practice. Clear Codes of Practice, guidance and training will also be essential so that all parties have a shared understanding of the relevant human rights, equality in rights enjoyment, balancing rights and legitimate and proportionate limitation of rights and roles as well as responsibilities in relation to the HRE as to assist in making informed judgments. By all parties we mean the person who is the subject of the HRE, their families and carers, courts, tribunals, the police, local authorities, monitoring and regulatory bodies, voluntary sector organisations and all practitioners.

The emphasis and objective is to maximise rights and enjoyment of persons with mental or intellectual disabilities. However, it also provides for situations where certain rights may be proportionately and non-discriminatorily restricted in order to ensure such rights enjoyment, including a person's safety, and to protect the rights of others.

8.1.2: What we were told

We found that, as with earlier feedback from our Lived Experience and Practitioner Reference Groups, a majority of consultation respondents supported the concept of HRE, particularly as part of the wider framework including SDM and ADM. Several practitioners and other respondents saw this as supporting what practitioners are already trying to achieve.

> 'We support inclusion of a framework which brings explicit and specific consideration of human rights to the forefront of care and support. The suite of HRE framework, SDM and an ADM test combine to ensure a focus on realising the human rights of the individual, not just in times of crisis and intervention, but in daily practice. The process of the HRE would allow for careful consideration of the legitimate aim for restricting a person's rights and the most proportionate means of doing so, and allows for scrutiny and accountability for that decision. It also enables consideration of duties to take proactive action to fulfil economic, social and cultural rights'. (Scottish Human Rights Commission)

> ‘The MWC considers that the HRE as a framework is a helpful means to ensure that a person centred, human rights-based, care plan becomes an established norm within mental healthcare services. Some practitioners are trained to have human rights at the core of their holistic practice so this is not new however a framework will support consistency across health/social work/social care/third sector’. (The MWC)

And from individuals, including those with lived experience, including unpaid carers:

> ‘I wholeheartedly agree with the outlined proposals, but urge you to enshrine them in law and not, as I saw in a previous chapter, in guidance.
>
> ‘It [HRE] makes sense. Everyone should have their rights and wishes respected… We can support everyone's rights, no matter how high their support needs are. All human rights are relevant’.
>
> ‘These are important principles and I welcome a longer term approach being undertaken to the consideration of HRE’.

However, various concerns were raised which we have grouped below:

- The need for further development of the concept so that it is clear how it would work in practice

Although there was general support for the guiding principles of the proposed HRE there was a feeling that it would benefit from further elaboration and detail as to how the framework would work in practice.

> ‘We support the principles contained in the HRE framework to promote and protect human rights. We are in absolute agreement in relation to the centrality of human rights in mental health legislation and recognise the benefits these principles could bring to care settings in which our members work and the person they provide care for. Our following points centre not on the principles, but on the practicality of delivering this in the currently

> proposed framework, particularly in inpatient settings'. (Royal College of Psychiatrists Scotland)
>
> 'We welcome the purpose of the HRE Framework, seeking to put human rights into focus in a practical and tangible ongoing assessment. We wonder, however, whether the terms "framework" and "enablement" will lead to sufficient understanding of the judgement and application of rights-based practice expected of practitioners'. (Law Society of Scotland)

Some respondents felt that while the HRE approach could be useful in certain circumstances such as ensuring community care plans and placements under guardianship are addressing the person's needs, there were concerns regarding the broadness of the proposal, and the fact it will have significant implications for all parts of practice.

Some respondents felt that case scenarios, detailing the triggers to initiate a HRE, in both crisis and planned situations, and detailing how the HRE is intended to work in practice, may be helpful to understanding.

We acknowledge that HRE does have significant implications across all areas. We recognise it is a radical change and will need a lot of time to realise. There is need for further development with practitioners and service users, those with lived experience, including unpaid carers.

- Lack of confidence in the ability to share HREs

It was mentioned that experience to date is that the systems currently in place do not support that ease of transfer of information. Respondents mentioned the challenge of sharing HREs between services and agencies because there is currently no universally shared IT system. It was noted that electronic systems across agencies, and sometimes within organisations, do not easily communicate with each other or allow for a single document to be shared across platforms. The significant challenges associated with this will need to be resolved, and some respondents felt that this practical challenge may impede achievement of the HRE approach.

The need for effective coordination between health, social work, education, police, and other key and relevant professionals involved in a person's life if responsibility for making and recording the enablement is to be shared was mentioned.

'There is lack of clarity on how HRE documentation will be accessed, how these will be shared with families/carers and how the HRE will be made easily accessible across a range of settings'. – Royal College of Psychiatrists. Access to and the sharing of appropriate individual information was identified as a key barrier for carers engaging fully with services (see chapter 7).

Again, we acknowledge these as real and valid concerns. They are not entirely IT issues; we recognise the challenges of shared hard copy information across various agencies. There are also concerns, including human rights/Article 8 ECHR and privacy concerns, about information being shared more widely than is needed or the person agrees to, especially about issues as sensitive as mental illness.

- Over assessing people and alignment with other assessments

Some respondents mentioned the need for there to be careful consideration of the practical applications of this framework and how it interacts with other statutory documents and processes. We had stated in our consultation document that we did not intend to add 'yet another assessment' to those that already exist, but instead to build on what exists now in order to ensure there is meaningful and holistic consideration of a person's human rights when decision-making. However, some concern was voiced that it might nevertheless result in being yet another assessment. Some respondents even suggested that the introduction of HRE is unnecessary as current assessment frameworks work well and roles and responsibilities are in the main clear and understood. Others suggested that it would be more helpful to incorporate HRE into other established assessment processes.

We acknowledge that more detailed work is required to determine how HRE will best work in practice. HRE should not be an additional and discrete assessment that must be made alongside, and possibly conflict with, existing health and social care assessments. It should be an enabling approach which develops such existing assessment structures.

- The need for a shared understanding of human rights and of the HRE process

Several respondents indicated that HRE would only be effective if there is a shared understanding of human rights across the professional groups. Others highlighted the need for extensive training and information in order to make the process work.

> ‘Given the number of practitioners that could be involved in HRE, we would imagine a considerable amount of training, education and awareness would be required in order to achieve good working practice.’ (AdvoCard)

We appreciate extensive training and comprehensive guidance will need to accompany the introduction of a HRE framework.

- Clarity as to roles and responsibilities within HRE.

Several respondents expressed confusion over, and felt more detail was required about, who would be responsible across practitioners for triggering and leading, conducting and completing HREs. It was also said that clear guidance would be necessary on this and how to resolve any disagreements.

> ‘If it is seen as an assessment tool for all who are involved in the person's care, then it would need to be agreed across all parties who will take the lead in completing the document - guidance and further clarity on the skills/competences for those who take on this role would be welcomed.’ (A Health and Social Care Partnership)

> ‘Not clear on who would complete the HRE record. There is potential for many supplementary versions to exist simultaneously in different files and it is not clear how this would work in practice. In addition, there seems to be a suggestion that for every new intervention a further updated record would need to be included. This would be problematic on a day-to-day basis; if records cannot be carried out for every new intervention at the time of the

> intervention taking place (thinking of care home and hospital settings); with potential disagreements between professionals regarding who would complete the record or on what basis the record would be completed. How would this be monitored in any workplace or clinical setting? How could this be achieved in any meaningful way?” (A mental health service provider)

As HRE supplements any current assessment of needs, we consider that the person with responsibility for initiating the HRE is the person who undertakes the care, treatment and/or service needs assessment, with any additional practitioners then, as may be required, reviewing and revising it. Moreover, HRE should be an evolving process as different practitioners become involved and consider the person’s needs from their specialist perspective thus avoiding repeated and fresh evaluations with every referral to a new service provider.

- Safeguards

The need for clarification around monitoring and ensuring appropriate reviews of a HRE was mentioned.

> ‘Clarity on how this framework will be monitored, including ensuring that the HRE is not just completed but is reviewed at the relevant trigger points, would be useful.’ (the Care Inspectorate)

Concern was also raised over accountability for decisions resulting in a person’s rights being limited in certain situations, with an example of how Advance Statement overrides are perceived being provided.

> ‘The requirement to record reasons for over-riding the HRE already exists for Advance Statements. It is not an effective safeguard because nobody checks (never mind challenges) that the reasons are justified or even adequate.’ (Mental Health Rights Scotland)

- How HRE will operate in different settings

Respondents also sought clarity over how HRE would operate in situations beyond those involving persons with long-term conditions. For example, in prisons, in relation to children and in secure hospital settings.

> ‘The proposal as outlined seems best suited to those with long term and enduring conditions, where there is time to compile a considered HRE assessment taking in the views of a range of relevant parties. There is less clarity on how this framework could work effectively for those presenting in crisis, for individuals involved with the criminal justice system or for individuals in physical health care settings who require non-voluntary interventions (eg managing agitation by someone presenting with delirium). It is unclear how professionals would access an existing HRE across a range of settings and how to avoid multiple HREs being in place for the same individual (which may contradict each other).’ (Royal College of Psychiatrists)

- Clarity on the triggers for HRE

Several respondents stated that it should be clear about when and for whom HRE is required.

> ‘Guidance on when to introduce the HRE framework would be welcomed.’ (A Health and Social Care Partnership)

> ‘Clarity on whether this document needs to be completed for every person with a diagnosis of a mental health condition when they have a first contact with a service would be welcomed.’ (A Health and Social Care Partnership)

Anxiety was also expressed about how a practitioner would manage a situation where the holistic approach of HRE revealed unmet needs, outside the remit of that practitioner, for example, the need to address poverty or housing issues (this relates to the realisation of wider rights, see Chapter 6). Guidance will be needed to cover the management of such situations, which we acknowledge will arise.

Fear was also raised that if a duty to complete and review HRE is imposed on professionals it may become a ‘tick box exercise’ only.

- Balancing rights

The need for clarification on the balancing of rights.

> ‘In situations where there is a conflict of rights and not all can be upheld, the HRE assessment needs to be able to reflect this. We would suggest that any appeals process also needs to incorporate consideration of conflicting rights and the risk posed (both to the individual and others) if certain rights are not infringed upon’. – Royal College of Psychiatrists.

> ‘Members considered how professional disagreement would be resolved if multiple practitioners were involved in an HRE, what structure would be in place to support differing views, and whose view would take precedence in disagreements? This was considered specifically in relation to hospital discharge and the differing views of health and social work professionals at times, where assessments for ADM can cause tension at points when hospitals are under pressure to discharge people. In these circumstances, members have advised that system need can often come into conflict with human rights.’ (Social Work Scotland)

We recognise that such tensions do exist and will continue to arise under a HRE approach. Guidance will cover how to manage difference of opinion.

Assurances were also sought that balancing rights does not result in a disproportionate restriction of some rights particularly those relating to autonomy and liberty in pressured situations.

> ‘We seek greater clarity and assurances that the provisos and exceptions built into the model – for example around overriding rights to ensure overall fulfilment of rights, and watering down HRE in crisis situations – would not allow the

> effective continuation of current working practices, including the use of coercion, in high-pressure situations.’ (See Me)

- Managing expectations and professionals’ accountability

The culture shift across services and appropriate and adequate resourcing that would be required to make HRE effective, was noted.

Concerns were raised around managing expectations of HRE. Questions arose about what would happen when resourcing issues or limitations on professionals’ powers may mean that rights identified cannot be realised. The accountability of the professionals in such circumstances was also an area of concern.

> ‘There is concern that expectations would be raised within the development of an HRE document that would not be met, and therefore pressures would come to bear on individual professionals or public bodies to uphold rights where these are out of reach for most. Where then is the compromise here? What might be considered as good enough upholding or balancing of rights with what is available and who would be accountable for rights, will or preferences not being met?” (a mental health service provider)

> ‘Many practitioners work within a context of eligibility criteria and limited resource; this may make easy targets for legal challenges. Whilst organisations are ultimately responsible for this, the stress on individuals will be significant’. (a mental health service provider)

- Barriers to care

Some respondents expressed concern that the requirement to conduct HRE may in fact delay or impede care where a clear and immediate need is identified.

It is intended that the process will be capable of being applicable to, and tailored for, all situations so that needs are met at the rights time thus not being overly cumbersome and a barrier to care and support.

- Increased bureaucracy and workloads

Some respondents also wondered whether HRE will increase bureaucracy and workloads for practitioners. It was particularly noted that social workers are already over-burdened and more resourcing is required here.

We acknowledge these concerns. In developing the concept we are very aware that this may be perceived as placing an additional bureaucratic and professional burden on already over-stretched practitioners. However, the objective of HRE is not to be unnecessarily burdensome but to provide a structure within which to identify and action an individual's needs at a given time. Such needs may therefore be simple or require fuller consideration with the level of HRE corresponding to this. An urgent situation or where a person is in distress may require an abridged HRE at that point in time, followed by a subsequent more detailed review once the presenting situation is controlled.

HRE will extend thinking about human rights, beyond those rights which simply prevent unnecessary non-consensual intervention in a person’s life. It will require active consideration of all of a person’s rights in order to support their wider needs necessary for the attainment of the highest standard of physical and mental health.

We also acknowledge the concerns that HRE may lead to courts or tribunals enforcing socio-economic rights underpinning access to support and services where resourcing is limited or unavailable. However, we consider that the HRE approach will operate within our recommendations concerning progressive realisation and adherence to the minimum core obligations mentioned in Chapter 6 of this report and any nationally set service standards (whichever adopts the most detailed and rigorous approach to human rights realisation). To reiterate, we propose that there be:

- A legal requirement for Scottish Government to establish minimum core obligations to people with mental or intellectual disabilities to secure their human rights.

- A statutory responsibility on public bodies to secure those aspects of the minimum core obligations reflected in their statutory powers and duties.
- Duties to provide health and social care to be reframed in terms of human rights standards, including the AAAQ (availability, adequacy, acceptability and quality) framework.
- A systematic process of data monitoring to assess whether these obligations are being met.
- The development of these should be carried out with the full participation of people with mental or intellectual disabilities and their representative organisations.

In addition, we suggest that a revised Scottish Mental Health Strategy should:

- Set out a clear framework for the progressive realisation of economic, social and cultural rights for people with mental or intellectual disability.
- This should not be confined to health and social care services, but address other relevant government policies and strategies, including housing, poverty, employment and community support.

This should ensure that the needs of persons with mental or intellectual disabilities are timeously met without the provision of support and services being denied or limited on the basis of their disability. Service providers will have to illustrate that any denial or limitation of such support or services does not disproportionately impact persons with mental or intellectual disabilities.

8.1.3: Our final recommendations

Recommendation 8.1: The Scottish Government should develop and adopt the HRE approach.

HRE maximises a person's ability to make an autonomous decision and thereby ensuring that priority or 'special regard' is given to a person's will and preferences. An HRE approach

a) **Ensures that the person's will and preferences are known in respect of the given issue;**

b) **Identifies what rights, if any, are in need of protection, including the rights of others or another;**

c) **Considers whether all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment;**

d) **Weighs advantages to human rights against harms to human rights. Significant harms to certain human rights would be justifiable only exceptionally, on the basis of very significant advantages in the respect, protection and fulfilment of the person's human rights overall;**

e) **Provides a plan of action for giving effect to such identified right or rights in order to meet the person's needs at that time.**

Recommendation 8.2: The HRE approach should be developed with the full and equal participation of people with lived experience, including unpaid carers, and practitioners.

Recommendation 8.3: The HRE approach should cover the full range of a person's rights and operate as a framework together with SDM and ADM.

It should be accompanied by guidance, Codes of Practice and training

Recommendation 8.4: The Scottish Government should ensure sufficient resourcing to realise this HRE approach.

8.2: Autonomous decision-making

Chapter 4 covered the broad structure for SDM and Chapter 6 highlighted respect for the whole range of human rights, which we recommend becomes the tenet of our mental health and capacity law. Notwithstanding this, we accept there will be a limited number of occasions when it is necessary to act without a person's consent, when this is not available at the time: to prevent harm, to act for someone's wellbeing and even to give effect to will and preferences stated at some earlier point but still relevant.

8.2.1: Where we started

Currently, justifying non-consensual intervention is predicated on, amongst other criteria, a test of capacity (under the Adults with Incapacity (Scotland) Act 2000) or significantly impaired decision-making (SIDMA) (under the Mental Health (Care and Treatment) (Scotland) Act 2003).

Although these tests were considered to be the most ethical at the time both Acts were enacted, they have subsequently been subject to criticism. We also note that the UN Committee on the Rights of Persons with Disabilities has stated that the use of mental capacity tests lead to the discriminatory denial of the right to exercise legal capacity, which is the ability to put into effect one's will and preferences (UN Committee on the Rights of Persons with Disabilities 2014). This is because such capacity tests are decided on the basis of diagnosis of mental disability and various prejudices and misconceptions exist about the validity of a person's views, ability to make an authentic decision and capabilities.

In most of the State Party reports that the UN Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. This is decided simply on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered to have negative consequences (outcome approach), or where a person’s decision-making skills are considered to be deficient (functional approach).

The functional approach attempts to assess mental capacity and deny legal capacity accordingly. It is often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information. According to the Committee, this approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law. In all of those approaches, a person’s disability and/or decision-making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.

The Committee strongly directs a shift to an approach based on respecting the ‘rights, will and preferences’ of the person. It acknowledges there will be situations where it proves impossible to determine the person’s will and preferences, in which case a ‘best interpretation of will and preferences’ should be the basis for any decision.

We believe there is considerable force in the Committee’s arguments, but there are also some practical difficulties. There is no agreed methodology for assessing ‘will and preferences’ or resolving dilemmas where these are in tension. There are risks that using this as a yardstick could sometimes be just as subjective a test as the Committee believes capacity tests to be. We also believe that the situations where the person’s will and preferences cannot be determined and a best interpretation must be made may be more common than the Committee appears to acknowledge.

However, we strongly agree that a substantial change in approach is needed to strengthen respect for the autonomy of people with mental or intellectual disabilities.

Capacity and SIDMA in practice

In June 2020, The Review commissioned a review, taken from a range of key stakeholders, as to how capacity and SIDMA currently operated, in practice. The findings can be accessed here.

A summary of the findings against the three outcomes agreed for that review are:

1. To inform the MHLR in determining what changes might be required to the way capacity is assessed currently.

   The survey has provided a lot of information in this regard, including

   - views on the fusion of SIDMA and capacity.
   - what other factors may/should go into the definition.
   - how improved guidance can support practice.
   - reconsidering the prescribed class of person.
   - how training and potentially audit can improve consistency.
   - consideration of regular, independent, review of an assessment of incapacity.

2. To consider if assessment of capacity should be the threshold and, if not, what else may present a better indicator.

   Just over half the respondents (56%) said ‘yes’ capacity should be the determinant, the remainder felt it should be more than capacity and described a range of functional factors. These same functional factors were seen as deficiencies with the current capacity test. The collection of data does not allow us to analyse if the people who responded ‘no’ to capacity as the determinant are the same people who commented on deficiencies of the current definition.

3. To consider what approach we may need to take to maximise a person’s ability to make decision for themselves (exercise their legal capacity) (UNCRPD compliance).

   Generally speaking, respondents felt this would require ‘a paradigm shift’ but seemed committed to this aspiration and offered a range of constructive views as to how this may be achieved.

Capacity and Support for Decision-Making workstream

As part of the process of review the Executive established a number of focused workstreams, of relevance here is the Capacity and Support for Decision-Making workstream, which consisted of a range of key practitioners, people with lived experience, including unpaid carers and academics. The workstream’s views were taken on the current capacity and SIDMA tests. We heard divergent opinions, some people viewed the current tests as giving a level of objectivity and focus, favouring the tests if applied properly, but commenting that more clarity is required in how the tests should be applied, to enable consistency of application. Others raised a range of concerns such as the tests are:

- subjective and therefore allow for misperceptions and biases, e.g. about a person’s abilities because they have a particular diagnosis.
- can be discriminatory, particularly to certain groups.
- can be used regardless of a person’s ability to make specific decisions.
- can be manipulated to give the outcome one wants, inappropriately resulting in unnecessary restrictions of the person, or for securing appropriate support, or potentially denying vital support because the person is considered to have capacity.
- are applied inconsistently.
- are misunderstood.

- are applied too early in practice, to facilitate treatment and resource allocation decisions rather than considering other options.

The March 2022 consultation

As part of the March 2022 consultation The Review Team therefore sought wider stakeholder views on the current capacity and SIDMA tests; broadly, should these remain as they are, remain but in a reworked form, including being reworked as a combined test, or be abandoned in favour of an alternative test? An alternative, ADM test was accordingly proposed.

Autonomous decision-making (ADM) test

We accept that, even with every support available under the SDM regime, there may be occasions when a person lacks the ability to reach, or express, an autonomous decision and that in limited circumstances the use of measures without the person's consent may be necessary to ensure that their rights are fully respected through appropriate supportive and protective measures. Such measures may include detention, involuntary treatment or other health, welfare, financial or property decisions. We proposed that an ADM test replace the existing capacity and SIDMA tests as it provides a more rights-based criterion for non-consensual intervention.

We consider that an ADM test may be applied in any context, wherever it appears the person is unable to make an autonomous decision, but it should only be made where non-consensual measures are being considered. It must not be used to determine the nature of the measure or measures. These measures should only be decided after the person is found to not be able to make an autonomous decision.

However, it is essential to start from a position where all persons, irrespective of any diagnosis, must have the opportunity, if necessary with support, to make an autonomous decision. The ADM test should not be applied until every support has been provided to maximise the person's ability to make an autonomous decision. It must also be decision-specific and not allow for 'blanket' denials of a person's autonomy. It must also operate entirely within the framework which also comprises the HRE outlined above and SDM outlined in Chapter 4.

What is an autonomous decision?

An autonomous decision is one which is free from controlling influences, in other words, factors prevent the making or communicating of an autonomous, or voluntary, decision-making it impossible for others to know the person's authentic view.

When will an ADM test be relevant?

Normally, where care and treatment for a person's mental or physical health conditions, or support with their welfare, financial and property affairs may be required and the matter is not urgent, a review of the person's ability to make an autonomous decision can be part of a planned pathway. Where there is no serious or imminent risk of harm to the person, or other/s, the SDM framework, outlined in Chapter 4 and the HRE approach outlined above should be used to establish what the person's needs are, what their autonomous wishes are and how these can be best met. There is a section below about the application of the ADM during times of crisis.

The ADM test must not be based on any specific diagnosis but on whether the person can arrive at an autonomous decision, such assessment being made on a non-discriminatory basis. It may therefore apply potentially to any person although, of course, The Review's remit is in relation to persons with "mental disorder".

Usually, the test should include input from the person themselves and, with their consent, input from carers and family members who have significant involvement in the person's life, as well as any person with relevant proxy decision-making powers, and any relevant practitioners.

Two aspects of the ADM test should be made clear. First, whilst the test arguably has many similarities with capacity and SIDMA tests it is different as it encompasses more reasons why, and situations in which, a person may be unable to make decisions autonomously. Unlike capacity and SIDMA tests it is not confined to a diagnosis of mental disorder. It is also important, to appreciate that, as we have already stated, the ADM does not automatically lead to non-consensual interventions. Whether measures are necessary and the type of measure will be decided on a human rights and equality and non-discrimination basis. We have emphasised throughout this report that the presence of mental or intellectual disabilities does not lead to an automatic restriction of rights.

Second, although the ADM test may ‘capture’ persons other than those with mental or intellectual disability, for example those who are subject to coercive control or without mental or intellectual disabilities but in a crisis, this will not result in them being subject to non-consensual measures under mental health and capacity legislation. Appropriate support and non-consensual measures might, however, be sought through other legislation or services under these circumstances. Clearly these other measures should be made available but the remit of this review is to consider the law as it relates to persons with mental or intellectual disabilities.

We discuss the relationship of the ADM test to Adult Support and Protection interventions in Chapter 14.

Determining Autonomous decision making Ability

In determining whether the person is able to make an autonomous decision regard should be given to

- The ability of the person to understand information relevant to the decision.
- The ability of the person to use or weigh the information in order to make a decision.
- The ability of the person to communicate the decision.
- The ability of the person to act on their decision, or otherwise act to safeguard themselves from harm.

- The extent to which any apparent decision, or expression of will and preferences, may be undermined by one or more of the following controlling influences, if they cannot be sufficiently mitigated.
    - Undue influence by another person or persons.
    - The impact of any illness, disability or health condition, including a health care crisis.
    - The impact of any situational or environmental factors.

Essential points of note

The following points are intended to apply in the various contexts where an ADM test might be used, including appointing a Decision-Making Representative (DM Representative), making a decision on treatment for a physical condition, or detaining a person in hospital. The detail of how each point should apply will vary depending on the particular context and legal process, but the general approach should be consistent throughout.

1. There must be a presumption in favour of ADM ability.
2. At a time of crisis, or where it is otherwise not possible to establish the person’s will and preferences, consideration must be given to any advance wishes, for example those made in an advance statement or plan.
3. Where a person is found not to be able to make an autonomous decision, there would always be a presumption in favour of respecting their will and preferences **unless** this will result in a ‘harm’ being caused.

4. Intervention without first giving full effect to the person’s will and preferences should be permitted only if this will demonstrably lead to more respect, protection, and fulfilment of the person’s rights overall, or to protect harm to another person or other persons. The severity and duration of the intervention must only be proportionate to achieving these protections.

5. A decision to disregard, or to not give full effect to, a person’s will and preferences must not be based on the existence of a specific diagnosis, for example it should not be assumed that, because a person has dementia, or has a mental illness, it automatically follows that they are not able to express their autonomous will and preferences on any particular matter. That said, it is recognised that the influence of the person’s illness, as opposed to perceptions based on the diagnosis, may impact on the voluntariness, or authenticity, of their decision-making.

6. Where a person’s past will and preferences conflict with currently expressed will and preferences the person responsible for the ADM test and any decision to intervene should determine the best resolution of this conflict, which should be the option which best protects the persons human rights overall.
7. Any departure from a person’s will and preferences must be for as short a period as possible.
8. Any restriction on a person’s ADM must be lawful and proportionate, and non-discriminatory.
9. A record of the ADM, its duration and review date should be stored in the person’s records alongside the HRE, as this is part of a suite of key information.

Children and Young People

As we state in Chapter 12, we recommend that the Autonomous Decision Making test, along with the HRE approach and Supported Decision Making, should in principle apply to children subject to mental health law, but that further policy development will be necessary to address the complex relationship of ADM with parental rights and responsibilities, the Age of Legal Capacity (Scotland) Act 1991 and the UN Convention on the Rights of the Child. It may be that this framework is ultimately applied to children requiring support in other areas but this is a complex area and not within the remit of this review. We also mention this more specifically in relation to deprivation of liberty and children below.

ADM in urgent situations

In some situations, where there is a serious and imminent risk of harm and action is immediately necessary to protect the rights of the person, or others, it may not be possible to complete the ADM test process, before taking some urgent action.

That said, even in crisis, significant efforts should be made to provide every support and consideration must be given to any expressed advance wishes, for example those made in a statement of will and preferences. If there are no relevant advance wishes available, then every effort should be made to seek a best interpretation of the person's likely will and preferences – to understand what the person's true wishes are and what they may be seeking to achieve or communicate. In some situations, to proceed contrary to the person's likely will and preferences may exacerbate the crisis.

Before proceeding, anyone responsible for intervening should consider the human rights implications of acting against the person's wishes. Will the action demonstrably lead to more respect, protection, and fulfilment of the person's rights overall, or to protect harm to another person or other persons? Is it proportionate to the risks of not acting? We recognise, of course, that these are not always easy decisions to make and that the extent to which it is thought appropriate to respect a person's autonomy over potential or actual harm they may cause to themselves will ultimately boil down what is considered ethical and societally appropriate at a given time. However, the intention is that the ADM test will provide a structure to facilitate such decisions.

Intervention must only be to the extent required to achieve these protections. For example, it may be appropriate for a person to be detained but separate authorisation may be required for treatment. Please see Chapter 9 on Coercion, see below for commentary on DOL and discussion on necessity in the AWI Act chapter, where we discuss where and when depriving a person on their liberty may be justified.

Similarly, it may be appropriate to temporarily restrict a person’s autonomy where their environment or a person who has access to it poses a real and immediate threat to them. However, this must only be to the extent necessary to remove the threat and to put in place arrangements that respects the person’s overall rights on an equal basis with others. Decisions on whether it is lawful and appropriate to restrict a person’s choices about other aspects of their life must be assessed separately.

The position must be kept under strict review and the non-urgent approach implemented immediately after the crisis has abated, for any ongoing intervention that may be required.

Who performs the ADM test?

Other than where it is stated otherwise in law, we are not advocating that completion of an ADM test is the realm of a particular professional. The person completing the test should have the necessary skill, competency and expertise. They should be familiar with the matter in respect of which the decision is being made – for example if the matter related to a neurosurgical procedure, one would expect a person skilled in the procedure to assess the person’s ability to make an autonomous decision about consenting to, or refusing, the treatment. Likewise, if the matter related to, for example, the disposal of a significant capital investment one would expect someone familiar with such decisions to assess the person’s ability to make an autonomous decision about the appropriateness of the disposition, with medical advice if necessary.

Ideally, the person who has completed the HRE should be the person completing the ADM test; however, we recognise that this may not be possible, for example, there may be a gap in time between the HRE and the need for an ADM test; the service provider may have changed; or the person who completed the HRE may not have the necessary skills to complete an ADM test. The ADM will then be initiated by the person responsible for the intervention being proposed, who is also responsible for updating the HRE, as is stated above.

Comprehensive guidance

We recognise that comprehensive guidance will be needed to inform the new ADM test. Information should be provided on, but not limited to:

- ADM as a concept;
- What is an autonomous decision;
- When is ADM relevant;
- Who undertakes an ADM test;
- The process of assessing a person's ability, or not, to make an autonomous decision;
- ADM in urgent situations;
- The authority granted for non-consensual intervention i.e. only to the extent needed and only for as long as needed to achieve the protection required;
- The review and renewal process for an ADM test;
- The right of appeal / who may appeal / the appeal process;
- Dealing with differences for example when a family member feels the person cannot make an autonomous decision but the practitioner believes they can, or vice versa.

8.2.2: What we were told

Views on the current capacity and SIDMA tests

The divergent views on the current capacity and SIDMA tests remained in the responses submitted, with an even split between those who supported the concepts and those that would like to see them abandoned.

> ‘Both tests are antiquated and extremely disrespectful.’ (Faculty of Advocates)
>
> ‘We are broadly in favour of a common test, encompassing both capacity and seriously impaired decision-making capability.’ (General Medical Council)
>
> ‘I think the issues are strikingly different. SIDMA is necessarily much more narrowly focused on the circumstances of compulsion to treatment. The AWI Act deals with the width of life choices through health, welfare and finances. To conflate them would be to risk losing the fine focus that SIDMA requires.’ (An individual)
>
> ‘I am not in favour of changing current capacity (2000 Act) or SIDMA (2003 Act) tests.’ (An individual)

Views on an alternative test

A number of responses indicated a likely preference for an alternative test if there was more clarity on this.

> ‘We support a single system of ADM testing replacing capacity and SIDMA tests as suggested by The Review’. (Law Society of Scotland)
>
> ‘It is essential that every effort is made to support ADM to enable the person to understand proposed treatment and to gain their views.’ (An individual)

> 'The fundamental concept of autonomous decision-making (ADM) appears logically compatible with the process of human rights enablement (ADM) and the proposed uncoupling from diagnosis is rational though potentially very challenging in practice.' (An individual)

Some of the general comments we heard were

> 'Strongly agree with the concept of the ADM. I see it as a continuum from enabling the person to make their own decision through SDM to taking account of their will and/or preferences as far as possible to avoid harm to themselves or others. In the event of a crisis, an intervention will be based on human rights principle of acting on what the person would have wanted to happen when well (which may include wanting others to make the decision for them when they are in crisis). For people with a progressive neurological condition such as dementia, diagnosed early and accurately, it should be possible to avert the use of ADM except in extreme circumstances.' (An individual)

> 'We welcome and support both the basic concepts of HRE and of an autonomous decision-making test. They should be at the core of our way forward in Scotland in relation to all relevant areas of law. However, as described in the consultation document, both are seriously undeveloped.' (Law Society of Scotland)

> 'Please make the autonomous decision test easy enough for a person with a learning disability or a cognitive disability to understand. Please work with disabled people to create the test.' (An individual)

We have concluded that we should introduce a new test. We think it important to have a single test which focuses on the question of whether the person can make an autonomous decision. Neither capacity, as currently understood, or SIDMA, is quite appropriate. Evidence we have gathered suggests that they can lead to either a person being subject to unnecessary and disproportionate restrictions, where they are assessed as lacking capacity or having SIDMA, or, left without vital support and they, or others, placed at risk, where they are found to have capacity or not have SIDMA.

Both are predicated on the presence of mental disorder, which is potentially discriminatory. Capacity is a long-standing test, but one which is not always consistently applied, and which can, we feel, focus too much on an evaluation of cognitive capacity, to the exclusion of other factors which may enhance or diminish decision-making ability. SIDMA was arguably intended to avoid these problems in the context of detention and compulsory mental health interventions, but the ways in which it is intended to differ from incapacity are not always clear. We believe it better to start afresh with a new test which fits our wider human rights-based approach.

We have set out a general framework for what the test would consider and the consequences of being found not to be able to make an autonomous decision in a particular case. But we acknowledge that there is much detail to be worked out before such a test could be put into effect.

Work with practitioners and service users, those with lived experience, including unpaid carers, is required to develop this new test including how it should be applied in the various situations where it is relevant, and to develop comprehensive guidance on ADM as well as a statutory Code of Practice. An assessment of ADM making is distinct from any subsequent decision concerning support measures and restrictions. A finding that a person is unable to make an autonomous decision does not automatically authorise non-consensual measures.

Criteria for non-consensual interventions

Currently, detention and requirements to accept treatment under the Mental Health Act depend on a number of tests being satisfied. We consider in chapter 9 the criteria which should be adopted for non-consensual interventions, where a person is found to not be able to make an autonomous decision.

The current tests under the AWI Act are generally broader, for example the test applied by the sheriff in an application for guardianship is that ‘no other means provided by or under the Act would be sufficient to enable the adult's interests in his property, financial affairs or personal welfare to be safeguarded or promoted'.(section 58). The adult must also lack capacity as defined in section 1, and the principles of the AWI would need to be taken into account.

We discuss 'mental disorder' at Chapter 2, and the SIDMA and capacity tests earlier in this chapter. We did not receive substantial evidence suggesting major problems with the other criteria, although we are aware that the Wessely review of the Mental Health Act in England and Wales discussed questions on the 'risk' test in particular. At present, apart from the replacement of the capacity/SIDMA criterion for non-consensual intervention, we do not therefore believe major changes to the other criteria are necessary.

In the longer term, these tests would need to be accommodated within our wider framework of strengthened principles (see chapter 2) and HRE. As we discuss above, this is a radically different way of conceptualising the process for authorising a non-consensual intervention. Additional or alternative criteria may be needed to fully capture the approach to weighing different human rights which is core to HRE.

Also, in moving towards fusion, it would be desirable to consider how the criteria for intervention in the two Acts can be aligned more closely, with an overall focus on ensuring that non-consensual interventions are justified, proportionate and maximise respect for the human rights of the person.

8.2.3: Our final recommendations

Recommendation 8.5: The Scottish Government should replace the existing capacity and SIDMA tests with the test of ADM to provide a more rights-based criterion for non-consensual intervention.

The new ADM test would offer a more rights-based criterion for non-consensual intervention. The test should establish whether the person is able to make an autonomous decision on the matter in question, having regard to:

- **The ability of the person to understand information relevant to the decision.**
- **The ability of the person to use or weigh the information in order to make a decision.**
- **The ability of the person to communicate the decision.**
- **The ability of the person to act on their decision, or otherwise act to safeguard themselves from harm.**
- **The extent to which any apparent decision, or expression of will and preferences, may be undermined by one or more of the following controlling influences, if they cannot be sufficiently mitigated.**
- **Undue influence by another person or persons.**
- **The impact of any illness, disability or health condition, including a health care crisis.**
- **The impact of any situational or environmental factors.**

Recommendation 8.6: ADM should be developed with the full and equal participation of people with lived experience, including unpaid carers, and practitioners.

Recommendation 8.7: ADM should be accompanied by guidance, Codes of Practice and training.

Recommendation 8.8: The Scottish Government should ensure sufficient resourcing to realise ADM.

8.3: Deprivation of liberty

8.3.1: Where we started

We recognise that there is a human rights gap in Scots law around the Deprivation Of Liberty (DOL) for persons who lack capacity to consent to this voluntarily. This gap was exposed following the European Court of Human Rights 2004 ruling in the Bournewood case (HL v UK (45508/99) [2004] ECHR 471).

Article 5 of the European Convention on Human Rights (ECHR) precludes arbitrary or unjustified deprivations of liberty. It requires that there is a lawful process to authorise deprivations of liberty, including those where there is no objection from the adult or their family. It also requires that there is a practical and effective way for the person to be able to challenge the lawfulness of their detention (MH v UK (11577/06) [2013] ECHR 1008).

The Bournewood ruling made it clear that a deprivation of liberty engaging Article 5 ECHR occurs where a person is subject to continuous supervision and control and is not free to leave. It also made it clear that a person who lacks capacity but does not appear to be objecting to a deprivation of liberty cannot be taken as consenting to such deprivation of liberty. This was subsequently reiterated by the 2014 UK Supreme Court Cheshire West ruling (Cheshire West and Chester Council v P [2014] UKSC 19). This therefore widens the scope of situations in health and social care where (1) deprivations of liberty may occur, and (2) where safeguards are required for persons who lack capacity.

The Mental Health Act provides Article 5 ECHR compliant patient safeguards against arbitrary or unjustified deprivations of liberty. However, the Bournewood and Cheshire West rulings raised questions about whether deprivations of liberty in other Scottish health and social care settings are Article 5 compatible. The Scottish Law

Commission’s 2014 Report on Adults with Incapacity concluded that adults without capacity are being confined to hospital wards and residential facilities in Scotland without any underlying legal process, potentially contrary to Article 5 of the ECHR (Scottish Law Commission, 2014).

There has therefore been an increasingly urgent need to address this incompatibility and ensure that there is a process to authorise lawful DOL and to challenge the lawfulness of a DOL. At the same time, any process must be a proportionate one which does not discriminate against disabled people relative to others. For example, it is disproportionate to suggest that in the absence of any concerns, the adult living in a domestic setting with family or foster care style relationships should be treated as being deprived of their liberty and the family subject to monitoring by the State.

It is also important to distinguish between a DOL engaging Article 5 ECHR and a restriction of someone’s choices engaging Article 8 ECHR (respect for private and family life) which falls short of a DOL. A restriction of someone’s choices which does not amount to a deprivation must, of course, be necessary, lawful and proportionate. However, it is the restriction of Article 5 ECHR rights that we are considering here.

The Review is also mindful that Article 14 UNCRPD requires that persons with mental or intellectual disabilities enjoy the right to liberty on an equal basis as others. The Committee on the Rights of Persons with Disabilities has stated that detaining persons with disabilities against their will, either without their consent or with the consent of a substitute decision-maker, amounts to an arbitrary DOL and violates both Articles 12 and 14 UNCRPD (Committee on the Rights of Persons with Disabilities, 2014, 2015). The Committee has also emphasised that the right to liberty is also central to the implementation of Article 19 UNCRPD (the right to live independently and be included in the community) (Committee on the Rights of Persons with Disabilities, 2015).

In short, it is discrimination to deprive someone of their liberty where they are unable to consent to this if the only reason for doing so is the convenience of those providing care and support or because of misconceptions about the level of risk they present to themselves or to others, or to protect them from abuse by others.

This poses something of a dilemma in human rights terms. On the one hand, Article 5(1)(e) ECHR allows for a person to be deprived of their liberty, subject to safeguards, where there is a reliable diagnosis of ‘unsound mind’ ([1] Winterwerp v Netherlands (6301/73) [1979] ECHR 4). On the other hand, as already mentioned, the Committee on the Rights of Persons with Disabilities has stated that this is discrimination. However, we consider that this apparent mismatch of approaches between the two treaties can be significantly reduced, if not entirely eliminated, by virtue of the HRE, SDM and ADM framework we are recommending, as described above and in Chapter 4.

An objective of such a framework would be to ensure that whenever someone is deprived of their liberty this is either a reflection of their will and preferences (using SDM) or, where it is not, it is only possible if they are unable to make an autonomous decision and/or a risk exists to their or others’ rights that proportionately and non-discriminatorily warrants a DOL and must be in fulfilment of the person’s overall human rights. Importantly, a failure to reach the ADM test threshold would not automatically lead to a DOL. Clearly, where a risk to others exists then a DOL of the person may be justified depending on the immediacy and seriousness of that risk. A decision to deprive a person of their liberty decision should not, however, be made based on assumptions about the person simply because they cannot make an autonomous decision or have a particular diagnosis. There may be other more or equally effective ways to manage the risk that respects the rights of all parties.

8.3.2: What we consulted on

In our March 2022 Consultation we noted the need to address this DOL issue and to ensure Article 5 ECHR, and UNCRPD compliance and sought views on a number of proposals to address this.

- Locating DOL, of persons who lack capacity to consent to this, within the overarching HRE, SDM and ADM framework

The Review proposed, subject to safeguards, that it should be possible for more people to be considered able to consent to their living arrangements, even where these amount to a DOL.

We recognised that in order to provide care and support so as to protect a person's overall rights, including their safety and wellbeing, a DOL may occasionally be necessary.

- People able to consent to a DOL with or without support

Clearly, any person who can is able to make an autonomous decision to express their consent to their living arrangements, even where these might amount to a DOL, must be respected. We also felt that where a person cannot make an autonomous decision but can, with support subject to the safeguards within the SDM framework we propose, express a will and preferences to remain in their current living arrangements, even if these arrangements would otherwise constitute a DOL, there was no need for further judicial oversight.

That being said, we felt there should nevertheless still be a standalone right of review available to the adult, or a person acting on their behalf (e.g. an attorney) where they are de facto detained in a health or care setting – i.e. they are not subject to any order but are in fact deprived of their liberty. This would be accompanied by a right for The MWC to intervene in such cases if they have concerns. The Scottish Law Commission proposed such a review in Chapter 7 of their 2014 report on Adults with Incapacity, which we suggest should be the basis for this right.

We noted, however, that the challenge would be in ensuring that this standalone right is genuinely accessible to a person who has decision-making challenges. It must offer a practical and effective ability to challenge the lawfulness of a DOL in a court/tribunal and be discharged from it, if it is found to be unlawful. We therefore proposed that there should be comprehensive guidance similar to that currently provided for actions under section 13ZA of the Social Work (Scotland) Act 1968 together with provision in law giving legal protection to any caregiver who is acting in good faith and in line with the principles of the legislation.

- People who cannot consent to a DOL.

Recognising that there will occasionally be persons who, even with significant amounts of support, cannot express a will or preference in favour of, or against, a DOL we made a number of proposals:

1. A Power of Attorney (POA), with prescribed wording, may grant advance consent for the attorney to deprive the granter of their liberty, where the deprivation is proportionate and will demonstrably lead to more respect, protection, and fulfilment of the person’s rights overall. This would be accompanied by regular review and specific registration of such advance consent with an external body such as the MWC or the Office of the Public Guardian.
2. Authorisation of a DM Representative, or an intervention order, as set out in the chapter 13 on Adults with Incapacity, by a court or tribunal to deprive the person of their liberty. The court or tribunal should also be able to grant this power in advance to a DM Representative but only where the need for this can be reasonably foreseen. It should not be automatically included in a grant of powers to a DM Representative.
3. We are aware that a person may be deprived of their liberty and not able to consent to this in situations where they are receiving treatment in hospital or being conveyed to hospital for treatment. In such cases, Article 5 ECHR safeguards will also be required, as was indeed pointed out by the Scottish Law Commission (Scottish Law Commission 2014). In hospital, the proposed changes to section 47 of the AWI Act as set out in chapter 12, would also allow a health professional to authorise DOL in hospital during treatment, and conveyance to hospital for treatment, but subject to the enhanced safeguards we are proposing in relation to section 47.

We are conscious that the concept of a person empowering someone to consent on their behalf to a future DOL, where they no longer have capacity to do so, is problematic. It has been hinted at but not further developed by the European Court of Human Rights (Stanev v Bulgaria (36760/06) [2012] 55 EHRR 22, 176). We felt, however, that the actions we proposed were compatible with respect for a person's will and preferences. In the case of a POA, it accords with the autonomous will of a person. In the case of a DM Representative such a power would be a reflection of the requirement to give effect to the person's will and preferences.

There will still be situations where people cannot consent to their care arrangements, even with support, and are being deprived of their liberty but do not have an attorney or a DM Representative.

We therefore considered two options to cover these situations. First, a non-judicial process, such as the Deprivation of liberty/Liberty protection schemes in England, and, second, a judicial process as suggested by the Scottish Law Commission in their 2014 report. We were minded to favour a judicial process which could be adapted to reflect the wider approach we will take to support for decision-making and testing autonomy. We suggested there be standard and urgent orders for DOL and the court or tribunal could grant these as stand-alone orders, or as part of the DM Representative process.

Standard orders for DOL

Before proceeding to apply for a standard order for DOL, an evaluation of the human rights implications would need to be completed as set out earlier in this chapter. An application would then, if appropriate, be made to the court or tribunal for a hearing for a DOL order for the adult. We sought views on who should be able to make such an application. We gave the example of a person in a care home who is expressing a clear preference and significant will to leave the care home but the impact of their illness makes them unaware of the dangers of the main road outside.

We considered that any authority for a DOL order should be granted only to the extent it is needed and only for as long as needed to achieve the protection required. The authorising of the order should include a review date, which should be commensurate with the likely duration of the loss of the person’s ability to autonomously decide about the restrictions imposed on them.

In the case of standard DOL orders, authority should be granted for no longer than six months and must be revoked sooner if the person regains their ADM ability. There should be a right of appeal at the time of granting. This is to allow it to be heard quickly to avoid person becoming institutionalised – or the equivalent – before the appeal is heard.

Urgent orders

Where it is necessary to deprive a person of their liberty as a matter of urgency in order to preserve life or health an application should be made to a court or tribunal. An initial order should last for no longer than seven days, with a renewal for up to 28 days thereafter and a right of appeal must be available at all times.

In both cases, the timescales we gave were just suggested ones and we considered that the details of the duration of such an order would be for subsequent legislation to determine.

Any DOL authorisation would need to cover getting a person to an establishment for care and treatment, preventing them from leaving an establishment, including their own home, unaccompanied, detaining them there, as may be required, returning them should they leave and transferring them as required.

The record of any DOL order, its duration and review date should be stored in the person’s records alongside the HRE and ADM test outcome.

8.3.3: What we were told

Respondents all agreed that DOL is an issue which needs to be addressed as a matter of importance and urgency.

There appeared to be general support for our proposals

> ‘I strongly agree with the recommendation that in the circumstances set out that there should be no recourse to judicial review where there is adherence to what is understood to be the will and preferences of the person who, after every effort has been made to support decision-making, the person is unable to confirm their consent; it will be crucial to have embedded a right of review; accessible arrangements for appeal in place. The special safeguarding arrangements might include: independent advocacy; recording and external monitoring of such cases by The MWC or other appropriate independent body.’ (An individual)
>
> ‘We welcome, and commend, the work done by The Review in relation to this issue, and the thought given to an appropriate regime.’ (Law Society of Scotland)
>
> ‘We believe the proposals seem reasonable and proportionate.’ (Royal College of General Practitioners for Scotland)
>
> ‘The Care Inspectorate agrees with the proposed proportionality of legal intervention. This would allow minimal legal scrutiny in certain situations, while ensuring the benefit of a more robust legal intervention’ Also from the Care Inspectorate ‘A judicial process may be the most appropriate forum to deal with Deprivation of Liberty orders. We agree that a POA may be used to grant advance consent to restrict the granter’s liberty, with ongoing review once this power has been exercised. Consideration of the wording of the advance consent that refers explicitly to the DOL, to ensure the granter contemplates the exercise of this power and what it entails. It may be helpful to create guidance to ensure that the inclusion of this power is fully explained to granters prior to the document being signed. The inclusion of such a power could be separate from the general POA document with consideration on its implications and any restrictions.’

However, several concerns and questions were raised. These can be summarised as follows:

1. That any consent provided by a person to their DOL is an accurate reflection of their will and preferences, particularly in those circumstances where we are proposing the proportionate response that no formal or judicial process is required in the case of a person who cannot make an autonomous decision but can with support, express a will and preferences to remain in their current living arrangements.

   > ‘The threshold for deciding whether a person can express a will and preferences such that they are consenting to their deprivation of liberty will need to be carefully considered. We would also suggest that consideration will require to the situation where a person’s decision-making capacity declines, such that they can no longer express a will and preferences to stay somewhere or consent to treatment etc.’ (Society of Local Authority Administrators in Scotland)

   The Forensic Network expressed the view that a legal framework authorising DOL is required in all settings where individuals are subject to continuous supervision and would not be free to leave.

2. Related to 1 above, concerns were raised about the appropriateness and human rights compatibility of authorising attorneys and DM Representative in advance to consent to the person’s DOL.

   For example, the Faculty of Advocates expressed ‘serious doubts about the legality of permitting deprivation of liberty on the basis of powers of attorney. It seems to me that the right to liberty is inalienable – one cannot give it away - which is what happens with a POA’.

3. That the proposals were overly complex and legalistic, and that clarity was required

> ‘Proposals as they stand would not be those which we would support as the Standard order for DoL would appear to be that which could be overly complex and legalistic involving the court or hearing.’ (A Health and Social Care Partnership)
>
> ‘We would recommend that proposals which simplify the system, support the human rights of the individual, and are easy to adapt across practice areas, as being the most successful when there is a requirement to implement them. We would suggest that the proposals put forward could be amended to reflect as above.’ (Social Work Scotland)
>
> ‘These proposals lack detail but based on information given they appear impractical for delivery within a complex system, adding an unnecessary bureaucratic burden.’ (Convention of Scottish Local Authorities)

4. How the provisions would apply in clinical settings and how they would be applied to urgent matters.

> ‘With regard to the statement “Where it is necessary to deprive a person of their liberty as a matter of urgency in order to preserve life or health an application should be made to a court or tribunal”, we find this a concerning suggestion that is likely to be unworkable in acute general hospital practice. We are concerned that as written, the focus of consideration of deprivation of liberty issues lies in domiciliary, rather than general hospital, settings.’ (Royal College of Physicians Edinburgh)
>
> ‘There are a number of concerns around the clinical application, practicality and potential lawfulness of this proposal, which would require consideration if working this proposal into useful law. It would be helpful to also have details on the application of what is proposed to mental health settings and on whether and how these orders would

> apply to children and young people. The detailed proposals must clarify who would have authority and clinical responsibility to apply for such an order.' (Royal College of Psychiatrists Scotland).

5. How the proposals would be applied to children and young persons.

> 'An understanding of the use of deprivation of liberty orders across the lifespan is crucial. Children and young people, as well as adults, may be subject to deprivation of liberty and the unique personal circumstances of each group should be considered against a sound understanding of the alternative methods that may be considered to support an individual to give effect to their human rights. For children this consideration of human rights and specifically UNCRC before progressing any deprivation of liberty is critical. Depriving a child or young person of liberty is serious action, with implications for their longer-term health and development. As such it should rightly be considered extremely carefully, and only progressed only as a last resort and following appropriate scrutiny and consideration of alternatives by all those involved in the Team around the Child and in line with the GIRFEC principles. including those with specific knowledge of children's development, impact of trauma and relevant legislation before being progressed. Consideration and rigour of application of children's rights and UNCRC in the context of GIRFEC as the core policy context for children is a critical safeguard.' (Social Work Scotland)

6. How the proposals would be resourced.

> 'The HSCP has highlighted issues specifically around resources, and workforce that will influence the likelihood of successful implementation of some of The Review's proposals. Whilst [we] welcome the ambitions of The Review, extensive financial modelling to provide realistic

> costings for the proposal is required in order to adequately resource those institutions tasked with its effective implementation and delivery.'
> (A Health and Social Care Partnership)
>
> 'The biggest barriers are funding and availability of resources.'
> (Scottish Association of Social Work)
>
> 'Resource constraints are regularly reported currently and this will be a barrier if resources are not increased to deliver on these intentions.'
> (the MWC)

We note and fully appreciate the importance of there being an accurate reflection of the person's will and preferences in relation to DOL situations. The human rights imperatives are also set out above. For this reason, the person must be protected by the proposed SDM regime which will ensure that their genuine will and preferences, or a best interpretation of these, are respected. It must also be noted that we propose a standalone right of review as an additional safeguard.

In terms of advance consent to a DOL, we note the concerns expressed and feel that as both the POA and DM Representative arrangements must operate within the SDM regime, which will also allow for account to be taken of changes in the person's will and preferences, any DOL should be in accordance with the person's wishes.

We also realise that the proposals must not only meet human rights standards and protect the rights of the person concerned. However, the law and any related processes must also be clearly expressed for those responsible for implementing these. They must also be accompanied by guidance, Codes of Practice and training so that all parties have a shared understanding of the relevant human rights, equality in rights enjoyment, balancing rights and legitimate and proportionate limitation of rights, in this case the right to liberty, and roles as well as responsibilities, and how they must be applied in a range of different settings.

We also note the desirability of aligning the timescales with commensurate ones within mental health legislation.

We also appreciate the need to have both robust protection for the person's right to liberty and the need to avoid, where possible, unwieldy and unnecessary bureaucracy. However, we cannot emphasise enough that the need for new legal provisions to authorise DOL does not arise from a wish by The Review to add new legal procedures, but the fact that Scotland is currently vulnerable to an ECHR challenge because of the lack of a legal response to the requirements set out in the Bournewood and Cheshire West rulings. This cannot continue.

In response to the concerns of the Royal College of Physicians, we do not propose that new court procedures should normally be necessary to authorise someone's stay in hospital. We set out our separate proposals for that situation in chapter 13.

We propose that the DOL arrangements will take place within the HRE, SDM and ADM framework, and the amended POA Section 47 and replaced guardianship arrangements, so that the additional costs of seeking Deprivation of Liberty orders should be minimised, although we once again acknowledge the need for appropriately aligned resourcing to make it effective.

Children and young people

As we state in Chapter 6, we recommend that our proposed SDM, HRE, and ADM framework will apply to children subject to mental health law. It may be that this framework is ultimately applied to children requiring support in other areas, and it is therefore possible that our DOL proposals may also be applied to them. However, until then we do not envisage that such proposals will apply to children under 16 (an 'adult' under the AWI Act being someone who is 16 years or older). We discuss in Chapter 12 the fact that there is a separate and complex legal framework concerning the deprivation of liberty for children. The detail of that framework is beyond our terms of reference and is under review as part of the implementation of The Promise.

8.3.4: Our final recommendations

The Scottish Government should establish a legislative framework for situations where a person may be deprived of their liberty. This is a short-term recommendation. Longer term, this framework should be revised as the HRE, SDM, ADM are developed.

Recommendation 8.9: The framework should include provision as follows:

> **8.9.1: Where a person cannot make an autonomous decision but can, with support, express a will and preference to remain in their current living arrangements, even if these arrangements would otherwise constitute a DOL, this must be respected.**
>
> **8.9.2: There must be a standalone right of review available to the adult, or a person acting on their behalf if they are not subject to any order but are or may in fact deprived of their liberty.**
>
> **8.9.3: The MWC may intervene in such cases if they have concerns. This ability to challenge the lawfulness of this actual or perceived DOL must be practical and effective.**
>
> **8.9.4: A POA, with prescribed wording, may grant advance consent for the attorney to deprive the granter of their liberty, where the deprivation is proportionate and will demonstrably lead to more respect, protection, and fulfilment of the person's rights overall. This should be accompanied by regular review and registration with an external body such as the MWC or the OPG.**

8.9.5: A court or tribunal may authorise a DM Representative, or an intervention order, to deprive the person of their liberty. The court or tribunal should also be able to grant this power in advance to a DM Representative but only where the need for this can be reasonably foreseen. This power must not be automatically included in a grant of powers to a DM Representative.

8.9.6: Where a person cannot consent to their care arrangements, even with support, and is being deprived of their liberty but does not have a welfare attorney or a DM Representative, a court/tribunal may grant a Standard Order for Deprivation of Liberty in order to preserve the person’s overall human rights or an Urgent Order for Deprivation of Liberty in order to preserve life or health.

8.9.7: A carer, proposed DM Representative, local authority, allocated clinician for a residential care home, hospital clinical staff (where the matter is outside section 47 AWI Act and The MWC should all be entitled to apply for the order.

8.9.8: The order must be granted only to the extent it is needed and only for as long as needed to achieve the protection required, with regular review dates and a right of appeal at the time of granting.

8.9.9: The details of the duration of both orders will be for subsequent legislation to determine but should be aligned to commensurate timescales in mental health legislation.

8.9.10: Before proceeding to apply for a standard order for deprivation of liberty, an evaluation of the human rights implications must be completed as set out in earlier in this chapter.

8.9.11: The record of any DOL order, its duration and review date should be stored in the person's records in accordance with the HRE approach.

Recommendation 8.10: The Scottish Government must ensure that the above framework is supported by clear and targeted guidance, Codes of Practice and training detailing processes, and roles and responsibilities in relation to the range of different settings.

Chapter 8 recommendations

Recommendation 8.1: The Scottish Government should develop and adopt the HRE approach.

> **HRE maximises a person’s ability to make an autonomous decision and thereby ensuring that priority or ‘special regard’ is given to a person’s will and preferences. An HRE approach**
>
> **a) Ensures that the person’s will and preferences are known in respect of the given issue;**
>
> **b) Identifies what rights, if any, are in need of protection, including the rights of others or another;**
>
> **c) Considers whether all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment;**
>
> **d) Weighs advantages to human rights against harms to human rights. Significant harms to certain human rights would be justifiable only exceptionally, on the basis of very significant advantages in the respect, protection and fulfilment of the person’s human rights overall;**
>
> **e) Provides a plan of action for giving effect to such identified right or rights in order to meet the person’s needs at that time.**

Recommendation 8.2: The HRE approach should be developed with the full and equal participation of people with lived experience, including unpaid carers, and practitioners.

Recommendation 8.3: The HRE approach should cover the full range of a person’s rights and operate as a framework together with SDM and ADM.

It should be accompanied by guidance, Codes of Practice and training

Recommendation 8.4: The Scottish Government should ensure sufficient resourcing to realise this HRE approach.

Autonomous decision-making

Recommendation 8.5: The Scottish Government should replace the existing capacity and SIDMA tests with the test of ADM to provide a more rights-based criterion for non-consensual intervention.

- **The new ADM test would offer a more rights-based criterion for non-consensual intervention. The test should establish whether the person is able to make an autonomous decision on the matter in question, having regard to:**
- **The ability of the person to understand information relevant to the decision.**
- **The ability of the person to use or weigh the information in order to make a decision.**
- **The ability of the person to communicate the decision.**
- **The ability of the person to act on their decision, or otherwise act to safeguard themselves from harm.**
- **The extent to which any apparent decision, or expression of will and preferences, may be undermined by one or more of the following controlling influences, if they cannot be sufficiently mitigated.**
- **Undue influence by another person or persons.**
- **The impact of any illness, disability or health condition, including a health care crisis.**

- **The impact of any situational or environmental factors.**

Recommendation 8.6: ADM should be developed with the full and equal participation of people with lived experience, including unpaid carers, and practitioners.

Recommendation 8.7: ADM should be accompanied by guidance, Codes of Practice and training.

Recommendation 8.8: The Scottish Government should ensure sufficient resourcing to realise ADM.

Deprivation of liberty

Recommendation 8.9: The Scottish Government should establish a legislative framework for situations where a person may be deprived of their liberty. This is a short-term recommendation. Longer term, this framework should be revised as the HRE, SDM, ADM are developed.

Chapter 9: Reduction of coercion

9.1:Defining coercion

The March 2022 consultation asked for views on our understanding of ‘coercion’, which are summarised in annex C**.** This annex includes a detailed consideration of our thinking on the concept and terminology of ‘coercion’ in mental and intellectual disability services.

Having considered the responses to our consultation, we continue to believe that ‘coercion’ is a valid description of part of the approach to support, care and treatment of people with mental or intellectual disability. We understand that this description is not appreciated by everyone who works in those services, and some prefer other terms such as restrictive practices. However, the word and the concept do exactly describe a part of practice within mental health services, and are recognised by people with lived experience and by the United Nations. Coercion should be recognised as such, so that we can address it.

Drawing from what we have heard and read in the review, we offer the following as a basis for a possible approach to understanding coercion.

We could say that an action is **coercive** if:

- Force is used or force is threatened (this is inherently coercive); and/or:
- The action is done with ill intent; and/or:
- The action is not done to give effect to the person’s will and preferences; and/or:
- The person perceived that there was coercion in relation to the action

All orders under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), authorise the possible use of force and are therefore inherently coercive.

The table on the following page shows our final understanding of the differences between support, care, and treatment which is voluntary, non-voluntary or coercive.

Voluntary	**Not voluntary**		
In line with the person’s will and preferences **and** with free and informed consent	**No coercion** No perceived coercion No ill-intent	**Coercion** With or without perceived coercion With or without ill-intent	
	In line with the person’s will and preferences **but** without free and informed consent	**Informal coercion** Including: threats inducement interpersonal leverage Can include persuasion, if there is ill-intent or perceived coercion	**Formal coercion** Including: detention restraint seclusion compulsory care or treatment Includes actions in line with the law (de jure) and also actions not authorised in line with the law (de facto)

The same action – for example, giving care to a person – could be voluntary, not voluntary, or coercive, depending on the circumstances of that action. Each category of voluntary or non-voluntary actions might be understood as follows:

Voluntary	The person is offered access to support, care or treatment; understands what is being offered and its expected effects; and clearly chooses to accept what is offered. They accept the offer because they want to, not because other people want them to accept the offer.
Not voluntary: No coercion	Decisions are being made for a person on their behalf by someone who has authority to make those decisions. The decision-maker can show that they understand the person's will and preferences, and that they are making decisions which give effect to person's will and preferences, and which respect, protect and fulfil the person's rights. The person does not show signs of objecting to or resisting the effects of those decisions and does show signs of accepting the effects of those decisions.
Not voluntary: Informal coercion	The person is unsure whether they want to accept support, care or treatment. They agree to accept it because other people want them to accept it, or because they are afraid of what other people will do if they do not accept it. There is no legal order in place which requires them to accept the support, care or treatment
Not voluntary: Formal coercion	A legal order is in place which requires the person to accept support, care or treatment; or: Someone has imposed support, care or treatment on the person as if they have authority to do this, but without the authority to do this.

9.2: Reducing coercion, including reducing the use of involuntary treatment

9.2.1: Law reform to drive reduction of coercion

This is where we started

The March 2022 consultation document proposed that law reform can and should drive reductions in the use of coercion, even though a need for coercion may remain in some circumstances.

This is what people told us

Most of the organisations which responded to this question did have a view that law reform can drive changes which could reduce the use of coercion, but most of those also felt that increased resources would be needed to have effect. For example, the Royal College of General Practitioners wrote:

> Changes to reduce coercion levels are likely to be possible only if the resources follow, and if change is guided by those with lived experience and by the practitioners on the front line.”

Organisations which saw a role for law reform also raised a number of points:

- Education and training in the application and implementation of the new law will also be required (Royal College of Physicians of Edinburgh), along with supervision and monitoring (Law Society of Scotland) and support for reflective practice (Mental Welfare Commission)

- The Scottish Association for Mental Health called for a presumption towards sustainable funding models.

Some organisations agreed in principle but found it hard to think of these changes as a possibility due to resource limitations.
Some organisations did not seem to think that the proposed approach to law reform would drive reduction of coercion:

> Glasgow City Council wrote that reducing coercion with a focus on better inclusive environments would benefit services, but there are increased pressures on finances on statutory services, resources and staffing levels and retention of staff
>
> The Royal College of Psychiatrists in Scotland, including the Scottish Faculty of Eating Disorders, expressed a need to "stress test” proposals with clinical scenarios including people whose conditions can show marked fluctuations over time in severity
>
> Moray Council felt that care must be given to avoid barriers to appropriate care and treatment; and conversely, the proposed approach to assessment for ADM may bring more people into coercive interventions

The Royal College of Psychiatrists in Scotland wrote that there should be no obligation on professionals to automatically attempt alternate practices to compulsory care. The Review has not proposed that there should be a duty to attempt alternate practices to compulsory care. However, in chapter 3 on principles we recommend the continuation of a principle of ‘least restrictive alternative’ for non-consensual treatment. This is required to ensure that any intervention is the least restrictive of the options likely to fulfil the aims of the intervention, and to comply with ECHR in particular.

There will be some situations where compulsory care is immediately essential to preserve life, for example, but alternatives to compulsory care should be developed and researched in order that they become readily available and part of normal practice. Chapter 11 on accountability addresses this point in relation to a recommendation from recent research on experiences of the Mental Health Tribunal for Scotland.

Most individuals who responded agreed that law reform can and should drive reductions in the use of coercion. Several individuals highlighted the need for more resources in order to achieve this purpose. The following was fairly typical of responses from individuals:

> ‘Law reform in itself will drive behaviours: but these behaviours need to be reinforced by supportive action in the wider community.’

We did not propose only law reform – see below – but we did specifically ask respondents for their views on whether law reform could drive changes which could reduce the use of coercion. Having considered the responses, our view is that law reform can help with this process, in that it can lead to shifts in practice through new duties and safeguards.

We make recommendations for law reform in this chapter and elsewhere which seek to drive this shift. We are taking an approach that law reform is not the whole answer but is part of the answer: an approach where reduction of coercion is a national priority over a period of years. This will require us to change, as a society and through systems, the way that we ‘do’ mental health. We acknowledge that resource limitations will make this more difficult, but we make proposals to address these (see chapter 6 on economic, social and cultural rights).

We realise that resourcing will need to be sufficient and appropriately targeted if such an approach is to be truly effective. The Scottish Government, in meeting its stated commitment to give effect to rights identified in international human rights treaties, would need to ensure sufficient resourcing to achieve this.

Recommendation 9.1: We recommend that the Scottish Government should make reduction of coercion a national priority over a period of years.

9.2.2: General approach to reducing coercion

This is where we started

There is international evidence that different models of hospital and community services can dramatically reduce the need for coercion, but with a few exceptions, we have seen limited evidence of similar innovation in Scottish mental health services in recent years.

The review proposed the following **general approach** to reducing the use of coercion:

- Scotland may need to do much more to record, monitor and address coercion across settings
- We cannot end coercion at a stroke, but we need to go as far and as fast as we can to reduce the use of coercion within mental health services and the wider care system
- We are not proposing targets to reduce the use of coercion
- Future law should require changes to the mental health system which make it less necessary for coercion to be used
- This requires a 'full spectrum' approach across law, policy and practice (United Nations, 2017)
  a) Mainstream alternatives to coercion with a view to legal reform
  b) Develop a well-stocked basket of non-coercive alternatives in practice
  c) Develop a road-map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders
  d) Establish an exchange of good practice between and within countries
  e) Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.
- Scotland can and should be a leader in a comprehensive approach of combining the full suite of laws, policies and practices which are available (Gooding et al, 2020) and which taken together might further the goal of eliminating coercion.

Although we wish to move in this direction, we do not assume that it will ever be possible to completely eliminate coercion from care and treatment.

This is what people told us

Most individuals who responded appeared to agree with the general approach which we proposed. Organisations, on the other hand, were quite evenly split.

Of those organisations which appeared to disagree with some or all of the approach, many felt that solutions did not lie in law reform but in more resources. We clearly see a very important role for law in this work, but in our view, the biggest issue here is resources. As discussed in the chapter on economic, social and cultural rights (chapter 6), solutions to the resource issue need to include rights-compliant approaches in how governments prioritise and allocate resources.

Some of those respondents who disagreed with the proposed approach felt that involuntary treatment is already only used when it is necessary. Glasgow City Council wrote that:

> '…There are many circumstances where the current legislative measures positively support service users to manage their mental health needs in a positive way, and in a way that supports their own will and preference...'

Some respondents would have preferred that we set out findings on research on specific approaches to reducing the use of coercion and how these might apply in the Scottish context. The Review did consider systematic review and meta-analysis evidence on international approaches, and we met with a wide range of leading experts on reduction of coercion. This evidence confirmed our view that Scotland can and should be a leader in a comprehensive approach of combining the full suite of laws, policies and practices which are available. However, as this is a review of law, rather than a review to select the most effective approaches to reducing coercion in practice, we decided not to give detailed examples of practical approaches, nor to recommend particular approaches. Instead, we proposed an approach where people with lived experience of mental or intellectual disability, unpaid carers and practitioners to work together within a research, development and implementation programme to determine which existing and new approaches work best for Scotland.

The Scottish Human Rights Commission (SHRC) welcomed the ‘full spectrum’ approach proposed by the former UN Special Rapporteur on the Right to Health:

> ‘We believe a focus on these actions sets Scotland on a practical path towards eradicating coercion. We appreciate also the weight accorded to the views of people with lived experience on the sometimes necessary role of coercion, but requiring significant improvement in the experience of coercion. We support the ambition for Scotland to become a leader in taking a comprehensive approach to tackle coercion through a range of efforts and learning from best practice in alternative models across the world.’

Many organisations agreed with the proposed general approach. These respondents saw a need for law reform, and many recognised the need for increased investment.

See Me was ‘pleased that the review is committed to reducing the use of coercion over the long term’ but wrote that some focus group participants felt that some goals such as fostering a ‘sense of belonging connection and trust in society’ were so optimistic and widely focused that it was difficult to see what effect the language would have in practice. Setting out a vision which considers the role of society is, in our view, necessary rather than idealistic. However, we would agree that much more than words are needed in relation to society’s role in this, and we make recommendations on investment in infrastructure for diverse, disadvantaged communities [see chapter 6].

British Deaf Association Scotland believed that the proposed approach would only be successful for Deaf people if educational resources and content are made available in BSL, with cultural mediation taking place throughout.

The Coalition for Racial Equality and Rights (CRER) wrote:

> ‘In terms of reducing coercion more widely, it is essential to recognise the disparate use of coercive practices on BME individuals - e.g., emergency detentions are disproportionately used on the Black population, with 54% of Black detentions occurring under emergency protocols compared to 41% of white Scottish detentions. Further, SHELS report that the psychiatric

> admission of BME individuals was 4.8 times more likely to use 'compulsion' than that of white Scottish individuals.
>
> Specific training and culture shifts are required to prevent BME individuals in times of mental distress from being perceived as a greater threat to themselves and others than their white Scottish counterparts. As these statistics clearly indicate major systemic failures and prejudices, they should be central to and explicitly stated within the review's approaches to reducing coercion, rather than sidelined to broader issues of inequality within mental healthcare settings.'

This Review is making recommendations which should address systemic failures and prejudices. Please see the section below on 'racism and anti-racism' which also refers to Chapter 1 on human rights and equality.

The Care Inspectorate had seen restraint incidents in regulated providers reduce from 6890 in 2018 to 4800 in 2020/21 and offered some practical suggestions on how coercion can be reduced (data reporting changed from calendar year to financial year reporting). For example:

> 'All use of any form of coercion, including covert, must be justified and all alternatives explored. Necessary coercive actions must be explicitly identified, and interventions planned and reviewed in consultation with the person subject to coercive measures where possible and/or a suitable representative…It would be helpful for care plans to give clear indication of the outcomes required for coercive measures to be ceased or reduced. The aim of ending coercive measures should always appear as an outcome, with appropriate actions, in care plans for people subject to coercion….'

The Scottish Commission for People with Learning Disabilities (SCLD) also described aspects of the sort of approach which we would expect:

> '…improved governance and oversight of data to support better collection and ongoing monitoring of information and to ensure that we can identify the scale and scope of the use of restrictive practices in Scotland. This should also

> support the development of a learning culture where staff are encouraged to reflect on their practice and suggest and implement changes. It must also include learning from incidents and post incident review and reflection. Evidencing personal stories from those with lived experience is also critical...'

We see an ongoing need for people who feel they have been mistreated in the mental health system to be listened to and validated. We also see a need for this to happen collectively, through collective advocacy, as part of ongoing culture change for services.

The Royal College of Psychiatrists proposed:

> 'Psychological, trauma-informed support following compulsory care, recognising how traumatising this can be, is compulsory care and treatment is addressed, and better meet the needs of those who had received compulsory treatment. The additional resources required to deliver this are needed.'

Consistent with this, the British Psychological Society wrote that:

> '…the use of coercive interventions could be minimised with the more consistent application of trauma informed systems of care and support, for staff and patients… Psychologists (and other professionals) who are expert in trauma informed interventions may need to have recognised statutory responsibility in order to support systems of care and treatment to be more trauma informed and patient centred.'

In this chapter, we make a recommendation on support for trauma following compulsory care.

Mental Health Network Greater Glasgow made a range of observations, including:

> '..we believe that continuity of care is critical here. Our work with patients shows that they are seeking to build relationships with staff that are respectful and supportive…Staff who have an established relationship with a patient may be in a better place to spot crisis triggers or to de-escalate a situation

> and thus avoid an incident requiring restraint or some similar intervention. We feel that a high staff turnover or high usage of bank staff is an indicator of issues here.
>
> We also agree that culture is a key element of the reduction of coercive practice. Ward/service level leadership is absolutely crucial in setting the tone regarding any reduction of restrictive practices. We have seen some excellent examples...'

The Royal College of General Practitioners (RCGP) raised their concern about the challenge of GPs being asked to undertake emergency detentions of patients in the community. We address this at the end of the chapter.

The Forensic Network and National Forensic Allied Health Professions Leads Group were supportive of actions to reduce coercion, including training that increases awareness of coercion and the complexity of this, and the 'full spectrum' approach / five "concrete actions". However, these organisations felt that more detail was needed on how they would be achieved and associated timescales, and more detail on how alternatives to coercion could be applied within forensic services where people are subject to restrictions.

We have considered the consultation responses and have developed our recommendations in light of responses, which can be seen in the sections that follow.

This is what we recommend: general approach

- **We recommend the general approach which we proposed in the consultation. In summary:**

Recommendation 9.2: The Scottish Government should ensure effective recording, monitoring and action to reduce coercion across settings. This should include:

- **Mainstream alternatives to coercion with a view to legal reform**
- **Develop a well-stocked basket of non-coercive alternatives in practice**
- **Develop a road-map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders**
- **Establish an exchange of good practice between and within countries**
- **Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals**

Recommendation 9.3: The Scottish Government should set standards for trauma-informed mental and intellectual disability services, including access to psychology or other services which provide support for trauma that results from coercion.

9.2.3: Specific approaches to reduction of coercion

The review also proposed more specific approaches to reducing coercion in services. These included all of the following elements:

- Sense of belonging, connection and trust in society
- Support, services, and approaches which reduce the use of coercion
- Stronger safeguards when compulsion is authorised
- Monitoring and scrutiny

In addition to law reform, a national mental health strategy will continue to be needed.

9.2.3.1 Sense of belonging, connection and trust in society

This is where we started

The March 2022 consultation proposed:

- Communities enabled to develop their own forms of peer and community support
- Community wellbeing hubs to serve every community, both for people with mental or intellectual disability, and to support the wellbeing of the general population
- A range of open, flexible and accessible crisis and crisis-prevention services
- Community mental health teams which are fully integrated within communities
- Community and in-patient mental health services, and strategies for these, developed with the full and equal participation of people with lived experience including unpaid carers

This is what people told us

The Coalition for Racial Equality and Rights (CRER) wrote:

> ‘The development of community-driven and alternative (non-institutional) support structures is fundamental to tackling mental health inequalities for BME groups. These not only help tackle intensified mental health stigma within certain BME communities but also improve the capacity for early intervention, reducing the risk of future coercion. However, the development of these structures must be collaborative, with sufficient investment to ensure communities are suitably equipped and trained to meet their needs.’

An individual wrote:

> ‘Models developed elsewhere such as community hubs for peer support, easily accessible and supportive could reduce the escalation of ill health - it will be important for Scotland to apply the lessons learnt from services and approaches which have proved to be successful in reducing coercive

> interventions. The intention to reduce the use of coercion and empower the individual to take more control goes hand in hand with support for decision-making.'

The Royal College of General Practitioners wrote:

> 'We support the proposed approach to reducing coercion, especially the suggestion of better access to peer support communities and the focus on compassionate, supportive, comfortable environments in which to receive care. This will require significant investment but be highly beneficial.'

Mental Health Network Greater Glasgow wrote that:

> 'We would welcome developments that enabled peer support to flourish and to access other wider forms of support. An ideal that our members have frequently desired is for services that operate on a self-referral model. They feel that this would enable them to flexibly respond to their own variable wellness and to initiate a service level response. Despite recent welcome developments such as assessment centres in the [Greater Glasgow and Clyde area] we would very much welcome the coproduction of community based support and services that reflect the varying needs of people across the NHS [Greater Glasgow and Clyde area] and would welcome this being part of a Scottish Government led review of such services.'

An individual wrote:

> 'In Scotland the quality of cohesion has deteriorated in our most disadvantaged communities since community work eroded as a profession. Your approach would need to be backed up with some very targeted resources to enhance the sorts of supports that would be needed. Were we to go down the line of community supports for people who live with challenged mental health, we would need to end the predominance of the large, central-belt-based national voluntary organisations, which deliver tendered services for local Health and Social Care Partnerships and develop our withering small, local services which can develop real community orientated services.'

VOX Scotland gave feedback from people with lived experience of social / community hubs:

> ‘One of the points that participants mentioned a few times was around the need to create spaces where people can come and meet others who will accept and understand them. This came through within all the group discussions.

Validation, connection and peer support were all highlighted and felt to be of importance in making the new laws effective. Without this there were concerns over the ability to raise awareness of concepts e.g. advance statements and human rights assessments, the ability to support lower level mental health needs (if thresholds or specific criteria were identified) and furthermore that social rights may not be easily realised.

There were a number of strands within Social/Community Hubs which participants highlighted as being valuable. The first one was that the contact with others can stop you becoming more unwell and going downhill, mainly through a sense of belonging and validation.

> ‘this is the difference between life and death for me. Coming here.’ (Kintyre Link Club)

Secondly, the way it helps people to get more connected and find out what else is happening and link you to other potential support, information and networks.

> ‘I feel detached from my community, I really need somewhere I can go along to and hear what’s going on.’ (Phone call)

Thirdly, the benefit of peers who truly understand how you feel and can encourage you (whilst also experiencing a sense of meaning from supporting others) was felt to be important.

> ‘Giving peer support helps me too – encouraging people to get out for walks, be involved in communities, be socializing.’ (AWN)

Moray Council discussed the effect that rurality has on services with availability being in centres of population and not always readily accessible to people living outwith towns even within local authorities. Support in Mind Scotland wrote that people in rural communities should be able to access mental health training, to allow communities to intervene pre-crisis at the earliest point of someone experiencing poor mental health, which may reduce the use of involuntary treatment.

We read the responses to the consultation as mainly supporting our proposals. We note the concerns about support structures for tackling mental health inequalities for ethnic minority groups, addressed in Chapter 1, and access in rural areas. We need to assume that future research may highlight further inequalities for other communities and groups. Those inequalities will need to be responded to appropriately.

To reduce alienation, we see a need for investment in diverse disadvantaged communities for their ownership of their services, including funding communities to find their own solutions, to use their voices and to run their own services. This is in addition to mainstream services becoming fully accessible and acceptable to all communities. Investment should include infrastructure and be sustainable, and should not simply be a series of pilot projects.

These are our final recommendations: sense of belonging

Recommendation 9.4: The Scottish Government should ensure that:

- **Communities are enabled to develop their own forms of peer and community support**

- **Community wellbeing hubs are established to serve every community, both for people with a mental illness and to support the wellbeing of the general population**

- **A range of open, flexible and accessible crisis and crisis-prevention services is established**

- **Community mental health teams are fully integrated within communities**

- **Community and in-patient mental health services, and strategies for these, are developed through co-production by people with lived experience including unpaid carers**

9.2.3.2 Support, services, and approaches which reduce the use of coercion

This is where we started

The consultation proposed the following:

- A systematic improvement programme is needed, led by Scottish Government and involving services, people with lived experience, unpaid carers and regulatory bodies, over several years

- Support, services, and approaches which have been successful in reducing coercion in other countries should be piloted, developed, and then implemented across Scotland

Ward-level interventions which reduce coercion including restraint, such as

- Safewards should be implemented
- Academic research on approaches to reducing coercion which is led by people with lived experience including unpaid carers

This is what people said

On a **systematic improvement programme**, the Care Inspectorate supported:

> '…the full range of support, services and approaches which are proposed to reduce the use of coercion. A systematic improvement plan involving people with lived experience, services and regulatory bodies is welcomed…Ensuring a wide range of 24-hour services are available to assist people who are experiencing crises and acute mental health symptoms may reduce the need for referral to hospital and inpatient services, with associated trauma. This would also reduce the impact on ambulance, police and social care services who may need to accompany individuals to hospital. Such crisis and acute response services could be made available from a range of NHS, social work, and third and independent sector providers with the result that interventions would be less restrictive than hospital-based settings.'

Social Work Scotland supported:

> '…an approach led by Scottish Government to consider how coercive practices within systems could be reduced, with a focus on learning from implementation science to support improvement activity. If a National Social Work Agency (NSWA) is taken forward as part of the National Care Service design, we would see it having a significant role in supporting and informing these considerations [for] social work research/practice.'

The Coalition for Racial Equality and Rights (CRER) wrote that:

> 'Changes must include specific anti-racist training for all mental health staff, so they can challenge structural biases and prejudice and handle mental health issues in a culturally sensitive manner. If BME individuals have improved experiences of accessing mental health services, the likelihood of early intervention may improve, reducing the need for coercive measures down the line.'

We make recommendations to address this in Chapter 1.

On **support, services and approaches,** the Care Inspectorate wrote that:

> 'Improving environmental design and staff knowledge and skills regarding mental health, capacity, protection and trauma-informed practice would assist with the reduction of coercion and the negative impact it can have… We are interested in how the use of coercion can be reduced through service design and delivery. This would take account of the culture, environment, compassion, empathy, humanity, peer support, shared decision-making, community connections and staff skills and knowledge in capacity, protection and trauma-informed practice… It may be helpful to consider coercion within the wider framework of restrictive practices, along with the use of blanket restrictions such as locked doors, restricted access to food, activities and social media.'

The Care Inspectorate also wrote that particular consideration should be given to the use of coercion and force with children and young people, which 'must be a last resort and their rights should be upheld'.

On children, COSLA wrote:

> 'There are ongoing pieces of work that should be considered in relation to coercion and children including the Children's Care and Justice Bill which is currently subject to consultation and the incorporation of the UNCRC…Legal requirements are only one way of effecting change and…the benefit of this needs to be considered alongside improvement approaches.'

Similarly, Social Work Scotland wrote that:

> 'There are specific issues around the use of coercion and medication with children, which require careful consideration to ensure that their rights are protected in line with the UNCRC. Scotland is progressing to a position of no restraint in residential childcare…and such an approach should be mirrored in any mental health setting for children.'

They also wrote that:

> ‘We are particularly interested in the points raised in relation to medication use in Care Home settings provided within the consultation as an example of coercive control used via the Adults with Incapacity Act…we would note the importance of a Human Rights lens being used to inform assessment and proposed interventions.’ and:
>
> ‘Without well-designed buildings, and well-trained people, no substantive change can be expected in the delivery of community-based support that can prevent individuals, including children and young people, from being unnecessarily detained in acute settings’

Inpatient facilities and environments are addressed below.

COSLA wrote that:

> ‘…resources to provide the support that is needed in the community both in terms of workforce and housing remains an ongoing and significant challenge and the issue cannot be resolved without this being addressed, regardless of legislation. COSLA is working closely with the Scottish Government and partners to address issues related to workforce. There remains significant uncertainty around the role that the proposed National Care Service will play.’

We note the emphasis on improvement approaches, emphasised by bodies with an interest in social work and social care. We see potential for this understanding to contribute substantially to developments in the reduction of coercion. In particular, we acknowledge the aim of no restraint in residential childcare and the requirements of human rights law that children with mental ill health be cared for and treated equally in comparison with other children.

AdvoCard wrote that they ‘would like to see more **lived experience research** helping to quantify, and qualify the impact of coercion on people’s health, trauma, recovery and autonomy.’

During this review, we spoke with lived experience researchers in Victoria, Australia and in Cambridge. We met with individuals from Scotland who had both lived experience and professional experience, in relation to reduction of coercion, and took evidence from them about future research needs on rising rates of detention and compulsory care. We continue to see a need for academic research on approaches to reducing coercion which is led by people with lived experience, alongside research which involves the full and equal participation of people with lived experience including unpaid carers

On **inpatient facilities and environments**, an individual wrote that: ‘If the place was made to be sensory and culturally sensitive, a person might not try to leave the building, and may behave in a better manner. All laws and policies must be made with people who have disabilities and lived experience.’

Thrive Edinburgh wrote that:

> ‘There is a strong desire and willingness in mental health services to improve in-patient environments and positive work has been done in Edinburgh with the opening of the Royal Edinburgh Building including many imaginative and therapeutic projects involving developing the green space around the hospital’.

The Royal College of Psychiatrists wrote that:

> ‘The physical, psychological, and cultural aspects of environments where care is delivered are fundamental to its quality. It has major impacts on the experiences of patients. Improvements, in line with our aspiration for Maggie’s Centre-esque care settings could foreseeably reduce the use of non-consensual or restrictive practice.’

Mental Health Network Greater Glasgow wrote:

> ‘…the physical environment of each setting is different, not all facilities are modern and each setting will have implications for the observation and risk management of patients. We have been involved in the commissioning and

> design of new facilities across all of the NHS GG&C psychiatric hospital sites and so are aware of the developments in hospital design in terms of things like reducing ligature risks, creating therapeutic spaces, providing privacy and enabling observation, etc. We are also aware of areas of physical environment that impact upon agendas such as suicide prevention which in turn impact upon the risk management of patients. In short if we provide a good environment for psychiatric care then we would hope to see a reduction of coercive practice due to better physical safety, easier staff/patient interactions and the ability to offer alternatives to coercion.’

We support the quality of Maggie’s Centres as a standard to aim for in new building design. However, we emphasise the need for lived experience leadership in all design and redesign projects. We do not know what the priorities of people with mental or intellectual disability will be for building design, and we cannot assume that priorities will be the same for all groups of people. It is also essential for all new buildings - and services – to be universally designed so as to be as accessible for all people as possible with the minimum of adaptations, along with reasonable adjustments for individuals. These are required by the CRPD.

Recovery from mental illness

In the Review’s March 2022 consultation document, we made no recommendations in relation to recovery. However, several respondents referred to recovery. For example:

The Scottish Association of Social Work, Social Work Scotland and the Care Inspectorate all called for a renewed focus on recovery orientated, community based services. Support in Mind Scotland wrote that:

> ‘Whilst we agree that medication has a role in mental health recovery for some people, there should be an easily accessible alternative to respond pre-crisis in the community. We advocate for non-medical approaches such as social prescribing to be actioned. This could potentially alleviate pressure from mental health services’

The Health and Social Care Alliance wrote that ‘peer support networks and innovative models of treatment are valuable in developing a community based approach to mental health, focused on recovery.’

Mental Health Network Greater Glasgow and Clyde wrote that they have:

> ‘…worked with partners such as Health and Social Care Alliance Scotland and the Scottish Recovery Network to promote a number of pro-active approaches that attempt to enable people to maintain their own wellness (such as the promotion of self-management tools, peer support groups, advance statement information and support and named person information and support). We also know that early intervention approaches often result in significantly improved outcomes for people, socially and medically. We would like to see the ‘mainstreaming’ of this kind of emphasis in the promotion of a full holistic ‘recovery’ from mental ill-health…
>
> We have a ‘reactive’ mental health treatment system that responds once a person becomes unwell and there is a level of risk presenting. It is our experience that current provision enables a person to reach a certain level of mental wellness (usually with pharmacological support) but beyond that there is far less support to support a person to achieve a longer term ‘recovery’…
>
> A large population of the mental health lived experience community will have experienced more than one episode of mental illness or crisis. Approaches such as Wellness Recovery Action Planning take learning from these previous episodes, encourage the person with a lived experience to reflect upon them and to plan preventatively. These approaches align closely with our own advance statement work and also crisis planning work undertaken by some statutory services.’

All of this fits well with the CRPD’s focus on recovery, seen most clearly in Article 26 on ‘habilitation and rehabilitation’, which requires the Government to ‘take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.’

The Wessely Review of England’s Mental Health Act (2018) briefly addressed the relationship between risk, safety and recovery. Wessely saw a need to reverse the trend where people are understood ‘primarily as risk entities, rather than as human beings who are in need of compassionate care and treatment’. Wessely quoted work on risk, safety and recovery (Boardman and Roberts, 2014):

> ‘A recovery-orientation is concerned with the development of hope, facilitation of a sense of control, choice, autonomy and personal growth, and the provision of opportunities. Risk management is normally concerned with avoiding danger, restrictions, containment, protection and staff control. These approaches appear to be in opposition…In reality, there is much overlap. The challenge is to see how these apparent contradictions can be reconciled and an approach to risk assessment and management developed which will effectively and safely support people in their recovery.’

Recovery from mental illness is often understood through the ‘recovery approach’. In its current guidance on community mental health services, the World Health Organisation (WHO, 2021 p.5) states that:

> ‘The recovery approach aims to address the full range of social determinants that impact on people’s mental health, including relationships, education, employment, living conditions, community, spirituality, artistic and intellectual pursuits. It stresses the need to place issues such as connection, meaning and values, centre-stage and to holistically address and challenges the idea that mental health care is just about diagnosis and medication…The meaning of recovery can be different for each person and thus each individual has the opportunity to define what recovery means for them, and what areas of their life they wish to focus on as part of their own recovery journey. The recovery approach, in this way, embodies a complete paradigm shift in the way that many mental health services are conceived and run…Both the human rights and recovery approach are very much aligned.’

We see alignment between the human-rights based approach which we recommend in this report, and the recovery approach as described above: an approach which would include mutual support, hope, appreciation, being valued, having people ‘on your side’ and having activity which the person values. This approach is not a mandate for expectations that everyone will overcome and will live a ‘good quality normal life’. Many people feel that they cannot recover. We commend the recovery approach as expressed by the WHO and also as developed by the lived experience movement, rather than as a justification for ‘promoting independence’ without adequate support.

These are our final recommendations: support, services, and approaches

Recommendation 9.5: The Scottish Government should lead a systematic improvement programme with the full and equal participation of people with lived experience, including unpaid carers, and services and regulatory bodies. This should include:

- **Support, services and approaches which have been successful in reducing coercion in other countries are piloted, developed and then implemented across Scotland**

- **Ward-level interventions which reduce coercion including restraint, such as Safewards, are implemented**

- **Academic research which is led by people with lived experience is commissioned on approaches to reducing coercion**

Recommendation 9.6: The Scottish Government should ensure that all new buildings and services should be universally designed. Design and redesign

processes should aim for the highest quality, as defined with the full and equal participation of people with lived experience including unpaid carers.

Recommendation 9.7: In practice, the general approach to mental health care and treatment should reflect the recovery approach as expressed by the WHO and also as developed by the lived experience movement.

9.2.3.4 Stronger safeguards when compulsion is authorised

This is where we started

The consultation document noted that:

- There is little judicial scrutiny at the time coercive interventions are made under mental health or incapacity law
- Medication can be forcibly or covertly administered under the Adults with Incapacity (Scotland) Act 2000(AWI Act) , and there are significant concerns about administration of antipsychotic medication in care homes
- There are no specific legislative safeguards for restraint and seclusion
- It is possible that high levels of coercion are currently used in situations which have relatively weak safeguards in law in Scotland
- We need law to regulate decisions that involve coercion, to protect the person
- Greater levels of coercion require stronger safeguards

The current position

A Compulsory treatment order (CTO) authorised by a tribunal, or a short-term detention certificate, may authorise the giving of medical treatment against a person’s will, including the possible use of force, and may permit covert medication. Safeguards for medical treatment are set out in Part 16 of the 2003 Act. These include a requirement that an independent ‘Designated Medical Practitioner’ (DMP) review and authorise

- any medication to treat mental disorder given without consent for a period of more than two months
- artificial nutrition without consent
- ECT given without consent to a patient who is not able to consent (ECT cannot be given to a capable patient who refuses it).

There are some exceptions for emergency situations where treatment is urgently necessary to save the individual’s life, prevent serious deterioration or suffering, or prevent the individual behaving violently or dangerously.

DMPs are senior psychiatrists. The DMP process is overseen by the Mental Welfare Commission. The AWI Act also has provisions concerning treatment without consent.

What we proposed

The Review considered:

- Strengthening the safeguards for medical treatment in Part 16 of the 2003 Act, including the current responsibilities of the Mental Welfare Commission and ‘Designated Medical Practitioner’, and ways in which the individual or their supporters might challenge particular interventions

- Law reform to ensure that involuntary admission of a person for mental healthcare is not construed as authorising treatment without consent

- Extending the ‘excessive security’ appeal; this is discussed in the chapter on Accountability

- The time limits which operate on compulsory measures, to assess whether they could be reduced

- What further safeguards could be included for restraint, seclusion and other non-medical interventions in a range of settings

This is what people told us

The March 2022 consultation asked: “Do you think that safeguards for medical treatment in Part 16 of the Mental Health Act should be strengthened?” Of the respondents who answered that question, most agreed.

A range of issues were raised by individual respondents, including: availability of Designated Medical Practitioners (DMPs); new human rights standards challenging the legality of these involuntary treatments including ECT, particularly the requirements of the UNCRPD; and that this proposal could lead to the Mental Welfare Commission becoming less autonomous and independent, with a role more like that of the Care Inspectorate.

Organisations tended to support these safeguards being strengthened.

The MWC, which operates the current DMP system, wrote:

> ‘We consider that the current range of treatments safeguarded has not kept pace with the developments in services. There is need for reform. Although this could be enacted through secondary legislation, in the Commission’s view, there is a need for a whole-scale review of what treatments are safeguarded and how this is done and by whom. There is scope to widen out the way this works.’

AdvoCard wrote that:

> ‘The current DMP oversight is a helpful legal safeguard. In practice, it is hard for service users and advocacy workers to be meaningfully involved in that assessment. Some DMPs have refused to speak with advocates, and other times it is impossible to find out who they are or when they are visiting. Some service users have reported not even meeting with the DMP when they visit, and that the process often is a medical review of notes. We are concerned

> that they are not treatment or time specific and often preauthorise a range of treatments in advance. We have spoken to a number of service users who have had ECT authorised with force, who have clearly expressed a wish not to receive that treatment, even if to alleviate serious suffering. We feel that authorisation of treatment should be done through a judicial process...'

The Royal College of Psychiatrists in Scotland wrote that:

> '…Throughout this process, we have taken the view that current practice can and must improve to ensure we are compliant with international human rights standards. This extends to strengthening safeguards. We fully support the role of independent reviews of compulsory treatment.
> …The work by DMPs and the MWC has been shown to influence care plans in a collaborative way with clinicians. That process needs to be continued through strengthening these safeguards.
> …The current part 16 safeguards and parameters of tribunal scrutiny are relatively narrow. This should be extended to encompass a broader range of interventions that are given under compulsory measures. As in current legislation, a balance will need to be struck around urgent situations where interventions should be proportionate to manage time sensitive needs with associated risks with DMP or equivalent review occurring at a practicable point. Reciprocity would be a critical principle to uphold within the application of safeguards.'

Support in Mind Scotland wrote that, amongst respondents to their survey:

> 'There was consensus for the need of a clear path for patients' supporters to challenge if the intervention shows signs of coercion.'

The Forensic Network wrote that:

> 'Having external DMP or equivalent scrutiny of care plans (beyond the narrow focus on medication) would be of benefit.'

British Deaf Association Scotland raised a concern that:

> '…if a Deaf BSL user cannot access the same information as their hearing peers at a time when it is most needed, i.e. when an intervention is required, then there is a likelihood of misdiagnosis or misinterpretation due to a communication breakdown.'

The Royal College of Nursing felt that more detailed proposals would be required before the review could make robust recommendations in this area.

The Coalition for Racial Equality and Rights wrote that:

> 'The disparate forcible treatment of BME groups clearly demonstrates significant shortcomings in current safeguards and their underutilisation for BME patients. The safeguards for medical treatment must be strengthened and specifically retailored to prevent this.'

Mental Health Rights Scotland said that:

> 'The intervention should require informed consent by law.'

The Scottish Association of Social Workers wrote that:

> 'Many coercive practices tend to take place outside of mental health settings. There is a need for greater consistency across different settings towards coercion which would mean strengthening the Adults with Incapacity Act to have parity with the Mental Health Act.'

Thrive Edinburgh argued that:

> 'RMOs are not often challenged or questioned by DMPs and…a more rigorous approach by DMP would be welcomed. Resourcing this service more fully is what may make the difference here.'

NHS Greater Glasgow & Clyde wrote that there is no clear way to challenge the Certificate of the Designated Medical Practitioner.

The Scottish Human Rights Commission responded on the review's more specific proposals about safeguards to reduce the use of coercion:

- Involuntary admission should not authorise treatment without consent ‘…Part 16 treatment requires stronger safeguards including a right of challenge. Introducing authorisation for non-consensual treatment, separate from detention, which would require to be detailed and justified, would address the challenge of X v Finland and provide robust scrutiny by a judicial authority.’ (European Court of Human Rights, 2012).

- Restraint, seclusion, and other non-medical interventions in a range of settings ‘…requirements for services to record, reflect on and reduce coercive practices would contribute to its eradication. Within this, we believe that restraint and seclusion practices must be identified separately to other forms of coercion, in recognition of their seriousness. Restraint and seclusion are forms of coercion with a particularly serious impact on the individual’s human rights, in particular, the right to freedom from inhuman and degrading treatment in terms of both ECHR (Article 3) and CRPD (Article 15). The UN Committee has made a concluding observation on the specific issues of restraint and seclusion in the UK. The Committee recommended that the State “Adopt appropriate measures to eradicate the use of restraint for reasons related to disability within all settings…as well as practices of segregation and isolation that may amount to torture or inhuman or degrading treatment”. This will require monitoring of the use of restraint and seclusion and specific safeguards around its use, so that it can be reduced to the absolute bare minimum possible to safeguard the full range of human rights of the individual.’

NHS Greater Glasgow & Clyde observed that if there is a proposal to extend what is covered to restraint or seclusion, then there would need to be careful consideration about what could be done in an emergency situation to protect an individual, as well as staff who may need to use such measures, to maintain the safety of the individual and others.

- Reducing the time limits which operate on compulsory measures

Consultation respondents did not directly address this proposal. The MWC has recently carried out work on this, in the context of concerns about rising rates of detention. We consider this proposal later in the chapter, in that context.

Overall, there is very wide support for increased safeguards, although responses were not always specific about what changes were needed. ‘Stronger safeguards’ could encompass:

- New kinds of treatment being included in Part 16, particularly restraint, seclusion or covert medication
- Additional safeguards for Part 16 interventions, whether
    - Tightening up responsibilities of DMPs
    - Having different people being DMPs
    - Removing the possibility of people being given treatment without consent when they are capable of making a treatment decision
    - Adding in rights of review or requirements of authorisation by a judicial body for particular treatments
    - Better recording and monitoring, including possibly public databases and proposed register of restraint
- Stronger safeguards for treatment under the Adults with Incapacity Act

We note the current Mental Health Bill in England proposes the following:

- The approval of a High Court judge will be required for ECT to override a refusal (at the time or in advance) for patients with capacity if it is necessary to save life or prevent a serious deterioration of their condition.
- In cases where the patient lacks capacity to consent, the Second Opinion Approved Doctor (SOAD) system (equivalent to Scotland’s DMP system) will

be strengthened, such that it must be documented in the records and the Care Quality Commission (CQC) must be informed if ECT is approved.

- Emergency treatment can still be provided under the Act where it is immediately necessary to alleviate serious suffering by the patient.

We also note England’s introduction of the Mental Health Units (Use of Force) Act 2018 – known as ‘Seni’s Law’

– which aims to clearly set out the measures that are needed to prevent the inappropriate use of force, and to ensure accountability and transparency about the use of force in mental health units. In that Act, the use of force includes physical, mechanical, or chemical restraint of an individual; and the isolation of an individual, including seclusion and segregation

We believe there is a strong case for broader safeguards, although we acknowledge that there are significant difficulties if this increases the demand on the scarce resource of senior psychiatrists. The safeguards also need to be seen in the context of the other changes we recommend, including the greater focus on respecting the will and preferences of individuals, and increased scrutiny by the Tribunal through the Human Rights Enablement approach. We agree with the RCN that more detailed work on this range of options is necessary and with the MWC that there should be a ‘whole-scale review’ of treatment safeguards. However, we have reached some preliminary conclusions which would inform and be tested out in this review.

There is European caselaw that involuntary admission of a person for mental healthcare should not be construed as authorising treatment without consent. Current mental health law in Scotland may not fully comply with this requirement, particularly in relation to short term detention, where the authorisation of the detention automatically brings with it authority to give treatment without consent, even if the patient is capable of making a treatment decision (section 44 of the 2003 Act). We believe this should be corrected.

These are our final recommendations: safeguards

Recommendation 9.8: The Scottish Government should undertake a detailed review of the safeguards for treatment contained in Part 16 of the Mental Health Act.

During this review, the following changes should be considered

- **Requiring authorisation by a DMP of any restraint, seclusion or covert medication, except in an emergency**
- **Broadening the category of who may act as a DMP, including the possibility of a suitably qualified psychologist reviewing restraint or seclusion**
- **Establishing safeguards derived from the Mental Health Units (Use of Force) Act 2018 for the Scottish context (see recommendation 9.10 below)**
- **Stronger duties on the DMP to consider and seek to give effect to the will and preferences of an individual wherever possible**
- **A possible appeal to the Tribunal against the decision of a DMP to authorise treatment for some particularly serious interventions**
- **MWC monitoring and reporting on the use of restraint, seclusion and covert medication, whether authorised by MHA or AWI**
- **It should not be possible to give a specific treatment without the consent of an individual if the individual is able to make an autonomous decision about that treatment.**

Recommendation 9.9: Section 44 of the Mental Health Act (short-term detention) should be amended to separate out authorisation for detention and authorisation for the giving of treatment, with each being separately considered and justified on the short-term detention certificate, and it being possible to be detained without authorisation for non-consensual treatment.

9.2.3.5 Monitoring and scrutiny

This is where we started

The consultation proposed that the following may be needed:

- A scrutiny system with sufficiently wide scope to consider evidence and data, and to identify underlying causes of coercive treatment
- Measures to address those underlying causes may need to be systemic measures, not just measures for individual institutions
- Stronger requirements for services to record, reflect on and reduce coercive practices, and national monitoring of coercive practices which drives learning and improvement
- Work to define various forms of coercion across settings, drawing from work in England and the Netherlands on coercion in healthcare settings, care homes and community care
- A system which is not unduly bureaucratic and does not have perverse consequences

This is what people told us

Issues about data sharing and publicly-available data were raised (we make recommendations on data below). Social Work Scotland wrote:

> '…we would support information sharing and data collection to improve services for individuals. However, the current systems in place are not linked and with regard specifically to data collection, we understand that the best learning is taken forward from data collections when clear definitions and indicators are developed and understood, allowing a wider application of findings. Taking forward such an approach in relation to coercion would be useful if clearly defined and aligned to a strategy or work plan with clear goals

> set to monitor progress, without this, it will not maximise the potential impact of taking forward such activity. We would agree that a new system to support such collection should not be bureaucratic or time consuming.'

The Coalition for Racial Equality and Rights wrote about the need to:

> '…recognise the intersectional dynamics of race, sex, gender and sexual orientation and how these may influence the prevalence and treatment of mental health…
>
> Data collection should be transparent (with participants aware of why the data is collected and how it is used), after which, it must be efficiently processed and made available through services like the Equality Evidence Finder in a timely manner…
>
> As identified by the Mental Welfare Commission and others, there are significant problems relating to data scarcity on ethnicity within mental health settings. By extending the scope of and improving data collection and monitoring practices, a better picture of mental health treatment pathways can be obtained, identifying which groups are particularly affected and allowing for better analysis and action on the underlying inequalities contributing to the disparities. While providing and improving the infrastructure necessary for such data collection may be costly and resource-intensive, it is an essential step towards understanding BME mental health inequalities and challenging the structural failings contributing to them.'

Data should include nationality, asylum status, carers, disability and intersectionality. Scottish Government should be required to show how datasets are being used. 'Data collection should be transparent, must be efficiently processed and made available through services like the Equality Evidence Finder' (CRER). Identifying which groups are particularly affected and allowing for better analysis and action on the underlying inequalities contributing to the disparities for ethnic minority people in mental health settings (CRER).

The Equality and Human Rights Commission wrote that:

> ‘In order for Scotland to become a leader in utilising a comprehensive approach to furthering the goal of eliminating potentially discriminatory coercion on the basis of disability, we first need a clear picture of where, when and why coercive methods are being used. Therefore, we agree with the Review that data collection is key in reducing coercion. The need for the listed authorities involved in mental health care to gather such data and use it to design, monitor and potentially amend policy and practice is a key as part of their compliance with the [Public Sector Equality Duty]. Our guidance on evidence and the Public Sector Equality Duty may help the Review consider in more depth the importance of gathering equality information on protected characteristics when proposing any changes to mental health, incapacity and adult support law.’

The Law Society of Scotland was of the view that:

> ‘Monitoring and scrutiny must include recognition, and identification in particular cases, of covert factors, including unintended ones. On the one hand, reductions in the need for coercion and of resistance to what is proposed could be said to limit requirements for coercion, but at the same time they could amount to subtle coercion.’

Mental Health Network Greater Glasgow agreed that:

> ‘…stronger monitoring and scrutiny is necessary, we feel that work to improve safety should acknowledge ‘near misses’ such as the need to deescalate a situation to avoid a coercive practice like restraint or isolation as well as actual incidents of coercive practice. We feel that areas such as de-escalation and harm-minimisation need more explicit recognition in order to identify good practice and to acknowledge excellence in this area that can be shared more widely.’

Support in Mind Scotland wrote that:

> ‘A public database should be established, this should be used to record the frequency and duration of involuntary treatment, and the frequency and the reason for using identified coercive practices used by mental health services. This data could be utilised for benchmarking and accountability. It would have to be

> broken down into type of 'mental disorder' and other protected characteristics such as age, gender, sexuality, ethnicity, and disability to establish if specific groups are more likely to experience coercion.'

In England, NHS Digital provides public access to the Mental Health Services Data Set which includes monthly statistics on how many people are known to be subject to the Mental Health Act, and comparisons between providers and areas. They also provide a monthly interactive report to allow users to explore data on restrictive interventions.

The Mental Welfare Commission and coercive interventions

The consultation document noted that the Mental Welfare Commission (MWC) is not currently able to monitor systematically particular coercive interventions, or to interrogate why they are being used. It proposed 'stronger powers' for this Commission to oversee the use of coercive interventions and to identify areas for action. The document cross-referred to Chapter 11 on Accountability, which is where MWC's powers are discussed.

Several organisations agreed with a stronger role for MWC. The Scottish Human Rights Commission wrote that:

> 'The process of developing improved practices should be tied to the process of monitoring and scrutiny so that areas for action identified can inform developments. We believe there is promise in providing powers to the Mental Welfare Commission, both to identify systemic areas for action and to require supports in individual cases to avoid the need for compulsion.'

In their consultation response, MWC proposed a national register of restraint. They also proposed:

> '…a statutory duty placed on the Commission to determine what data is collected to ensure that there is appropriate systems level scrutiny of new proposed legislation. This would be in addition to its generally set duty to monitor the legislation. This would require collaboration with other public sector bodies to

> ensure that data is made available to ensure accurate recording and drive systems improvement, in keeping with rules regarding use of data.'

The context for this proposal was previous 'work to reduce restraint in various different settings undertaken by different organisations. Whilst this is very welcome, the differing approaches represents a challenge and we consider that the work that the review proposes requires systems leadership across the mental health sector with regards to what data is collected, who collects it, how the data is integrated to make it useful for services, researchers, patients/individuals, those important to them, and for system wide improvements. There have been multiple attempts and much goodwill between organisations to enact these changes, some more successful than others.'

We agree with the MWC's observation that data and technology are not being used to their full potential to enable necessary change at local and national level, and we agree that there should be legislation for duties on an organisation to lead and ensure collaboration between organisations to use this potential (MWC, 2022 p.33). Our recommendations on this are set out below.

The Forensic Network supported the Commission's idea of a 'national register of restraint .' They proposed that using this

> '…across settings (education, residential setting, nursing homes, hospitals and mental health settings) would help to quantify and clarify the issues relevant to restraint. This would enable data driven improvements to physical environments, staffing and training to reduce the need for restraint and other restrictive practices.'

More generally, the Forensic Network supported the Mental Welfare Commission having stronger powers to oversee the use of coercive interventions and to identify areas for action

> '…if used proportionately. The remit of the MWC would potentially be significantly increased and consideration would need to be given to whether 'coercion' would become part of visits with published results. We also note the

> recent consultation on all Deaths in Detention being potentially reported to the MWC and the potential impact this may have on the remit of the Commission. These changes will require resource to implement and staff working across mental health services may require support to engage effectively with such expanded scrutiny. Collaborative approaches to addressing issues, which is currently the general approach taken by the MWC, is valued and the Forensic Network would support this being retained (in preference for a model of inspection and direction).'

Similarly, the Royal College of Psychiatrists generally welcomed the proposed expansion of MWC's role, viewing it as a key body to fulfil many of the aspirations of the review:

> 'We consider that the current oversight of the use of the Adults With Incapacity Act is disproportionately low in comparison with the Mental Health (Care and Treatment) Act and yet the level of compulsion and non-consensual treatment can be extremely high. Clearer oversight is required. We consider that the Mental Welfare Commission and Mental Health Tribunal for Scotland should have roles in this regard.
>
> An increase in roles and responsibilities, should not be at the cost of the Mental Welfare Commission's ability to engage and influence clinicians, supporting them to deliver best practice and rights-based approaches. This aspect of the Commission's work has been highlighted by many members. The Commission should not become a purely regulatory body.'

We agree that there is not enough scrutiny of coercive interventions under the AWI Act. Recommendations on this are in Chapter 13. Also, our more general recommendations on the MWC in Chapter 11 on accountability are intended to protect the MWC's ability to engage with clinicians: we do not recommend that the MWC should become a regulatory body.

Mental Health Network Greater Glasgow (MHNGG) agreed that:

> ‘…there may be a need for stronger powers for the Mental Welfare Commission to oversee the use of coercive interventions and to identify areas for action. We also would advocate that the Commission is able to report on developments to the Scottish Government within services set against a benchmark of the aspirations that we have for the functioning of our mental health systems and rights provision. Regarding enforcement the Scottish Government should then be bound to initiate remedial activity in order to respond to any shortcomings raised against their own aspirations.’

We agree with this, and also with MHNGG’s broader position on the need for developments to be strongly influenced by people with lived experience, which reflects in part their own experience of doing this.

We see a need for wide access to data for everyone, to enable data sharing, to make it possible to better identify issues, and to avert and learn from tragedies.

How would the MWC and other scrutiny bodies use this data?

We envisage that data would be used to bring about change individually and collectively. Data which showed a high level of restraint for an individual could flag that person’s situation for action within services, in addition to visits, investigations or other interventions by monitoring bodies and regulators. Those same services and scrutiny bodies would monitor and act on concerning trends that emerged from data, in addition to concerns raised by collective advocacy organisations and by communities of practice such as Restraint Reduction Scotland.

BDA Scotland agreed with the proposal in principle, but emphasised that:

> ‘BSL and Deaf Culture must be at the heart of any decisions made. These processes are inevitably set up on the assumption a person can hear and speak, and not from the perspective of a Deaf sign language user. These adaptations are necessary if we are to solve the overwhelming mental health care crisis within the Deaf community. BSL and Deaf culture must underpin this strategy. BDA Scotland would suggest that a Deaf BSL Intermediary service is considered for Scotland, such as the one available in England.’

Chapter 1 considers equality issues including accessible communication.

Some organisations opposed or did not clearly support an increased role for the MWC. COSLA wrote that:

> 'Any measure introduced to oversee the use of coercive intervention must respect existing process and governance. Previously COSLA commented on proposals within the Rome review noting it would potentially give the Mental Welfare Commission an inspection, monitoring and reporting role over Local Authority staff and services, and the ability to direct how resources are used, including the ability to close services or to direct local authorities to keep services open. It is local authorities and their elected members role to determine local priorities and to set their budgets within existing resources. It would be important to recognise this when looking at any enhanced powers for the Mental Welfare Commission resulting from revisions to mental health law.'

The Care Inspectorate wrote that:

> 'The Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS) provide scrutiny of mental health care providers (CI) and private hospitals (HIS). There would need to be clear protocols and strategies for joint working with the Mental Welfare Commission if stronger powers are granted.
>
> The Care Inspectorate has formal improvement and enforcement powers, up to and including closure of services where there exists serious risk to life, health, safety or wellbeing of people. At present the Care Inspectorate has taken enforcement action against 53 registered providers during 2020-22, many of which are relevant to mental disorder and adults at risk. These 53 services are comprised of 32 older people's care homes, 5 care at home services, and 3 are care homes for people with Intellectual disabilities and mental disability. Sixteen of these thirty-two care homes focus on alcohol related brain damage (ARBD).'

Social Work Scotland wrote:

‘No, we would not see a requirement for increased powers to the MWC around coercion. Local areas through social work and health regulators would be best placed to review whether their respective workforce is taking duties, policy and strategy forward and to understand the detail behind uses of coercive approaches. Regulation for improvement purposes works best when undertaken with those responsible for delivering social work services. The current work on Mental Health Quality Standards would provide a basis from which regulators can work to ensure social workers (through the SSSC) and services delivered (through the Care Inspectorate) meet the requirements of duties and powers within legislation.

Retaining current regulation requirements will support the considerations of wider legislative requirements on local authorities and HSCPs, taking into account the ability of the system as a whole to carry forward duties. Without the regular engagement around wider social work service business, there is risk that recommendations made from a single regulator with expertise in mental health legislation will not reflect the wider pressures and responsibilities on local authorities and HSCPs, thus leading to challenges in being able to create services that meet the wider requirements of communities.

The MWC play a vital role in the interface with individuals through investigations and providing advice and information, while also having a significant role in monitoring the Acts, this role should be preserved, with the reach and expectation to local areas, responsible for service delivery, and professional regulators to support the implementation and oversight of recommendations. Ensuring the role of Chief Social Work Officers, as professional oversight for services delivered by local authorities, would respect the current legislative duties in place. The National Care Service may create an opportunity for a National Social Work Agency; if this occurs then quality and improvement for social work practice should sit here, with direct links into regulators responsible for overseeing other aspects of social work practice’

A new National Social Work Agency (NSWA) has been proposed as part of the new National Care Service (NCS).

The Scottish Association of Social Workers responded along similar lines, adding that ‘the scope of social work and health and the delivery of holistic services extends beyond mental health.’

We agree with these organisations, except that we do not see the MWC as a body which is limited to a clinical or legal-advisory remit. The MWC has always had a role in the community, and we make recommendations in Chapter 11 on accountability about how that role should develop. The MWC’s expertise extends beyond mental health legislation – its professional staff are psychiatrists, nurses and social workers – and the MWC’s core business is in visiting people and in reviewing cases. The MWC is not a regulator and would not take over the regulatory function of the Care Inspectorate, which will continue to challenge coercive practices in registered care settings. At this time in the development of the NCS, we cannot know exactly how the National Social Work Agency would operate, so we cannot know how the MWC’s role might fit with the role of NSWA in the context of care services. Scottish Government’s current proposals include a role for the NSWA in monitoring and improving the quality of the social work and social care services provided by the NCS.

We are recommending a ‘system leadership’ role for the MWC in relation to mental and intellectual disability and human rights, including leadership of the whole-system approach to reducing coercion which we recommend. The MWC would not be ‘doing everything’: it would identify what needs to be done, monitor progress, give guidance on principles, and bring together agencies to make sure that all are doing what needs to be done in respect of their responsibilities.

To reduce the use of coercion, Scotland will require co-ordination of the monitoring, inspection and improvement activities of relevant organisations. Those organisations include the MWC, the Care Inspectorate, Healthcare Improvement Scotland, a new National Social Work Agency and other relevant agencies. This work will require sustained additional resourcing.

We recommend in Chapter 11 on accountability that the MWC provides system leadership for mental health services and there will be a need for the MWC to provide leadership for data monitoring. This does not necessarily mean that the MWC should host or provide public access to all forms of mental health-related data: some larger organisations may be better placed to further develop the infrastructure for data linkage, data sharing and public dissemination. We would expect the MWC, working with partners, to provide direction for monitoring and research and to propose technical solutions on data and technology to Scottish Government.

Over the course of the review, we spoke with experts at the Care Quality Commission in England, and at universities in the Netherlands and in the Republic of Ireland. There is much which should be learned from how these nations have addressed coercion in mental and intellectual disability services through legislation. For example, the concept of coercion in Dutch law is defined more broadly than only detention, compulsion, restraint and seclusion (Frederiks, 2020). Examples include: using surveillance technology to supervise a person; checking for the presence of behaviour-influencing substances; and restricting the right to have visitors. Our recommendations assume a very broad understanding and definition of coercion.

9.2.3.6 These are our final recommendations: monitoring and scrutiny

Recommendation 9.10: The Scottish Government should establish a scrutiny system with sufficiently wide scope to consider evidence and data, and to identify underlying causes of coercive treatment. This should include:

- **Measures to address those underlying causes through systemic measures and measures for individual institutions**

- **Stronger requirements for services to record, reflect on and reduce coercive practices, and national monitoring of coercive practices which drives learning and improvement; and**

- **No undue bureaucracy and no perverse consequences**

Recommendation 9.11: The Scottish Government and relevant public authorities should consider other countries' laws and approaches for monitoring and regulating the use of coercive measures when developing a new system.

Recommendation 9.12: The Scottish Government should propose legislation for a national register of restraint to be set up and maintained by a central public authority which is capable of hosting the exchange of data between multiple public authorities, and which is capable of reporting publicly on trends in data from all of those authorities.

Recommendation 9.13: The Scottish Government should commission and resource the Mental Welfare Commission, and propose legislation where necessary:

- **to work with partner agencies and deliver recommendations on which further powers the Mental Welfare Commission requires to ensure that co-ordinated work delivers reductions in coercion across settings**
- **to co-ordinate the development of consistent and effective approaches to the reduction of coercion across health and social care settings which serve people with mental or intellectual disability**
- **to provide system leadership for data monitoring on reduction of coercion**

In Chapter 11 on accountability, we recommend a duty on Public Health Scotland to lead work with the Mental Welfare Commission and other stakeholders to determine what needs to be monitored across mental health services to ensure human rights obligations are being met. We also recommend a duty on Public Health Scotland, the Mental Welfare Commission and organisations holding data to work together to gather and make available the structured, disaggregated, researchable data needed to monitor mental health services effectively and drive change.

9.3: Rising rates of detention and community-based compulsory treatment

In the main consultation document, we referred to this as ‘work in progress’. During that consultation we met with some more experts to discuss rising rates of detention and compulsory community-based treatment, including Professor Tom Burns (previously at Oxford), Professor Scott Weich (Sheffield) and Jacqui Dyer MBE with Zoe Reed (London). This Review had asked the Mental Welfare Commission (the MWC) to look at its data and report to the Review on how Compulsory Treatment Orders (CTOs) have been used (MWC, 2022). The MWC found that compulsion has been shifting towards the community under the current Mental Health Act, with an increasing number of people staying on community-based CTOs long-term. The number of people on hospital-based CTOs has also increased over time, but the increase in community-based CTOs has been much larger. The Review's secretariat brought together findings and carried out a literature review of relevant research. We considered this report. We then asked a group of people who have both personal and professional expertise in mental health services to consider the findings from that paper and our response to them.

9.3.1: Racism and anti-racism

This is where we started

The final report of Sir Simon Wessely's review of England and Wales' Mental Health Act wrote that (Wessely et al, 2018, p.56):

> "The [UK] government noted with concern the disproportionate number of people from black and minority ethnicities detained under the Mental Health Act. Whilst experiences vary across different ethnic minority groups, we were particularly concerned by the excessively poorer experiences and outcomes of individuals from black African and Caribbean communities...
>
> The development of the Patient and Carer Race Equality Framework (PCREF), an organisational competence framework (OCF), will improve mental health service access and outcomes in ethnic minority people…In line with the OCF, our wider recommendations include:

- Raising the bar for individuals to be detained under the Mental Health Act, as well as any subsequent use of Community Treatment Orders.
- Providing the opportunity for people to have more of a say in the care they receive, ensuring that people from ethnic minority backgrounds are involved in the care and treatment plans developed for them and thus increasing the likelihood that they are more acceptable…"

Wessely made many more recommendations to tackle the disproportionate number of people from ethnic minority communities detained under mental health law (p.57).

We have a major concern about racism in the use of orders in Scotland. Recent work by the MWC showed how orders have been used with different ethnic communities in Scotland (MWC, 2021 A). Compared to the general population, differences were greatest for community-based Compulsory Treatment Orders for black people: 2.1% of these orders, compared to their 1% representation in the general population. The MWC reported on the use of hospital-based and community-based CTOs for this Review (MWC, 2022). Minoritised ethnic groups were overrepresented among individuals on both forms of CTO, compared to representation in the general population. In this study, the MWC found that people of mixed race were more likely to experience a longer first CTO; that communities of colour were generally more likely to have longer subsequent CTOs; and that the Black community was over-represented, compared to their 1% representation in the general population, in both the hospital-based CTO population (10.9%) and community-based CTO population (12.8%).

The MWC wrote that this is ‘worrying’ but in keeping with findings from other parts of the UK: in England and Wales, recent data showed that black or black British people were over ten times more likely to be given a Community Treatment Order than white people (Laing and Garratt, 2022, page 17). Reflecting on their work for this Review, the MWC wrote:

> ‘This report adds to the discomfort that many feel on exploring the data around the use of mental health legislation across Scotland’s communities.’

A main aim of England’s recent review of mental health law, discussed above, was to address the extent of racism in the use of mental health orders. Scotland’s problem in this area appears to be no less significant.

This is what people told us

In response to the consultation document, the Coalition on Racial Equality and Rights (CRER) wrote that:

> ‘In order to effectively understand rising rates of detention and CTOs, there must be considerable engagement with the groups most affected by the practices. There is considerable evidence of racism affecting how these compulsory treatments are implemented in Scotland, indicating that system-wide anti-racist changes are required and should be centred within proposals for mental health law reform. Based on this recent and continuously emerging data, any future work on detention rates and CTOs cannot neglect the stark inequalities in their implementation and must aim to address them as a primary target in line with Scottish Government racial equality commitments.’

Social Work Scotland and the Scottish Association of Social Workers called for this Review to be explicitly anti-racist in its approach to understanding rising rates of detention and the use of community-based Compulsory Treatment Orders.

Glasgow City Council wrote that:

> ‘…there may be wider societal issues to address in relation to why there is a higher level of orders for certain ethnic groups, which would also apply to socio-economic factors as indicated in the MWC 2021 monitoring report when 29.6% of CTOs were in 20% of the most deprived area and this was on a sliding scale.’

A range of original academic research on ethnicity, mental health and compulsion has come from England in recent years, including work done for the Wessely Review. The present review was not resourced to commission similar research for Scotland. To give an example of recent research: Scott Weich and colleagues considered data on compulsory admissions in England for one year, data which represented more than 1.2 million patients and covered 93% of National Health Service provider trusts (Weich et al 2017). Black patients were almost three times more likely to be admitted compulsorily than were white patients. Compulsory admission was greater in more deprived areas and in areas with more non-white residents, after statistical adjustments.

The MWC has proposed that measures to address racial discrimination should not be targeted, but should be taken for all people to improve requirements, safeguards and scrutiny around the use of community-based CTOs to help to reduce inequalities across age, gender, ethnicity and deprivation (MWC, 2022, page 6).

In contrast, the Wessely Review recommended a targeted approach to addressing racial inequality, inequality which was particularly evident in the disproportionate use of Community Treatment Orders with Black people under England's mental health law. The Wessely Review's final report set out a wide range of measures, including some general approaches (Wessely et al, 2018, page 57), with a particular focus on a new Patient and Carer Race Equality Framework (PCREF) across health and care services. This is discussed in Chapter 1 of this report. The approach of PCREF has the potential to address discrimination in a targeted way, alongside actions which address discrimination through 'mainstream' measures (in relation to disability inclusion, this is known as a 'twin track' approach). We see value in a combination of measures to address racial discrimination in general, plus measures to address racial discrimination specifically in the use of orders and in the use of coercion as described in this chapter.

These are our final recommendations: racism and anti-racism

Recommendation 9.14: Legislation should require monitoring and scrutiny which specifically tracks and addresses ethnicity in rates of detention and compulsory treatment.

Recommendation 9.15: For people from ethnic minority communities, a human rights enablement approach should routinely consider whether:

- **all of the standard safeguards have been applied in full**

- **all assessments have been made on the same basis as for all people, and without any assumptions which could be related to race or ethnicity**
- **any challenge to the validity of assessments has been considered and resolved**
- **the person has been offered at least the same level of support for decision-making as for any other person**
- **the person's cultural, linguistic, religious or belief requirements have been identified and professionals can show how these needs will be met**
- **if the person or their supporters have indicated that racism or cultural insensitivity may be present in relation to the order or in relation to relevant services, these issues are being addressed**

Recommendations in other chapters are also relevant, including a recommendation in Chapter 11 on accountability for the Scottish Government to provide support for culturally appropriate collective advocacy; and recommendations on equality and human rights that Scottish Government should:

- resource and empower leaders of Scotland's minoritised ethnic communities to lead on solutions which ensure access to mental disability services for their communities.
- address racial discrimination though a targeted approach which develops the PCREF approach, with monitoring and enforcement by scrutiny bodies
- legislate to require public authorities to ensure that practitioners and paid carers are trained to recognise and address racism

We believe that the range of recommendations above, together with recommendations elsewhere in this report, constitute the basis for an anti-racist approach. All of the above should be clearly aligned with Scottish Government racial equality commitments. We note that there are existing non-discrimination requirements through the ECHR / Human Rights Act in relation to deprivation of liberty and interferences with autonomy, in addition to requirements of the Equality Act. We also note that the Scottish Government proposes to directly incorporate the Convention on the Elimination of All Forms of Racial Discrimination - the United Nations anti-racism treaty - into Scots law along with other UN treaties.

We also need an emphasis on, and work to understand, how other groups are affected by rates of detention and compulsion. This work needs to examine statistics on and experiences of mental health services, including perspectives from LGBT+ communities and from communities of people with sensory impairments or differences, for example. Our recommendations on racism could provide an initial model for work for other equality groups, and that work should also begin now. There are also a range of groups who are not directly protected as equality groups, but who need developments which reflect the specific needs of their communities, with these groups being involved in leading developments. Those groups would include veterans, homeless people and prisoners, for example.

There may also need to be targeted approaches for other communities which are discriminated against. For each community, there will be a need to link developments to that community’s own sense of identity and culture, in addition to universal approaches to improving the application of the law and experiences of services for all.

To an extent, we agree with a view expressed by the MWC that measures taken for all people to improve requirements, safeguards and scrutiny can help to reduce inequalities across age, gender, ethnicity and deprivation. We think that a universal approach is necessary, but we believe that where there is clear evidence of particularly high levels of discrimination or disadvantage, specific and targeted interventions are also required.

9.3.2: Criteria for detention and involuntary treatment

This is what we found

In the March 2022 consultation, we noted that criteria can have a major effect on how often detention and involuntary treatment are used in mental health services. As discussed below, research for the Wessely Review of England's mental health law could not give definitive reasons for increasing rates of detention in England, but that research did identify some factors which were more likely to have contributed to the increase (Rains et al, 2020). One possible factor was a rise in detentions processed under mental health law as a consequence of changes in English legislation and case law. However, that factor may not explain the overall increase in detentions (Smith et al, 2020). Ireland has around half the rate of involuntary psychiatric admission of England, and different legislation may be one reason for this (Conlan-Trant and Kelly, 2022; Gilhooley and Kelly, 2018). Norway introduced a capacity-based criterion to its Mental Health Act in 2017. This led to a significant and unexpected increase in the use of community-based treatment orders (Høyer et al, 2022). We spoke with Professor Brendan Kelly (Dublin) about differences between countries in rates of detention and involuntary treatment, differences in criteria for these, and how we might protect against unintended consequences of changes to criteria for detention and involuntary treatment. We understand that it is valuable but difficult to compare rates of detention and involuntary treatment between countries. There can be significant differences in criteria for detention between countries, as well as differences in which groups of people can or cannot be detained. Not all countries have community-based compulsory treatment. There can be de facto detention across a range of different situations and settings which is not formally recognised or addressed as detention within each country's legal system.

We recognise that new criteria for detention and involuntary treatment could lead to more use of coercion, in various forms. For example, community-based Compulsory Treatment Orders were introduced as a less restrictive alternative to hospital detention, but as discussed below, they are being used in a way which continues to drive up compulsion in the community.

Scotland does not have an understanding of why rates of detention and involuntary treatment have quite consistently continued to rise, across the range of orders under the Mental Health Act. We do not yet have a system which shows how much deprivation of liberty is taking place outside of mental health settings in Scotland (see Chapter 8 recommendations). There are some instances where more use of orders brings good outcomes: the increased use of Mental Health Act orders in England appears to have given increased legal protection to individuals without decision-making capacity who were not actively objecting to admission (Rains et al, 2020). However, we do not have evidence that increasing use of Mental Health Act orders has brought better outcomes for people, overall.

Of course, we cannot know what the unintended consequences will be of any change until those changes and consequences happen. Although it is not our intention, we recognise that the breadth of the Autonomous Decision Making test might include more people in involuntary measures. Other recommended changes may have the potential to be used in ways which include more people in detention or in involuntary care and treatment. Monitoring of trends will need to continue, but this can only tell us about changes in the use of orders, not about the causes of those changes. We will need research to tell us whether changes in the use of orders are caused by changes in law, or by changes in culture, resources, or society.

In Chapter 3, we recommend that the Scottish Government takes active steps to align existing mental health, capacity and adult support and protection law. For the medium term, we recommend that the Scottish Government moves to better align mental health and capacity law, with complete fusion of those areas of law as a longer-term goal. This means that Scotland would continue to have separate mental health law and capacity laws for some time. Those laws currently have different criteria which must be met before deprivation of liberty or involuntary treatment can be authorised, and our recommendations mean that differences between mental health and capacity law would exist for some time. One area of difference would be the criteria in these laws which must be met before non-consensual interventions can be authorised.

In Chapter 3 we also recommend better alignment of adult support and protection law with mental health and capacity law. However, adult support and protection law does not authorise deprivation of liberty or involuntary treatment and does not have criteria for these.

Detention and involuntary treatment under the 2003 Act depend on a number of tests being satisfied, which can be summarised as follows:

(a) presence of mental disorder

(b) treatment which would alleviate symptoms or prevent the disorder worsening is available

(c) without such treatment there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person

(d) the patient's decision-making is significantly impaired and

(e) the order is necessary. (See for example section 64(5)).

These tests are modified somewhat for emergency interventions. The tests under the Adults with Incapacity Act are generally broader – for example the test applied by the sheriff in an application for guardianship is that 'no other means provided by or under this Act would be sufficient to enable the adult's interests in his property, financial affairs or personal welfare to be safeguarded or promoted' (section 58). The adult would also need to be found to lack capacity as defined in section 1, and the principles of the Act would need to be taken into account.

We discuss 'mental disorder' at chapter 2 and the SIDMA and capacity tests at chapter 8. We did not receive substantial evidence suggesting major problems with the other criteria, although we are aware that the Wessely Review of the Mental Health Act in England and Wales discussed questions on the 'risk' test in particular (e.g. page 107). In the short term we do not believe major changes to the other tests are necessary. For the longer term, we have recommended that fused (unified) mental health and capacity legislation should be the ultimate goal in Scotland. In moving towards fusion, it would be desirable to consider how the criteria for intervention in the two Acts can be aligned more closely, with an overall focus on ensuring that non-consensual interventions are justified and proportionate, and maximise respect for the human rights of the person. That opens the door for reconsidering ‘risk’ and ‘necessity’, including society’s response to risk in terms of restrictions.

In the longer term, new tests would need to be accommodated within our wider framework of strengthened principles and Human rights enablement. The Scottish Government’s planned incorporation of a large range of UN treaties raises the question of how these rights and duties will be applied in practice. Human rights enablement offers an approach which all stakeholders appear to agree is, in principle, practicable. The broad range of relevant rights and duties may require a shift away from understandings of risk which are tied only to health, safety and welfare. A concept of ‘risk of harm to human rights’ may accommodate this shift. In particular, the overall risk to human rights would be important: significant harms to human rights would be justifiable only exceptionally, on the basis of very significant advantages in the respect, protection and fulfilment of the person’s human rights overall.

These are our final recommendations

Recommendation 9.16: In the medium term, the criteria for detention and involuntary treatment under the Mental Health Act; or for involuntary measures under the AWI Act, should be that:

- **a person has a mental or intellectual disability or for the purposes of an AWI intervention is unable to communicate because of a physical disability, whether short or long term, and**
- **is unable to make an autonomous decision as set out in Chapter 8;**

And for the purposes of a Mental Health Act intervention that:

- **treatment which would alleviate symptoms or prevent the disorder worsening is available, and**
- **without such treatment there would be significant risk to the health, safety or welfare of the patient or to the safety of any other person, and**
- **the order is necessary.**

Recommendation 9.17: In the longer term and in the context of fusing mental health and capacity law, other tests for detention and involuntary treatment under the 2003 Act and for involuntary measures under the AWI Act should be redefined to fit with the new principles and the Human Rights Enablement framework.

We make recommendations below in relation to monitoring and research, and understanding rising rates of detention and involuntary care and treatment. Those recommendations are relevant to understanding the effects of different criteria for detention and involuntary measures under mental health and capacity law.

9.3.3: Rising rates of detention and compulsion

This is what we found

This section does not address rates of detention and compulsory treatment in situations such as de facto detention in residential care homes. Scotland does not yet have a full system for authorising and monitoring deprivations of liberty and non-consensual treatment outwith mental health detention, so we are unable to comment on current rates of detention and compulsory care outwith the context of mental health law in Scotland. Recommendations for a system for authorising such deprivations of liberty and non-consensual treatment are made in Chapters 8 and 13.

Rates of mental health detention are rising in many, but not all, Western nations (Rains et al, 2019). In Scotland, rates of detention have risen over time, with more new orders being made each year in most years since 2009/10, across Compulsory Treatment Orders, Short Term Detention Certificates and Emergency Detention Certificates (MWC, 2019 B, figure 3.1; MWC, 2021 B, figure 3). There was an even sharper rise during the first year of the pandemic: a 9.1% rise in 2020/21, compared with an average year-on-year rise of 5% for the previous five years (MWC, 2021 C). Rising rates in 2020/21 were associated with less use of safeguards against inappropriate detention. The most dramatic increases have been in the use of orders for emergency detention and short-term detention (MWC, 2021 B, page 14) and community-based CTOs (MWC, 2022, figure 2). The total number of all CTOs has increased over time. There were more than twice as many individuals on a community-based CTO in 2020-21 compared to 2007-08; and the number of hospital-based CTOs increased by 16% over the same period of time (MWC, 2022).

The Review's terms of reference require us to consider 'why there has been an increase in compulsory detention and treatment and the reasons for variation in compulsory orders across Scotland'. We have had to conclude that, due to a lack of research, it is not currently possible to know with confidence why has there have been large increases in detention and compulsory treatment in recent years in Scotland. As discussed above, it is clear that rising rates of detention and compulsion have not affected people equally in Scotland, with an overrepresentation of people from ethnic minority communities. On the reasons for variation in compulsory orders across Scotland, MWC data has long indicated that there is significant variation in the use of orders between areas across Scotland (for example: MWC, 2021B, figures 6, 13 and 21). However, in contrast to England (e.g. Weich et al 2017), it appears that no research has been completed or commissioned in Scotland to explore the possible causes of this variation.

The lack of research in Scotland also means that it is not possible to know whether rising rates of detention and compulsion are 'good, bad or neutral': an order for an individual could have positive, negative and neutral effects on a range of different human rights for that person, but the effects of orders are not currently assessed in this way.

We agree with this view from NHS Greater Glasgow and Clyde:

> ‘…rising rates of detention should not always be seen as a negative, if it ensures that the patient's rights are being protected through consideration of Millan principles and having a right to appeal. It is preferable to the unacceptable position of 'de facto' detention, where coercion is used through ‘persuading’ someone to remain in hospital or accept treatment, when there is often an inherent implied threat to consider detention if the person does not agree to comply.’

Substantial research in this area for the Wessely Review of England’s mental health law identified possible reasons for rising rates of detention and involuntary treatment (e.g. Rains et al, 2020). Possible contributing factors included: increasing compliance with human rights law through the application of mental health law to people who might previously have been admitted ‘voluntarily’ but without informed consent; rising levels of mental illness; an increase in the population within demographic groups who are at higher risk of detention; mental health services and the police getting better at identifying people who meet criteria for detention; and increasing demands on resources which reduce the availability and intensity of preventive support. Other research in England found an association between rising rates of detention, the economic recession, legislative changes and the impact of austerity measures on health and social care services (Smith et al, 2020). This contrasts with static or declining rates of detention in several European nations (Rains et al, 2019).

It may be effective to replicate or develop studies which were carried out in England on rates of detention and compulsion. However, studies have been limited by available data and the existing research base. None have been able to demonstrate the causes of rising rates of detention and compulsion with certainty. An alternative approach to future research would be to examine differences between Scotland and some or all of those nations where rates are not rising, towards understanding what Scotland can do to reach a stable or decreasing rate of detention in future. Another approach would be to research variations between areas. Any research programme would be a substantial undertaking, and it will be important to consider which forms of research could potentially contribute most to the aim of reducing coercion in mental health services, including rates of detention and compulsory treatment. We discuss a human rights-based framework for future research, below.

This is what people told us

Individuals and organisations expressed many different views on what may be contributing to rising rates of detention in Scotland. In addition, respondents gave insights into a range of professional experiences:

An individual wrote that:

> ‘I am aware of the rise in detention and use of emergency powers which is concerning. The intention of the 2003 Act was that while [short term detention] was seen as a gateway, it was intended that CTOs could be applied for "cold". Partially, this does not happen due to a lack of training for RMOs and to an extent also MHOs. In my experience, RMOs particularly often express a view that someone's mental health needs to deteriorate to a degree where [emergency detention] or [short term detention] can be applied, which is clearly not in the interest of a service user's wellbeing…Work pressures also mean that consultant psychiatrists are less able to attend home visits. This means that crisis home visits are often undertaken by MHOs and GPs, leading to emergency detentions, which is the only available option. To add, many RMO posts are filled by locums who are not very familiar with Scottish law. There is also often a significant shortage of beds which means that situations which would be preventable through early intervention and for example, informal admission (as stipulated in the 2003 Act) does not happen.’

Some of this may reflect issues about resources, training and workforce capacity. There has been a high vacancy rate for psychiatry (The Herald, 2019; RCPsychiS, 2021) and other professions. Spending on locums has increased substantially across medical specialties (NES, 2022; The Herald, 2022), and we do not know what proportion of locums have training in relevant Scots law.

Thrive Edinburgh wrote that:

> ‘Risk aversion and genuine fear and concern amongst mental health professionals that any change in a care plan could be seriously adverse for an individual in terms of their safety and well-being are common. Where the grounds can be evidenced and an individual is relatively speaking, doing well it can be tough to justify a more risk taking/enabling approach. Conversely, improved awareness and understanding amongst professionals about the human rights agenda and rights enshrined in current law, may contribute to some extent to a proportion of the increase in detentions. It is proposed that de facto detention is much reduced in in-patient and community settings due to enhanced awareness and understanding of MH Act rights and the concept of Deprivation of Liberty.’

We acknowledge that mental health professionals are often in a position of managing a high level of risk of harm, with limited resources and support available to ensure that individuals and the public are protected. This must have an effect on what practitioners feel willing to do, and are able to do. The law reforms which we recommend aim to drive up the availability of resources for the immediate realisation and progressive realisation of the right to health and the right to independent living. Human Rights Enablement (HRE) should clarify the range of risks which relate to a person’s situation at any point in time. That should include risks to the whole range of the person’s human rights. Risks of harm which exist because of inadequate staffing or other resource limitations should be clearly expressed within that context.

A local authority wrote that:

> ‘[Emergency Detention Certificates] EDCs are rarely used locally as GPs normally refer to the [Community Mental Health Team] before it reaches that stage. Similarly, general hospital staff normally contact the on-call [Community Psychiatric Nurse] or psychiatrist for advice or intervention if dealing with a mental health crisis, which usually prevents it escalating to an EDC.’

We feel that research on what drives differences between areas in the use or orders is important. We discuss this below.

The Law Society of Scotland wrote that :

> ‘Work relating to rising rates of detention could usefully take account of broader issues arising from Article 5 of ECHR.’

That comment fits with research for the Wessely Review of England’s mental health law, discussed above, which found that this was a possible contributing factor to rising rates of (formalised) detention in England: increasing compliance with human rights law through the application of mental health law to people who might previously have been admitted ‘voluntarily’ but without informed consent (Rains et al, 2020). We make recommendations for future research in Scotland, and that research may need to consider the extent to which Article 5 ECHR compliance has affected rates of formal detention in Scotland, in response to the UK Supreme Court’s Cheshire West judgment.

In this chapter, we make recommendations on how restraint, seclusion and other forms of coercion should be scrutinised. Our recommendations for a system for authorising deprivations of liberty, including recommendations on monitoring, should enable full and consistent monitoring of all forms of coercion, including understanding of the reasons behind the use of coercion.

Rising rates of detention can occur alongside deteriorating experiences of detention, and lack of investment in the community may also drive up hospital use. However, in some instances, rising rates of detention may indicate progress. For example, some children and young people may now be detained rather than treated under parental consent, and so have access to appeal and to a second opinion.

A new approach to rising rates: the international human rights framework

Research on rates of detention and of community-based compulsory treatment, in the UK and in other countries, has rarely given us clear information about why rates have increased, or about whether community-based compulsion leads to good outcomes for people. We know that CCTOs account for a large and increasing proportion of 2003 Act orders (discussed below), but the causes of rising rates in Scotland are not understood. There has not yet been research in Scotland to explain why rates of detention have risen, why the use of CCTOs has continued to increase in Scotland, or why there is large variation in the use of orders across different areas of Scotland. In this context, we cannot know whether the 2003 Act has consistently ensured access to ‘least restrictive alternatives’.

A different perspective on these issues - the perspective of the international human rights framework – can potentially bring clarity to what we know from international research to date, and may provide clear direction for future policy development, implementation, monitoring and research in this area.

This Review is recommending a new purpose for mental health and capacity law: to ensure that all the human rights of people with a mental or intellectual disability are respected, protected and fulfilled. Scotland’s current mental health and capacity law – and mental health strategy and national policy – do not directly assess whether the application of mental health and capacity law leads to respect, protection or fulfilment of human rights. Although the proposed purpose for future mental health and capacity law does not directly refer to the human rights of unpaid carers, a principle for carers is recommended, and the rights of carers would be addressed in law, policy and practice. We note that it would generally be artificial to understand a person as being completely separate from family and other people in their life. Although we are considering the rights of individuals, decisions and actions affect family, friends and community. Their rights and needs must also be considered.

Effects on human rights should be measured at the individual level, and individual measures of a very broad range of human rights should inform population-level measures. Data recorded for Human Rights Enablement (HRE) should provide a rich and detailed source of information for monitoring the effects of detention and compulsory care and treatment on all relevant human rights. However, there is no guarantee that the introduction of HRE will slow or reverse the increase in the use of orders in Scotland. Close and careful monitoring of data from HRE will be essential.

A human rights-based approach to indicators on the right to health, for example, should reinforce, enhance and supplement commonly-used health indicators. Paul Hunt wrote that (United Nations, 2006, paragraph 27):

> ‘A human rights-based approach to health indicators is not a radical departure from existing indicator methodologies. Rather, it uses many commonly used health indicators, adapts them so far as necessary (e.g. by requiring disaggregation), and adds some new indicators to monitor issues (e.g. participation and accountability) that otherwise tend to be neglected. In short, a human rights-based approach to health indicators reinforces, enhances and supplements commonly used indicators.’

We need a new human rights-based approach to ongoing monitoring of all detention and compulsory care and treatment, and a coherent programme of human rights-based data gathering and research. We need a clearer understanding of how detention and compulsion affect people’s human rights, which can come from directly measuring effects on people’s human rights. This should give clearer direction on how policy and practice should develop and inform future law reform.

In future, orders would be monitored directly in relation to their positive and negative effects on human rights. Much more qualitative information will be needed from the people who experience being subject to orders. More generally, monitoring also needs to cover people who use mental health services and people who want to use services but do not have access to them. A new approach to research and monitoring may well be required. We should learn from and with other countries which appear to be ahead of Scotland on rates of detention, on monitoring and managing coercion, and on monitoring human rights in mental health services.

Combined perspective: lived and professional experience

We discussed our thinking on rising rates of detention with a small group of people who have combined personal and professional expertise of mental health services.

These discussions developed our understanding and thinking as follows:

- It is clear to us that there is a need for lived-experience-led research in Scotland
- Using the international human rights framework to give a different perspective on rising rates of detention will be valuable for future research and monitoring
- The issue of orders being allowed to lapse may reflect high and increasing caseloads, leading to reviews being left until formal reviews, perhaps along with some intention to be on the 'safe side' in some people's cases
- There is a need for a mechanism which allows the person and their family to be able to confirm that the Human rights enablement approach has been used and if not, to request that it will be used and also to call for a review of that process. This would need to include instances where family members, for example, are seeing crisis situations or significant risk to life and health.
- The Human rights enablement approach would also enable professionals in their work, as it would provide then with the opportunity to clearly demonstrate their reasoning

These are our final recommendations: rising rates

In taking forward the following recommendations to address rising rates of detention and compulsory measures, the Scottish Government should be informed by the international human rights framework, including the ECHR and relevant UN treaties. These recommendations should be read with recommendations on accountability.

Recommendation 9.18: The Scottish Government should ensure that the Mental Welfare Commission and the Scottish Human Rights Commission, as independent bodies and in collaboration, are sufficiently empowered and resourced to monitor the extent to which future law meets its purpose of respecting, protecting and fulfilling human rights.

Recommendation 9.19: The Scottish Government should work with the Mental Welfare Commission and the Scottish Human Rights Commission to determine new requirements for data collection on detention and compulsory measures which should be set in law.

Recommendation 9.20: The Scottish Government should invest in establishing or developing a coherent, integrated system to achieve data collection on rates of detention and compulsion, with local authorities, health boards and other public bodies sharing data, and should ensure public access to significant data and analysis.

Recommendation 9.21: The Scottish Government should commission ongoing monitoring, analysis and research on the effects and effectiveness of detention and compulsion for public protection in Scotland.

Recommendation 9.22: The Scottish Government should commission research to understand rising rates of detention and rates of community-based compulsion, and the large variation in the use of orders across different areas of Scotland. This work and research should be carried out the full and equal participation of people with lived experience, including unpaid carers.

Recommendation 9.23: The Scottish Government should ensure that data is collected and analysed on the economic, social and cultural barriers that prevent or discourage people for using and benefitting from services, including people from diverse communities and people with protected characteristics.

9.3.4: Time limits on compulsory measures

In addition to the number of people on orders, the length of those orders is important. The MWC has found that many short-term detentions appeared to be allowed to lapse instead of being ended as soon as possible (MWC, 2021 D). This is contrary to what is required. The MWC were concerned to find that 22% of all STDCs lapsed at 28 days, the final day of the maximum duration of an STDC. The MWC proposed two ways to address this ‘reflexive’ practice: additional clinical scrutiny at 14 days from outside the service; or a shorter duration for short-term detention. They felt that any proposed changes should carefully consider the impact on lengths of other detentions and the resource implications. The MWC wrote that:

> ‘As far as we are aware, such data was not available and considered when the Mental Health Act was last reviewed. Informed changes to the maximum length of detentions can make a difference to those who experience detentions and those important to them.’

The MWC previously wrote that (MWC 2020 B, paragraph 75):

> ‘There does not appear to have been any discussion about the length of a STDC (28 days) at the time of the last review of the legislation (Millan Report) with most respondents suggesting that this time frame was about right. The duration of detentions authorised through the Act has remained the same for decades and does not appear to reflect the strides made in treatment and care for people with mental health difficulties in hospital and community settings.’

For this Review, the MWC looked at Compulsory Treatment Order (CTO) episodes which ended during the 14 years between 2007-8 and 2020-21 (MWC, 2022). They considered both hospital-based CTOs and community-based CTOs, and found that:

- new orders had a median length of 6 months, which is the statutory review point
- the median length of all subsequent CTOs was 9 months
- new CTOs were longest for people of mixed ethnicity

- over time, fewer CTOs that lasted beyond the mandatory review point were extended

The MWC commented that:

> '…the endpoints of CTOs more generally coincide with the mandatory points of compulsion ending. This is in keeping with the Commission's work on STDCs which showed that compulsion tended to end with mandatory endpoints. For CTOs this is even more important given the longer duration of compulsion…'

Failure of ongoing review appears to be a particularly serious problem with community-based CTOs. The MWC has suggested that there should be a mechanism to consider 'revocation strategies' to ensure that orders are ended as soon as is appropriate (MWC 2020 B). Findings on these orders, discussed below, are consistent with previous MWC findings that these orders are often being used without revocation strategies (MWC 2011, MWC 2015). Despite periodic reviews, it appears that some community-based CTOs are effectively being used indefinitely.

The person and their family should be involved in review. Due in part to workforce pressures, there may also be a need for a wider range of professionals to be involved in review. We are aware that more reviews could involve more work for professionals and more stress for people who are subject to orders and for their family members, so we are not recommending a simple increase in the number of automatic Tribunal hearings on CCTOs extension.

At the moment, the data seem to show that the duty to review orders on an ongoing basis is not being met. The MWC recommended that this Review consider whether duties to review detention and compulsion are being met and consider whether durations of CTOs and review points or mechanisms require revision.

Current evidence suggests that RMOs are not ensuring that there is ongoing review of orders made under the 2003 Act. However, we do not know what the reasons are for the MWC's findings, and we do not yet know what the positive and negative implications would be of changing the maximum duration of orders, or of including additional mandatory, formal reviews.

Other countries do take different approaches. For example, we note that in New Zealand, people found to meet the threshold of the Mental Health Act are subject to a period of assessment of up to 5 days, which can be extended by a further 14 days if needed, at the end of which time the responsible treating consultant may apply to court for a 6-month treatment order (Soosay and Kidd, 2016). We also note the intended reforms to reform the Mental Health Act in England and Wales (Laing and Garratt, 2022, page 34), where people can currently be admitted to hospital without their consent for a short-term assessment for up to 28 days. Proposals for reform include a duty on the Responsible Clinician to formulate a detailed care and treatment plan (CTP) for each person within seven days of being detained, which is subject to approval by a Medical / Clinical Director within 14 days of detention. There is also an intention to shorten the initial detention period to three months and renewal to three months, then six months thereafter. In contrast to Scotland, Tribunals do not take place at the end of the initial 28 day period.

These are our final recommendations: time limits on compulsory measures

Recommendation 9.24: In relation to approval for orders:

- **Professionals should ensure that people who are on orders, or who may be put on orders, are aware of Human Rights Enablement (HRE). Professionals should provide access to support to request or challenge HRE.**

- **Responsible Medical Officers (RMOs) and Tribunals should ensure that CTO care plans include a revocation strategy that outlines what needs to happen for that person to come off the CTO and what benefits the person is deriving from staying on it, expressed in terms of the Human Rights Enablement approach .**

Recommendation 9.25: In relation to review points for orders:

- **In advance of legislation, the Scottish Government should commission the Mental Welfare Commission to work with a health board or boards, to test the practical effects of short time-limits for reviewing orders, or other processes for internal review during the life of an order.**

Recommendation 9.26: On post-legislative scrutiny:

- **The Scottish Government should propose law reform which includes provisions that enable future innovations to be developed through research and implemented across law, policy and practice, before major reforms to law.**

In relation to the recommendations above:

- These recommendations will require a context of frequent reviews of orders including reviews of access to support, care and treatment.
- Recommendations in other chapters make clear that all decisions and actions should aim to give effect to the person's will and preferences (Chapters 4 and 8). A person's perspectives and feelings about an order or possible order are also a relevant consideration
- Research on review points for orders would: report on lived experience and professional experience of RMOs' reviews of orders; identify reasons for current practice in reviewing orders; and report on benefits and disadvantages of more frequent reviews. This work would involve RMOs formally reviewing orders at proposed additional review points of 14 days for STDCs and 3 months for a first CTO. This research should be commissioned now and should conclude in time for law reform, to inform time limits in law for the review and duration of these orders.
- Reviews of orders by RMOs - as for all assessments and decisions - should reflect the person's will and preferences and follow the Human Rights Enablement. In some cases, these reviews should trigger a need for Tribunal review, including where Human Rights Enablement does not show that continuation of the order was justified, and where the person or their supporters provided evidence which challenged professionals' conclusions on Human Rights Enablement.
- Post-legislative scrutiny is needed so that adjustments can be made when unintended consequences and possible improvements are identified, and the need for this applies more broadly than coercion. Once procedures are enshrined in primary legislation, it can be difficult to adjust them, even if it is established that they are not having the desired effect. There would be value in authorising temporary changes in particular localities or for particular groups to test out legal reforms before full adoption.

9.3.5: Community-based compulsory treatment

This is where we started

In 2001, the Millan Review recommended community-based Compulsory Treatment Orders (CCTOs) for Scotland's mental health law (Millan et al, 2001, chapter 6). The main intention was to create a new and less restrictive alternative to compulsory hospitalisation. Millan did not think that the only way to give effect to compulsory measures should be by detaining someone in hospital, and this recommendation reflected a commitment to the principle of 'least restrictive alternative'.

CCTOs contain greater safeguards than the previous model, which was leave of absence at the discretion of the person's psychiatrist. CCTOs may be too narrow in approach, in that they do not address the wider needs of the person such as social inclusion. This Review recommends a range of approaches to address people's wider needs, and those recommendations apply to people who are subject to community-based orders.

The level of use of CCTOs in Scotland is much higher than was expected around the time that the law was reformed. The use of these orders continues to rise (MWC, 2022). Millan reported three concerns which were expressed during consultation, but concluded that CCTOs were justified in principle and had potential for practical benefit. The concerns were:

- A concern about imposing treatment in community settings, and particularly in a person's own home.

- CCTOs might become an additional control imposed on people who would otherwise have been dealt with on an informal basis.

- Once on such an order, it might be hard for a patient ever to be discharged. The patient would be maintained on medication and could not prove that he or she was able to take responsibility for his or her care.

On the first concern, as Millan intended, treatment is not forcibly administered in someone's own home. However, CCTOs have led to large-scale imposition of treatment in community settings in Scotland, on people who are living at home and are living with the possibility of involuntary hospitalisation.

Our March 2022 consultation reported evidence that the second and third concerns may have been realised. It appears that CCTOs are being used as an additional control in situations that would otherwise be dealt with in the community, not as an alternative to detention in hospital: the very substantial increase in CCTOs has not been associated with a decrease in hospital-based CTOs (MWC 2020 B, paragraphs 92 and 94), and the use of hospital-based CTOs has increased over time (MWC, 2022). Also, the MWC has found relatively little planning for discharge from CCTOs (MWC 2011, MWC 2015).

For this Review, the MWC analysed its data-set on Compulsory Treatment Orders and found that (MWC, 2022):

- The rise in CCTOs over time was driven by more individuals from the previous year staying on an order. New individuals were also placed on new orders, but the rise was driven by existing orders.

- Among those who had a direct transfer to a CCTO, about one in three had no previous episodes of detention under the Mental Health Act.

The MWC wrote that long durations of compulsion are an important issue, 'especially for community-based CTOs where the numbers are rising year-on-year.'

Scotland is not alone with these concerns about the length and numbers of community-based CTOs. The White Paper on reforming the Mental Health Act in England and Wales sets out the UK Government's commitment to reducing the number of Community Treatment Orders (UK Government, 2021, page 56). It introduces more stringent measures before these orders can apply, a time-limit, and a requirement that they produce a genuine benefit to the individual. Those proposals were generally reflected in the Bill as introduced to the UK Parliament.

This is what people told us

Driving compulsion into the community

In a submission to the Review, the MWC asked (MWC 2020 B):

> ‘What is driving the increased rate of community-based CTOs? And was this the intention of the Act to drive compulsion into the community. Across the world there has been considerable ethical debate about these sort of powers and yet there seems remarkably little debate currently about whether these powers should continue in their current form…What this continual increase of people subject to restrictions in the community means for the operation of the Act could be profound with impacts on a range of human rights.’

In discussion with the Review, the MWC indicated a need to think about compulsory treatment orders as a whole: compulsion is shifting to the community, and people are staying on CCTOs long-term in the community with little evidence that they will come off of these orders, sometimes for very many years. MWC found that around 30% of new CCTOs did not follow a previous episode of compulsion (MWC, 2022). This does not happen in England, and this is not as Millan expected. Millan’s final report stated (Millan et al, 2001, page 71):

> ‘…we think it unlikely that a person would be considered suitable for such an order unless that person had a prior history which involved admission to hospital.’

These findings raise questions such as: how much time should elapse before there is additional scrutiny of a CCTO; how do we ensure that resources flow into the community for people on CCTOs; and what is the experience of people on CCTOs.

We address additional scrutiny of orders above. On ensuring that resources flow into the community, our recommendations on principles and on economic, social and cultural rights in Chapter 6, should serve to ensure this, along with recommendations in Chapter 8 on Human Rights Enablement.

We expect the MWC to continue to provide leadership in this area. We understand that the MWC will be undertaking a themed visit to people subject to CCTOs in 2022 to learn from their experiences and from the staff supporting them. We note the Care Inspectorate's intention to focus on the theme of mental health in a joint inspection process with Healthcare Improvement Scotland in 2023, below. People who take part in collective advocacy might choose to address issues with CCTOs.

On an ongoing basis, the shift towards giving effect to people's will and preferences, and much-enhanced support for decision-making, should ensure that the experiences of people on CCTOs have much more effect on decisions and outcomes for those individuals.

Consultation responses

In the main consultation, several respondents commented on CCTOs. The Royal College of Psychiatrists made a case for retaining CCTOs:

> 'Community CTOs can be a preventative measure. They can enable a reflection of the balancing of rights, with the infringement of rights inherent in the order balanced against the likelihood of a greater infringement of rights, such as hospital admission or harm to the patient themselves or others if no order are in place. Well-resourced services will have some impact on reducing the need for community CTOs but will not reduce it entirely.'

Glasgow City Council saw CCTOs as being useful for engaging with the most marginalised people:

> 'We find the community-based order can reach the people often on the fringes of society in the first place and support to improve their circumstances/health had there been no "coercion" to treat them at all. We agree that a human rights approach with broad reaching informal community-based resources would be the ideal scenario in treating/supporting mental ill health for individuals, however this currently is very far removed from the reality in terms of resourcing and the endemic social problems faced by many of the communities we serve in our city. The community CTO, although not ideal in

> some ways, offers an in road for intervention and treatment that is unlikely to exist for many otherwise.'

However, some expressed concern that CCTOs are used as means of ensuring access to benefits or services. An individual wrote:

> 'There is a perverse advantage for patients to remain on CCTOs – in Edinburgh it ensures they continue to have a social worker and do not make a financial contribution to their care package. I have patients who ask for their detention to be continued because of these benefits.'

The MWC wrote that (MWC 2020 B):

> 'Within the Commission, we have been informed from practitioners and service users in Scotland that there is a perception and a practice for people to remain subject to community CTOs to ensure that they receive input from wider Community Mental Health Teams or financial or other benefits.'

CCTOs may also be used to ensure control or compliance in the context of limited services. As an individual wrote:

> 'Access to timely care in an inpatient setting can be beneficial for safety and stabilisation. However, assess to this can be limited to delayed discharges and lack of community infrastructure, this is meaning more community levels of care more risk managed in community settings which may require a legal framework. At times I believe the MHA is used, when other legislation would have been more appropriate and of less duration but local authorities are more reluctant to use these areas and do focus on the MHA to put in some measure of control or treatment compliance.'

Some advocated a change of focus for CCTOs. Social Work Scotland and the Scottish Association of Social Work agreed that there should be a re-emphasis towards recovery orientated, community-based services. Also:

> ‘Awareness of the views of people with lived experience regarding community-based Compulsory Treatment Orders is also paramount and we hope that a trauma informed lens will be used in this process.’

COSLA also called for work to understand people’s experiences of orders:

> ‘Ongoing engagement is required with those who have been subject to Compulsory Treatment Orders (CTO) to understand their experience and whether coercion was used to establish the order. This should also seek to understand what factors led up to the CTO being put in place the utility of the order and whether or not it resulted in improved outcomes for the individual.’

This may be exceptionally difficult to do with people on CCTOs, who may be particularly disengaged from services, but we agree that this is important work.

The Care Inspectorate wrote that:

> ‘We would welcome a focus on recovery and trauma informed models of community-based care. There may be a need for short-term and long-term studies to examine the range of factors that impact on the incidence of Compulsory Treatment Orders. An area of focus could be the availability of suitable community-based resources to support people in crisis and post-discharge from hospital.’

The Care Inspectorate also made proposals for understanding rising rates of detention and compulsion:

> ‘…joint strategic inspections of adult services, undertaken by the Care Inspectorate and Healthcare Improvement Scotland could assist in understanding the changes in detention and community-based compulsory treatment orders. The Public Bodies (Joint Working) (Scotland) Act 2014 sets the legislative framework for such inspections. Integrated health and social care services are important to ensure that people have quick access to the range of services and support they need, that this care is seamless to them and that they experience good outcomes. This is particularly vital for the

> increasing numbers of people with multiple, complex, long-term conditions in Scotland. Our next programme of adult integrated inspections will be resuming in June 2022, and it is anticipated that from late 2023, the theme will be mental health.’

A local authority also called for work to understand the effects of CCTOs:

> ‘CCTOs are less restrictive than repeated compulsory admissions to hospital. It would be interesting if the review could explore in areas where detention rates have increased if that is related to services being reduced? Likewise in areas where sufficient social supports and adequate housing is provided are detention rates lower?’

This is what we found

Evidence on the effectiveness of community-based compulsory treatment

This section addresses the question of whether Scots law should continue to provide for community-based compulsory treatment (CCT). Here, we set out how we think Scots law could take a coherent, human-rights based approach to CCT.

We considered evidence on:

- Whether CCT has ensured respect, protection and fulfilment of human rights, and to what extent their use has failed to do so
- How CCT could contribute to, or detract from, the proposed new purpose of law
- Whether CCT has protected the public and would protect the public in future

A full understanding of clinical and legal effects of CCT would require both quantitative and qualitative information. It is not currently possible to answer the questions above in full. However, based on currently-available evidence, we do answer the main question of whether CCT should continue in Scotland.

There is debate in the research literature on some fundamental issues about evidence in this field: debate about how we can have knowledge of whether CCT works, and about what we can possibly know about in relation CCT (Duncan et al, 2020). There has also been a division between findings from research based on randomised controlled trials (RCTs) - which have generally shown little or no benefit - and findings from a variety of non-experimental designs which have shown both positive outcomes (e.g. increased follow-up with mental health services and improved forensic outcomes) and negative outcomes (e.g. no reduction in hospitalisation; Duncan et al, 2020).

Our understanding of the state of the evidence on CCT came from a review of literature for this Review, and from discussions with experts including Professor Tom Burns, who ran Oxford University's OCTET study of CCT effectiveness. That study was one of only three Randomised Controlled Trials (RCTs) on CCT which have been carried out worldwide (Burns and Molodynski, 2014). We also spoke with Professor Scott Weich, whose research informed the Wessely Review of England's mental health law (Rains et al, 2020). Weich advocates a shift away from a biomedical approach which prioritises RCT evidence above all other evidence, towards an approach which values RCTs but also has high value for other quantitative research in conjunction with targeted qualitative research.

This Review has taken a human rights-based approach, but it appears that no evidence on CCT has previously been directly collected, analysed or reported in relation to human rights. The Review therefore used the Review's human rights framework to collate findings of systematic reviews and meta-analyses on CCT, from a range of studies in a range of nations.

In summary, there has not been enough research to make it possible to conclude that CCT has 'worked' in Scotland or elsewhere. We have found that there is not strong international evidence of the value of community-based compulsory treatment. The English evidence from the OCTET study which suggests that it makes no difference to outcomes is important. International research has also been unable to demonstrate clear effectiveness of CCT in its intended aims. Where CCT appears to be associated with an advantage, such as lower rates of mortality, it is not clear whether or how CCT causes the advantage. There is very limited Scottish evidence, although some positive evidence exists and is discussed below. Some other evidence is also more positive and suggests that CCT is of value for some people. In our view, the task should be to find out in what circumstances CCT works best, rather than whether it ‘works’ as a whole.

As discussed above, in relation to Millan’s reported concerns about CCTOs: the use of CCTOs has led to large-scale and increasing imposition of treatment in community settings in Scotland; CCTOs may be being used as an additional control in at least some situations that would otherwise be dealt with in the community, not as a simple alternative to detention in hospital; and it does appear to be difficult for a individual to be discharged once they are on a CCTO. In Scotland, CCTOs were regarded by some service users as a positive innovation when they were introduced, but the limits imposed on autonomy, choice and control were universally unpopular (Ridley and Hunter, 2013). We do not appear to have evidence that this experience has improved in Scotland.

This Review is, however, recommending that compulsory community-based treatment should continue to be allowed in Scottish mental health law, for a range of reasons. Internationally, there is a consistent but unexplained finding of reduced mortality for people who are subject to CCT (Kisely et al, 2013 A & B; Kisely et al, 2014; Segal & Burgess, 2006). This finding does indicate that there is something about the use of CCT which can tend to protect life. In Scotland, research with MWC data found that after beginning a CCTO, the average of number ‘hospital bed days’ per patient fell very substantially for most age ranges (Taylor et al, 2016). This work was unusual and important in that it analysed large-scale data which had been routinely recorded since the introduction of CCTOs. The researchers did not simply explain the reduction in hospital use as a result of the compulsory treatment mandated by CCTO, as the CCTO might bind the individual into a more assertive or effective form of holistic community service. However, this is an indication of a strong and beneficial effect of CCT in some circumstances.

So far, most stakeholders have not asked for CCT to be removed from mental health law, which would be a major change. In this Review, some carers were alarmed at the thought of CCTOs being removed from law and wondered what would replace them. The Review is recommending that mental health law and capacity law should be brought closer together (Chapter 3), and involuntary treatment in the community very often happens under incapacity law in Scotland. Instead of bringing mental health and incapacity law closer together, removing CCT treatment from mental health law would create a major difference between those areas of law.

As discussed across this chapter, we are making a wide range of recommendations which should lead to improvements in the use of CCT. We are not suggesting that the future development of CCT should be left to chance: the use of these orders should be closely and continuously interrogated, both for individuals and at a national level.

One recommendation which should increase the effectiveness of CCTOs is the new approach of Human Rights Enablement (HRE). This approach will require professionals to consider all of a person's relevant human rights including economic, social and cultural rights. In ongoing practice and at Tribunal, we expect that the HRE approach will be used to determine whether each CCTO should continue, with input from a range of relevant people.

As recommended above, stronger safeguards are needed to ensure that people actually benefit from CCTOs and do not stay on those orders for too long. There is a need for revocation strategies to be in place for CCTOs from the beginning, and professionals should clearly demonstrate whether and why a CCTO is still needed. It should be possible to be clear about the purpose of a CCTO, what it is supposed to be achieving, whether support is actually being provided, whether restrictions on people's rights are being minimised in practice, and whether people are actually able to enjoy their rights in reality.

The MWC's work on Compulsory Treatment Orders for this Review (MWC, 2022) looked at both hospital-based and community-based CTOs, and found that CTOs tend to end at the latest permitted time - at the end of the maximum duration of the order. The MWC's finding indicates that many psychiatrists may not be reviewing CTOs as required: these orders should be continuously reviewed and should be lifted as soon as possible. In 2015, the MWC visited people who had been on CCTOs for more than 2 years (MWC 2015). Half of the people whom they visited had issues with the order, related either to medication or the requirement to accept care and support. In addition to more reviews, we see a role for the MWC to monitor practice of individuals and of institutions. Changes in culture, changes in professional development and MWC scrutiny all have potential to shift practice.

This is what people told us

Combined perspective: lived and professional experience

We discussed our thinking on community-based compulsory treatment with a small group of people who have combined personal and professional expertise of mental health services. These discussions developed our understanding and thinking as follows:

- Group members gave support for retaining CCTOs in Scots law, but with a wide variety of feeling on this, including some very strong reluctance.
- CCT seems to be, too often, a ‘go to’ as an easier way to deal with people.
- Whilst we stand by our recommendations, we acknowledge that the changes which we recommend may seem impossible to many, given the current state of services. We think that these challenges demonstrate the need to plan for progressive realisation and to commit increasing resources to services.
- We have not concluded that CCT works in general, nor that it works for certain groups of people. We have concluded that there may well be significant benefit overall for some individuals, and that CCT should therefore be retained. However, there is much work to do. This work should include substantial and innovative research to understand which people CCT tends to work for, and in which types of circumstances CCT works best, not whether it works ‘as a whole’. Also, much more scrutiny is needed of orders for individuals, as described above.

- Individuals who are on CCTOs longer term should all be reminded of Human Rights Enablement and supported to request or challenge that process, in a context of frequent reviews of their order and of their access to support.

- Substantial shifts in practice are needed. For some people who are ‘stuck’ on CCTOs we see a need for scrutiny of Community Mental Health Teams, to see how teams have reviewed the person’s case and to test the revocation strategy, all in the context of Human Rights Enablement. People on CCTOs could be routinely considered at team meetings to identify individuals who could come off of CCTOs in the near future, or if more resources were invested into that person. For example, a person may be continuing on compulsory medication for years, in part because they have not been given access to psychological services.

- Another shift in practice, at least in some areas, should be that discharge from a CCTO would not imply that services no longer see the person: for some people, this should mean that services are seeing the person more.

- As discussed in chapter 11, in future the Tribunal would be expected not only to make orders to ‘keep people safe’, but also to ensure respect, protection and fulfilment of those individuals’ human rights. In that context, the Tribunal would be looking at what the person needs to life live well under a CCTO, such as support to be less isolated and to get out of house. In approving the continuation of a CCTO, the Tribunal could require support be provided.

These are our final recommendations: community-based compulsory treatment

Recommendation 9.27: Community-based compulsory treatment should continue to be allowed in Scottish mental health law and capacity law. However, research, monitoring, inspection and individual scrutiny of CCTOs should be enhanced and should all be based on the international human rights framework as it applies to Scotland.

Recommendation 9.28: The Scottish Government should define a new purpose for community-based compulsory treatment: CCTOs should ensure access to recovery-focussed, trauma-informed, community-based services.

Recommendation 9.29: The Mental Welfare Commission should lead on embedding the new purpose of CCTOs in practice, through work with other organisations and through continuing scrutiny of the operation of CCTOs.

Recommendation 9.30: The Scottish Government should commission substantial and innovative research:

- **To explain why the use of CCT has continued to increase in Scotland**
- **To understand the circumstances which make CCT effective or ineffective**
- **To show which groups of people CCT tends to work for**
- **To understand the experiences of those who receive regular voluntary treatment in the community and who are not on a CCTO**
- **To explain why so many individuals are now being placed directly onto CCTOs with no previous order**

The findings of this research should be used to determine whether further law reform is needed in this area.

9.3.6: Suspension of detention and other transitions

We heard from Moray Council that

> ‘Suspension of CTOs is sometimes used to place people from hospital to a care home and then revoked rather than it being converted to a community CTO leaving people without a legal framework but with a guardianship in progress.’

We agree that the law should be clarified in this respect. Our recommendations on alignment of mental health and incapacity legislation should address this, including the recommendation for a single Tribunal to make orders under both mental health and capacity law.

We understand that it is quite common for hospital-based CTOs to be suspended for a period to allow what is sometimes called 'testing out'. This allows the person to live in the community including overnight stays, to enable all involved to monitor how the person copes. In these circumstances, the CTO is not revoked as there could be sudden deterioration in person’s mental health. The person’s hospital bed remains available in case they need to return to hospital. A CTO can only be suspended for a total of 200 days in a 12 month period. This is to prevent the person from subject to a hospital–based order after being in community for many months.

Patients should be being made aware of the existence of the CTO and what suspension means. There is a duty on the Responsible Medical Officer to inform the patient, named person and Mental Health Officer (MHO) of the proposal to suspend. The RMO must also inform the MWC within 14 days of suspension. However, we understand that families and other unpaid carers are not always given this information.

We are not proposing a new duty to inform families and carers (beyond the named person) about suspension of detention, as there are issues around an individual consenting to family involvement. Instead, our view is that it should become standard practice, with consent, to inform and involve in discussions all relevant family members and unpaid carers in the process of suspension of detention. The Carers (Scotland) Act 2016 currently places a duty on health boards to involve carers in discharge planning (section 28). Suspension of detention is not a discharge, but it is clearly a type of transition which public authorities need to involve family and carers in effectively for that transition to work. A successful transition to the community could lead to a final discharge and possibly the revocation of all orders.

Recommendation 9.31: The Scottish Government should revise statutory guidance to give direction to practitioners on how to involve family members and other unpaid carers in suspension of detention and other transitions. This is needed to ensure that transitions are effective and are respectful of all relevant human rights, such as the right to privacy including data protection.

9.3.7: Emergencies: reducing the impact of crises

Some responses to the March 2022 consultation addressed crisis planning and the process of detention.

Crisis planning

We discussed the concept of recovery from mental illness and the relationship between risk, safety and recovery in section 9.2.3.2 above. We see an increased focus on recovery as being important in work towards reduction of coercion. We also see the challenges inherent in promoting a recovery approach in a context where there is very often a requirement to act to minimise risks of harm. In their work on risk, safety and recovery, Boardman and Roberts (2014) concluded that:

> ‘…There needs to be a recognition that procedures for risk assessment and management have historically been centred on the responsibility of professionals to intervene in situations of high level risks for people with

> impaired capacity and failing lives. This is only applicable to a minority of people with mental health problems, some of the time. It has created an imbalance in terms of policies and procedures that now needs to be corrected…
>
> …Standardised techniques and tools for risk assessment may still be useful, particularly for those who present the greatest risks, but the majority of the information gathered by such instruments is most valuable when deployed in the context of recovery-supportive relationships and co-produced safety plans…
>
> ...It needs to be understood that over-defensive, risk-avoidant practice is bad practice and is associated with avoidable harms to both the people who use services and to practitioners…
>
> …we think that the effectiveness of person-centred safety planning should be a key research and development area for the future. We need to build our understanding of the strengths and weaknesses of these approaches and create a relevant evidence base.'

Boardman and Roberts recommend a shift to 'person-centred safety planning':

> 'This approach…can be applied to the full range of risks, dramatic and everyday risks, and used across a range of settings and age ranges. The focus is on conversations between mental health practitioners and service users to support positive risk taking, but it does not preclude the use of structured assessments and standardised risk assessment tools…
>
> A central element in the person's safety plan is likely to be an agreement between the individual and the clinical team about what will happen if the person experiences a crisis in the future. This uses the individual's – and the team's – experience of what has helped the person at times when they are unable to look after themselves to keep them safe, in a preferred way, in the future. Additionally, it can help them begin to exercise control and take responsibility when they are well and extend this to other situations. 'Joint

> Crisis Plans' formulated in this way have been shown to reduce compulsory admissions…'

We met with Sir Graham Thornicroft during the Review, a psychiatrist whose work on Joint Crisis Planning has produced one of the more promising approaches to reduction of coercion in mental health services (e.g. Henderson et al, 2015). From our consultation responses, it appears that there is a keen interest in the recovery approach in Scotland, both amongst people with lived experience and in social work. We suggest that with research and with investment in services, there is potential for Scotland to bring about reductions in coercion though approaches to recovery and through work on person-centred safety planning or joint crisis planning.

More generally, we expect that individuals' support, care and treatment should be worked out and planned with the person and by listening to the person. We would not recommend, for example, that a joint crisis plan be created as an add-on or an alternative to advance statement. We feel that such planning should be an integrated part of planning with the person.

The process of detention

The Royal College of General Practitioners (RCGP) was concerned about:

> '…the challenge of GPs being asked to undertake emergency detentions of patients in the community, especially when they are already known to mental health services. There is a huge amount of variation in how this scenario is managed across Scotland. Some GPs have no sector psychiatrist and no access to intensive home treatment teams (IHTTs).

> When GPs are expected to undertake this work, this means that clinicians who are less familiar with the paperwork and processes are put in a position where they are having to arrange a joint visit with a Mental Health Officer (and often police and ambulance too) to assess an individual who may be unpredictable, extremely distressed and potentially dangerous. Sometimes police or ambulance services are reluctant to be involved, especially where the guidance for that is not clear, leaving the GP in an even more difficult position.

> This often takes several hours, with no mechanism for managing the ongoing workload that is building up within the GP surgery. Rural areas have further issues with transportation and time delays. Out of Hours (OOH) is of particular concern – workforce shortages can see one OOH GP covering a whole local population, who can be then removed from service for a substantial time by one acutely mentally ill patient.
>
> We suggest [it] is more appropriate that a standardised approach is taken for this complex and sensitive work. GPs all need access to Psychiatry teams – IHTT colleagues can make assessments at home that can reduce coercive care. This should be an emergency, responsive, and nationally-defined service that is fit for purpose. Reforms must be data driven – considering where there is best practice and correcting the uneven spread to design a system that is least restrictive, but crucially it needs to be safe for patients and staff.’

RCGP also provided a case study example of what can go wrong with detention processes in the community. They indicated a need for multiagency training on the process of detaining a person and for good practice guidelines to ensure safety.

We agree that MHOs should attend for assessment. This would require the workforce capacity issue for MHOs in Scotland to be addressed. We understand that it is rare for a GP to be involved in a detention process, and that the GP may or may not know the person. Where they do know the person, the GP’s background knowledge may be very important. We agree that a national approach is required.

We understand that the issues with assessment for detention in the community affect the person, family members, and a wide range of professionals including police, ambulance staff, Community Mental Health Teams and GPs. We also understand that bed availability and availability of community resources are relevant factors. These issues must be addressed to protect patients, families and individual practitioners from the trauma which can arise when the right resources are not provided for people in crisis.

We are aware of the experiences that families can have in such situations. Relatives can be expected to deal with crisis, with danger and with transporting people in extreme distress, and they tend to bear the brunt in such situations. Families, friends and other unpaid carers at the forefront of crisis situations can be damaged by these experiences. We are aware that families often ask for help in crises, and quite often do not received support for the person whom they care for. Unpaid carers may be exhausted themselves and have other caring responsibilities. Our recommendations on unpaid carers are in Chapter 7.

Through the Review, we have also become aware of a common realisation that Scotland generally does not provide the right kind of services for many people in crisis. Whilst some people with diagnosed mental or intellectual disability will clearly require access to medical inpatient services, not everyone can be or should be in hospital at a time of peak mental and emotional distress. We have head from GPs, police, psychiatrists, social workers and people with lived experience that a new form of service is needed. Children, young people and adults need access to non-medical crisis services for acute mental and emotional distress, including at times of self-harm and of risk of suicide.

Place of safety

This is where we started

Under section 297 of the Mental Health Act, the police have powers to remove a person in a public place to a place of safety if they reasonably believe that the person has a mental disorder and is in immediate need of care and treatment, and removal would be in their interests or necessary for the protection of other people. The person can be detained in a ‘place of safety’ for up to 24 hours to allow a doctor to examine them and make any arrangements for their care and treatment. A place of safety can be a hospital, registered care home or other suitable place. It should not be a police station.

There has been concern that this system does not always work well, and the Mental Welfare Commission has, in recent years, published several reports on it. Their

Place of Safety monitoring report (MWC, 2018) highlighted that the great majority of people taken to a place of safety did not go on to be subject to further Mental Health Act detention, and that large amounts of police time were used up in dealing with these cases, partly attributable to a lack of local co-ordination. They also found significant local variation in the use of this power.

The Commission recommended that ‘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.’

On 18 May 2022 the Scottish Parliament’s Criminal Justice Committee hosted a roundtable on policing and mental health. They received a number of written submissions including one which said:

‘Mental health related incidents routinely take up to 8 hours and involve taking persons to the nearest NHS facility, with a recent evaluation of the cost to Policing estimated at £14.6 million per annum and each visit to A&E estimated to cost the NHS £5000. It is evident that Police Scotland is not the best service to deal with mental health demand, with a policing response often exacerbating the situation for those already in distress.’

It was also highlighted that section 297 could only be used where the person was in a public place. They said:

> ‘A significant number of interactions take place within a dwelling meaning that officers are frequently having to consider an arrest for a criminal offence to seek any immediate support for the person in crisis. In an ideal situation, a Mental Health Officer or GP would be available, but the police are routinely at the scene first. An extension to the power to include a dwelling combined with appropriate safeguards such as attendance of a medical practitioner within a reasonable time or the presence of a suitable person to support them could be considered to address this.’

We also received a response from an emergency service which raised similar concerns and suggested that:

> ‘A system-wide change could include an emergency pathway for mental health support that does not escalate the emergency to police level involvement. Police should only be dealing with incidents that amount to potential criminality or where the necessary legal powers (such as s.297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 or common law) can actually be used. This could even mean having doctors/trained staff from mental health practices accompany officers in more ambiguous scenarios where it is uncertain which organisations involvement would be the most suitable.’

We wanted to consider whether changes to section 297 were needed, and what other changes might be necessary to improve the response to people in distress. We met with Dr Inga Heyman of the Scottish Centre for Law Enforcement and Public Health, alongside representatives of Police Scotland, the Scottish Police Authority and the Mental Welfare Commission to explore this. Unfortunately we were not able to discuss these issues with people with lived experience, and this should be a priority for future work.

This is what we heard

The scale of the problem

From the police perspective, this is a very significant issue, taking up a large percentage of police time. Their duties mean they must do what they can to keep people safe, even when health and care services are unable to offer support. They accept that they have a role as first responders in emergency situations, and that the special role and authority of a police constable can be useful, but they are not best placed to deliver a substantive response to people in crisis. As financial pressures bite, this will become more acute.

The resource demands on the police go beyond the time taken to take the person to a place of safety. In many cases they will have to wait for several hours until the person can be assessed. And if, as is often the case, the person is not admitted, they may still assess that the person is still at risk, and that they cannot simply leave the person alone potentially to do themselves harm. That may necessitate further lengthy involvement. This fits with findings of the MWC's Place of Safety monitoring report, which concluded that (MWC, 2018) :

> 'The current system results in the police having to make very difficult and potentially risky decisions about individuals who may be at serious risk of self-harm. The police should not be expected to do this without proper support from health and social care professionals. The levels of distress they were dealing with was significant and there should be a joined-up response from services to this. The care, compassion and professionalism shown by police officers in dealing with very difficult situations was obvious'.

Private places

Our sense was that changing the legislation to allow the police access to distressed people in private places was not the main priority. Powers already exist to do this, subject to the authorisation of a sheriff or JP (sections 292 and 293). Extending section 297 to allow the police to enter a private dwelling to seize someone in advance of any medical evaluation raises significant civil liberties issues. The main practical concerns of the police appeared to be less about the power but the difficulty in accessing medical and social work support in an emergency, and having somewhere suitable to take the person.

'Mental disorder' vs distress

It was suggested that, for the small proportion of people who do have an acute and treatable mental illness, the system can work well in getting them to an appropriate setting for assessment and care. But what the system is really responding to in most cases is acute distress. According to the MWC, over 70% of section 297 cases involve suicidality.

Dr Heyman's evidence to the Justice Committee suggested that the 'medicalisation' of mental unrest and emotional pain has tended to distort the response of services:

> 'Unless several meanings of self-harm and distress are acknowledged, then the likelihood is that conventional and ill-fitting responses will remain.'

That suggests two things – that the focus on ‘mental disorder’ in section 297 may need to be rethought, but particularly that the services available to respond to distress must be substantially reformed.

We set out in this Report our view that the justification for any compulsory powers should be less on a particular diagnosis and more on ensuring that they are justified in human rights terms and on a non-discriminatory basis. We think it is reasonable for the state to intervene for a short period where there is evidence that a person may be unable to protect themselves from severe harm because of acute distress – provided it does so in a way which protects and promotes the person’s human rights overall. The Autonomous decision making test we recommend and describe in Chapter 6 will allow for non-consensual intervention in such situations. However, the Human rights enablement and Supported decision making framework we recommend and describe in Chapters 3 and 6 apply at the same time to ensure, whether or not there is a non-consensual intervention, that any decisions made and measures adopted will respect the person’s human rights, including respect for their autonomy.

We recognise that a huge part of the police’s work is dealing with people who are intoxicated, and it can be difficult to distinguish between someone who is ‘only’ intoxicated and someone who has other underlying issues. The Mental Welfare Commission highlighted some inconsistency in medical practice on when an intoxicated person would be assessed for any mental health needs. How to address intoxication is something which is beyond our remit, but we are clear that the need for a response from health or care services to distress goes beyond ‘mental disorder’ as currently understood.

There was agreement that what was needed was a holistic, multi-agency response to acute distress that focuses on outcomes for the individual, and links the immediate response to follow up support. This is not a new insight, which raises the question of why it hasn’t happened already. It may be because the problem cuts across many agencies, each of which is increasingly concerned to manage its boundaries at times of constrained resource

National vs local solutions

We did hear of examples of good practice, including the development of distress brief interventions, and different models of crisis team, as well as international examples, such as a Canadian ‘safe space’, adjacent to Accident and Emergency with police available but not leading the response. We also heard that existing frameworks such as the Care Programme Approach could be helpful, particularly for people who may experience distress frequently.

There is value in developing local and flexible solutions which reflect how services operate in particular areas, but it needs to be in the context of a clear national approach. The police have a Standard Operating Procedure for responding to mental illness, but it is limited in the guidance it can give when there are 15 different local multi-agency Psychiatric Emergency Plans (MWC, 2020C).

Section 297 is not the only part of the Act which involves the police. We were told that there can be practical difficulties in the operation of other parts of the Act, such as section 303, which deals with returning detained patients who have absconded. The Commission has come across cases where health and care services and the police cannot agree on whose responsibility it is to find, detain and return people in these cases. Again, the problem is less the law than the need for clear and agreed protocols on joint working.

The MWC’s review of Psychiatric Emergency Plans across Scotland’s Health Boards found that that when Police take a patient to a place of safety where they have to wait in public waiting areas with the patient, this leads to perceived criminalization of distress where the public often assume the patient has committed a crime (MWC, 2020C). We did not have the opportunity to gather evidence specifically from individuals on their experiences of being supported by Police during crises, but we did hear a view from people with lived experience that full implementation MWC guidance on Psychiatric Emergency Plans would address these issues to a large extent.

These are our final recommendations: reducing the impact of crises

Recommendation 9.32: Through the mental health strategy, Scottish Government should:

- **ensure adequate resourcing and multiagency training for detention in the community**
- **work with health and care agencies to develop alternative places of safety for people who are in distress and at risk, and whose needs are not met by in-patient psychiatric care**
- **further develop approaches to recovery**
- **develop person-centred safety planning, including joint crisis planning**

Recommendation 9.33: The Mental Welfare Commission should work with stakeholders to develop practice guidance on assessment in the community for detention.

Recommendation 9.34: The Scottish Government should propose legislation which creates duties on public authorities to provide or commission non-medical, age-appropriate and culturally-appropriate crisis support services.

Recommendation 9.35: The Scottish Government should review whether the place of safety powers should extend beyond suspected mental or intellectual disability to other people who may be at serious risk.

Recommendation 9.36: Health Boards should submit updated Psychiatric Emergency Plans every 2 years to the Mental Welfare Commission to be reviewed against the Commission’s guidance.

In relation to these recommendations:

- Individuals' support, care and treatment should be worked out and planned with the person, including listening to the person, and taking account of the views of their unpaid carer(s), so far as it is reasonable and practicable to do so. Joint crisis planning should be an integrated part of this planning with the person, where they choose to participate in this. Connections with Supported Decision Making (SDM) should be considered in the developing joint crisis planning and in developing SDM in Scotland.

- The availability of and absence of non-medical crisis support services should be monitored for individuals and at local levels by the Mental Welfare Commission, with an expectation that Scottish Government will act to ensure consistent availability of provision for persons in acute mental distress across Scotland. Therapeutic and social support for crises should become readily-available at all times.

- Under our proposed redefinition of the scope of mental health and capacity law, the requirement that a person be suspected of having a 'mental disorder' to come within the legislation would be replaced by the person being suspected of having a 'mental or intellectual disability' whether short or long term (chapter 2). It may be that the scope of emergency provisions should be even wider than this to encompass others in acute distress. However, the biggest priority is to ensure that there is better and wider support for people in distress including, but not limited, to safe spaces other than Accident and Emergency or acute in-patient wards.

Chapter 9 recommendations

Reducing coercion, including reducing the use of involuntary treatment

Law reform to drive reduction of coercion

Recommendation 9.1: We recommend that the Scottish Government should make reduction of coercion a national priority over a period of years.

Recommendation 9.2: The Scottish Government should ensure effective recording, monitoring and action to reduce coercion across settings. This should include:

- **Mainstream alternatives to coercion with a view to legal reform**
- **Develop a well-stocked basket of non-coercive alternatives in practice**
- **Develop a road-map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders**
- **Establish an exchange of good practice between and within countries**
- **Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals**

Recommendation 9.3: The Scottish Government should set standards for trauma-informed mental and intellectual disability services, including access to psychology or other services which provide support for trauma that results from coercion.

Sense of belonging, connection and trust in society

Recommendation 9.4: The Scottish Government should ensure that:

- **Communities are enabled to develop their own forms of peer and community support**

- **Community wellbeing hubs are established to serve every community, both for people with a mental illness and to support the wellbeing of the general population**

- **A range of open, flexible and accessible crisis and crisis-prevention services is established**

- **Community mental health teams are fully integrated within communities**

- **Community and in-patient mental health services, and strategies for these, are developed through co-production by people with lived experience including unpaid carers**

Support, services, and approaches which reduce the use of coercion

Recommendation 9.5: The Scottish Government should lead a systematic improvement programme with the full and equal participation of people with

lived experience, including unpaid carers, and services and regulatory bodies. This should include:

- **Support, services and approaches which have been successful in reducing coercion in other countries are piloted, developed and then implemented across Scotland**
- **Ward-level interventions which reduce coercion including restraint, such as Safewards, are implemented**
- **Academic research which is led by people with lived experience is commissioned on approaches to reducing coercion**

Recommendation 9.6: The Scottish Government should ensure that all new buildings and services should be universally designed. Design and redesign processes should aim for the highest quality, as defined with the full and equal participation of people with lived experience including unpaid carers.

Recommendation 9.7: In practice, the general approach to mental health care and treatment should reflect the recovery approach as expressed by the WHO and also as developed by the lived experience movement.

Stronger safeguards when compulsion is authorised

Recommendation 9.8: The Scottish Government should undertake a detailed review of the safeguards for treatment contained in Part 16 of the Mental Health Act.

During this review, the following changes should be considered

- **Requiring authorisation by a DMP of any restraint, seclusion or covert medication, except in an emergency**
- **Broadening the category of who may act as a DMP, including the possibility of a suitably qualified psychologist reviewing restraint or seclusion**
- **Establishing safeguards derived from the Mental Health Units (Use of Force) Act 2018 for the Scottish context (see recommendation 9.10 below)**
- **Stronger duties on the DMP to consider and seek to give effect to the will and preference of the patient wherever possible**
- **A possible appeal to the Tribunal against the decision of a DMP to authorise treatment for some particularly serious interventions**
- **MWC monitoring and reporting on the use of restraint, seclusion and covert medication, whether authorised by MHA or AWI**
- **It should not be possible to give a specific treatment without the consent of a patient if the patient is able to make an autonomous decision about that treatment.**

Recommendation 9.9: Section 44 of the Mental Health Act (short-term detention) should be amended to separate out authorisation for detention and authorisation for the giving of treatment, with each being separately considered and justified on the short-term detention certificate, and it being possible to be detained without authorisation for non-consensual treatment.

Monitoring and scrutiny

Recommendation 9.10: The Scottish Government should establish a scrutiny system with sufficiently wide scope to consider evidence and data, and to identify underlying causes of coercive treatment. This should include:

- **Measures to address those underlying causes through systemic measures and measures for individual institutions**

- **Stronger requirements for services to record, reflect on and reduce coercive practices, and national monitoring of coercive practices which drives learning and improvement; and**

- **No undue bureaucracy and no perverse consequences**

Recommendation 9.11: The Scottish Government and relevant public authorities should consider other countries' laws and approaches for monitoring and regulating the use of coercive measures when developing a new system.

Recommendation 9.12: The Scottish Government should propose legislation for a national register of restraint to be set up and maintained by a central public authority which is capable of hosting the exchange of data between multiple public authorities, and which is capable of reporting publicly on trends in data from all of those authorities.

Recommendation 9.13: The Scottish Government should commission and resource the Mental Welfare Commission, and propose legislation where necessary:

- **to work with partner agencies and deliver recommendations on which further powers the Mental Welfare Commission requires to ensure that co-ordinated work delivers reductions in coercion across settings**
- **to co-ordinate the development of consistent and effective approaches to the reduction of coercion across health and social care settings which serve people with mental or intellectual disability**
- **to provide system leadership for data monitoring on reduction of coercion**

Rising rates of detention and community-based compulsory treatment

Racism and anti-racism

Recommendation 9.14: Legislation should require monitoring and scrutiny which specifically tracks and addresses ethnicity in rates of detention and compulsory treatment.

Recommendation 9.15: For people from ethnic minority communities, a human rights enablement approach should routinely consider whether:

- **all of the standard safeguards have been applied in full**
- **all assessments have been made on the same basis as for all people, and without any assumptions which could be related to race or ethnicity**

- **any challenge to the validity of assessments has been considered and resolved**
- **the person has been offered at least the same level of support for decision-making as for any other person**
- **the person's cultural, linguistic and, religious or belief requirements have been identified and professionals can show how these needs will be met**
- **if the person or their supporters have indicated that racism or cultural insensitivity may be present in relation to the order or in relation to relevant services, these issues are being addressed**

Criteria for detention and involuntary treatment

Recommendation 9.16: In the medium term, the criteria for detention and involuntary treatment under the Mental Health Act; or for involuntary measures under the AWI Act, should be that:

- **a person has a mental or intellectual disability or for the purposes of an AWI intervention is unable to communicate because of a physical disability, whether short or long term, and**
- **is unable to make an autonomous decision as set out in Chapter 8;**

And for the purposes of a Mental Health Act intervention that:

- **treatment which would alleviate symptoms or prevent the disorder worsening is available, and**
- **without such treatment there would be significant risk to the health, safety or welfare of the patient or to the safety of any other person, and**

- **the order is necessary.**

Recommendation 9.17: In the longer term and in the context of fusing mental health and capacity law, other tests for detention and involuntary treatment under the Mental Health Act and for involuntary measures under the AWI Act should be redefined to fit with the new principles and the Human Rights Enablement framework.

Rising rates of detention and compulsion

In taking forward the following recommendations to address rising rates of detention and compulsory measures, the Scottish Government should be informed by the international human rights framework, including the ECHR and relevant UN treaties. These recommendations should be read with recommendations on accountability.

Recommendation 9.18: The Scottish Government should ensure that the Mental Welfare Commission and the Scottish Human Rights Commission, as independent bodies and in collaboration, are sufficiently empowered and resourced to monitor the extent to which future law meets its purpose of respecting, protecting and fulfilling human rights.

Recommendation 9.19: The Scottish Government should work with the Mental Welfare Commission and the Scottish Human Rights Commission to determine new requirements for data collection on detention and compulsory measures which should be set in law.

Recommendation 9.20: The Scottish Government should invest in establishing or developing a coherent, integrated system to achieve data collection on rates of detention and compulsion, with local authorities, health boards and

other public bodies sharing data, and should ensure public access to significant data and analysis.

Recommendation 9.21: The Scottish Government should commission ongoing monitoring, analysis and research on the effects and effectiveness of detention and compulsion for public protection in Scotland.

Recommendation 9.22: The Scottish Government should commission research to understand rising rates of detention and rates of community-based compulsion, and the large variation in the use of orders across different areas of Scotland. This work and research should be carried out with the full and equal participation of people with lived experience, including unpaid carers.

Recommendation 9.23: The Scottish Government should ensure that data is collected and analysed on the economic, social and cultural barriers that prevent or discourage people for using and benefitting from services, including people from diverse communities and people with protected characteristics.

Time limits on compulsory measures

Recommendation 9.24: In relation to approval for orders:

- **Professionals should ensure that people who are on orders, or who may be put on orders, are aware of Human rights enablement (HRE). Professionals should provide access to support to request or challenge HRE.**

- **Responsible Medical Officers (RMOs) and Tribunals should ensure that CTO care plans include a revocation strategy that outlines what needs to happen for that person to come off the CTO and what benefits the person is deriving**

from staying on it, expressed in terms of the Human rights enablement approach .

Recommendation 9.25: In relation to review points for orders:

- **In advance of legislation, the Scottish Government should commission the Mental Welfare Commission to work with a health board or boards, to test the practical effects of short time-limits for reviewing orders, or other processes for internal review during the life of an order.**

Recommendation 9.26: On post-legislative scrutiny:

The Scottish Government should propose law reform which includes provisions that enable future innovations to be developed through research and implemented across law, policy and practice, before major reforms to law.

Community-based compulsory treatment

Recommendation 9.27: Community-based compulsory treatment should continue to be allowed in Scottish mental health law and incapacity law. However, research, monitoring, inspection and individual scrutiny of CCTOs should be enhanced and should all be based on the international human rights framework as it applies to Scotland.

Recommendation 9.28: The Scottish Government should define a new purpose for community-based compulsory treatment: CCTOs should ensure access to recovery-focussed, trauma-informed, community-based services.

Recommendation 9.29: The Mental Welfare Commission should lead on embedding the new purpose of CCTOs in practice, through work with other organisations and through continuing scrutiny of the operation of CCTOs.

Recommendation 9.30: The Scottish Government should commission substantial and innovative research:

- **To explain why the use of CCT has continued to increase in Scotland**
- **To understand the circumstances which make CCT effective or ineffective**
- **To show which groups of people CCT tends to work for**
- **To understand the experiences of those who receive regular voluntary treatment in the community and who are not on a CCTO**
- **To explain why so many individuals are now being placed directly onto CCTOs with no previous order**

The findings of this research should be used to determine whether further law reform is needed in this area.

Suspension of detention and other transitions

Recommendation 9.31: The Scottish Government should revise statutory guidance to give direction to practitioners on how to involve family members and other unpaid carers in suspension of detention and other transitions. This is to ensure that transitions are effective and are respectful of all relevant human rights, such as the right to privacy including data protection.

Emergencies: reducing the impact of crises

Recommendation 9.32: Through the mental health strategy, Scottish Government should:

- **ensure adequate resourcing and multiagency training for detention in the community**

- **work with health and care agencies to develop alternative places of safety for people who are in distress and at risk, and whose needs are not met by in-patient psychiatric care**

- **further develop approaches to recovery**

- **develop person-centred safety planning, including joint crisis planning**

Recommendation 9.33: The Mental Welfare Commission should work with stakeholders to develop practice guidance on assessment in the community for detention.

Recommendation 9.34: The Scottish Government should propose legislation which creates duties on public authorities to provide or commission non-medical, age-appropriate and culturally-appropriate crisis support services.

Recommendation 9.35: The Scottish Government should review whether the place of safety powers should extend beyond suspected mental or intellectual disability to other people who may be at serious risk.

Recommendation 9.36: Health Boards should submit updated Psychiatric Emergency Plans every 2 years to the Mental Welfare Commission to be reviewed against the Commission’s guidance.

Chapter 10: Forensic Mental Health Law

10.1: Introduction

10.1.1: A separate forensic mental health system – discrimination or reasonable accommodation?

In this Chapter, we consider how our mental health legislation applies to people with mental health disorders who offend. The law in this area is mainly to be found in Part 6 of the Criminal Procedure (Scotland) Act 1995. This is where sections from the Mental Health (Care and Treatment) (Scotland) 2003 Act and several subsequent legislative changes are to be found, although some provisions are to be found in other pieces of legislation. Together these govern the law on "mentally disordered offenders". It is an area of law that applies to only a relatively small number and percentage of those touched by mental health law. Indeed, it only applies to a small percentage of those with an identified mental or intellectual disability who offend. Most go through the normal criminal justice system, although they may in some cases be diverted out of it at the discretion of prosecutors or, if convicted, be treated differently in terms of sentencing but without receiving a specific mental health disposal.

Despite this, it is an area of importance, especially given the significant impact which may follow in terms of deprivation of liberty.

It is generally agreed that the Convention on the Rights of Persons with Disabilites (UNCRPD) demands more anxious consideration of the rights of the individual. What is not yet the subject of general consensus are the Implications of UNCRPD in the detail of the law – does non-discrimination mean that we should have only one system which deals with everyone who offends or is accused of offending? Can we avoid discrimination if we retain a separate system for such individuals?

We set out some proposals for change in this area of law in our consultation paper in June 2022. These were made on the basis of our belief, informed by what we have heard, that it remains appropriate and justifiable at present to keep the option of a different judicial route with different disposals for those who have offended who have a mental or intellectual disability, if the consequences of that disorder have implications for either the person’s culpability or the appropriate disposal. Within the context of a different judicial route, we suggested that implementation of the UNCRPD should therefore aim to make sure that any limitations imposed on people within this separate system result in equal treatment, having regard also to the State’s duty of reasonable accommodation under Article 5 of the UNCRPD which addresses equality and non-discrimination.

However, there are arguments about the justification for retaining a separate judicial route. Some, for example, the Law Society of Scotland, suggest that having a separate system is discriminatory and incompatible with UNCRPD and possibly even current law. They said:

> ‘To an extent, it could be argued that over time Scottish criminal law (or at least the way in which it is characterised) has taken a “wrong turning” away from underlying principles. Even in accordance with existing fundamental principles, there should be no differentiation “solely on grounds of mental disability” or on grounds of “mental disorder”. As regards guilt or innocence, the fundamental question, if the act alleged is proved to have occurred, is whether there was or was not mens rea (criminal intent). If mens rea is absent, that, not the reasons for its absence, is the determinative factor. The reasons may be a mental disorder, or other reasons. The principle is the same.
>
> On the issues of risk to others, including to their safety and risk of serious harm, existing provisions are wrong in principle in that they start with the presence of a mental disorder, rather than the presence of risk. …If people are to be deprived of their liberty, or have their freedoms limited, because they present a risk, there should be a uniform regime for that which is non-discriminatory… As with application of the principle of mens rea, there should be no fundamental discrimination in relation to the application of the principles of mitigation…

> Similar principles of non-discrimination should apply to any link between mental health provisions and criminal disposals. …If measures relating solely to the mental disorder are appropriate, they should be shown to be appropriate by the same criteria as for people who have not reached that point through the criminal justice system.
>
> No new regime following upon the Review should start life in breach of international human rights obligations. It should be based on the above principles.'

Others, for example, the Forensic Network, emphasised that having a separate system avoids the prejudice that can be suffered by the mentally unwell in a mainstream system. They said:

> 'Forensic mental health services exist to provide assessment, care and treatment to those with major mental disorder who come in contact with the criminal justice system; and to protect the public from harm that may arise because of major mental disorder. These systems are designed to be humanitarian and protective, and to divert individuals to the appropriate levels of care. The European Convention on Human Rights requires that the detention of an individual for reasons of mental health needs a formal diagnosis of a mental disorder to be made. We are concerned that any plan to fully adopt the UNCRPD would disadvantage people with major mental disorder who come into contact with the criminal justice system and result in a punitive rather than health based disposal. We also know that outcomes in terms recidivism and public safety for those placed within the criminal justice system are worse than those place within the forensic mental health system.'

We have sought to navigate through some of the challenges and contradictions explored in the evidence we received, on balance preferring at present to retain a distinct forensic system.

Turning to UNCRPD, Article 5 states:

> 5.1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
>
> 5.2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
>
> 5.3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
>
> 5.4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Article 2 defines what the UNCRPD means by both ‘discrimination’ and ‘reasonable accommodation’:

> “Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.
>
> “Reasonable accommodation” means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Of relevance here is Article 13 of the UNCRPD relating to access to justice:

> 13.1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
>
> 13.2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

The State's duties to provide procedural accommodation are not limited in matters of justice in the way that state's duties are limited by the 'reasonableness' of reasonable accommodation. The Committee on the Rights of Persons with Disabilities has placed emphasis on procedural accommodations which can facilitate effective communication. (Flynn, 2018)

Procedural and age-related accommodations may be more generic and less individualised in approach than the obligation in Article 5 of UNCRPD to provide reasonable accommodation to persons with disabilities. However, the obligation to provide accommodations in the context of access to justice 'cannot be mitigated by arguments about reasonableness and the extent of the burden they would place on the duty-bearer' since the providers of such accommodations will inevitably be the state or public officials involved in the administration of justice. (Lawson, 2013)

]Article 14 deals with the right to liberty and security of persons with disabilities on an equal basis with others, stating 'that the existence of a disability shall in no case justify a deprivation of liberty' and that 'if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.'

The UN Committee on the Rights of Persons with Disabilities has issued guidelines on Article 14 of the Convention. These guidelines say that criminal defences based solely on the grounds of mental disability breach Article 14. The Committee states that this is because they deprive the accused of equal rights to due process.

When considering our forensic mental health system, it is also important to consider Article 15 of UNCRPD. This article is about preventing people with disabilities from being subjected to torture or inhuman treatment. It states:

> 15.1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.
>
> 15.2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

This mirrors but extends the terms of Article 3 of the European Convention on Human Rights (ECHR):

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The High Court of Justiciary has considered the implications of Article 3 ECHR as well as the UNCRPD in the sentence appeal, RC v HMA [2019] HCJAC 62. This was not a case involving mental health considerations. A custodial sentence was quashed in the case of a man with spina bifida in recognition of the additional punishment on him of the fact of a sentence of imprisonment. No specific mention was made of reasonable accommodation but the disposal of the appeal represented an adjustment made in recognition of his condition.

The word discrimination raises legitimate and understandable concerns. Sometimes what is described as ‘discrimination’, however, might more appropriately be described as ‘reasonable accommodation’ although it is important that such categorisations are not used simply to mask discrimination. The point about ‘reasonable accommodation’ is that it is designed to ensure ‘the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.'

The purpose of distinct procedures for those who are 'mentally disordered' is to try to ensure that they are dealt with in a manner appropriate to their condition and not in a manner that is cruel, inhuman or degrading. Matters are clearly complicated by the current inclusion within the definition of 'mental disorder' of learning disability (section 328 of The Mental Health Act). The independent review of learning disability and autism in the Mental Health Act (the Rome Review) and the independent review into the delivery of forensic mental health services (the Barron Review) both address this issue. We are mindful of the possibility, even if the forensic system we envisage following our recommendations should be non-discriminatory, that such individuals may need special consideration. There is a recommendation from Barron for a presumption to have those with an intellectual disability progress through mainstream justice systems with support and only be diverted to hospital if progress proves impossible with all necessary support. It is important to note that this should not mean that all people with an intellectual disability will necessarily go to prison in circumstances where those without an intellectual disability would be sentenced to imprisonment. Sentencing would still have regard to the personal characteristics of the convicted person, including any disability.

Greater support for all in our systems is a fundamental part of our proposals. This should allow more individuals to go through mainstream systems. In effect, subject to what the Government decides as regards the Rome and Barron recommendations, there would still be a separate system but entry would not result simply from an intellectual disability or autism and more people would go through mainstream justice systems with the provision of necessary support.

Greater effort to support people through justice processes should address some concerns about current lack of access to support throughout the processes and lengthier detention being imposed or suffered by way of mental health law than would apply if someone with an intellectual disability were convicted after being appropriately supported through the standard justice processes.

When it comes to personality disorders, also included in the statutory definition of 'mental disorder', practice suggests that those in this category will often end up in mainstream criminal justice systems due to the supposed 'untreatability' of such conditions according to some psychiatrists. We know that there is evidence of a high prevalence of personality disorders among those who offend.

The notion of personality disorders as untreatable has, in theory, been discarded but 'treatability' remains an often elusive aim.

The Royal College of Psychiatrists produced a report on Personality Disorder in 2018. It addressed some of the issues around personality disorder and stated that:

> 'This group of patients is generally not well served by mental health and other services, despite a number of UK and Scottish documents over the past 15 years which have highlighted the challenges in providing good care for this patient group, as well as describing good practice.'

While that report acknowledged some improvements, it also identified patchy provision of relevant services and the need for a more strategic approach nationwide. In part, the problem stems from the fact that much of the effective treatment of personality disorder often lies within the area of psychological therapies and therefore requires better co-ordination across different areas of professional practice.

For a long time, where relevant disability has been suspected or identified it has been considered inappropriate to simply follow the same criminal justice processes and procedures as used where there is no 'mental disorder'.

Appropriate assessment and treatment appears to be an important means of ensuring a fair approach to 'mentally disordered offenders'. It is hard to conceive of available 'reasonable accommodations' which would result in fair treatment in every case in mainstream justice systems. Our justice systems are on a journey towards greater understanding and allowance for the impact of trauma and other adverse experiences, especially in childhood, as well as what we have learned about the development of the brain. It is likely to take some time to achieve the necessary understanding and adaptation throughout our systems. As our understanding continues to develop, the definition of universal design under Article 2 of the UNCRPD may be relevant to future planning of court processes and procedures. This definition includes the ‘design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.’ It also include assistive devices for particular groups of persons with disabilities where this is needed.

Discussion with colleagues internationally suggests that forensic mental health law is an area that is underdeveloped in the thinking of the relevant international bodies. It may be necessary to bear that in mind as, despite the aims of UNCRPD, some aspects of different treatment / reasonable accommodation may well continue to be appropriate for some time, especially if the alternative is that everyone is otherwise treated equally - meaning equally badly.

There is much in our systems which is recognised as traumatising or re-traumatising when it comes to complainers, victims and witnesses. Although less frequently recognised, the same can be said of suspects and accused persons, especially those who are vulnerable or who have a mental or intellectual disability. While there has been some progress generally, the parts of our systems which are least developed in this respect are often those which deal with suspects and accused persons. In part this is due to resource issues but there are additional considerations for accused persons which complicate what can be done in terms of some fair trial rights.

Without robust procedures for assessment and treatment of those who offend or are alleged to have offended, there is a risk of compounding the damage and trauma which our justice systems can cause them. This may contravene Article 3 ECHR and Article 15 UNCRPD.

Even if meaningful assessment, support and treatment are available, we still see the need for a distinct system for forensic matters although more people will be able to go through mainstream justice processes in a manner that allows fuller participation.

Those identified as needing different processes despite having appropriate support will be diverted to a forensic mental health pathway.

10.1.2: A forensic mental health system – who is it for?

When we refer to ‘forensic orders’ in this Chapter we mean orders imposed by criminal courts that relate to those with mental disorders who have offended or to the transfer of prisoners from prison to the mental health estate.

Our forensic mental health system is supposed to deal with those with a ‘mental disorder’ who have offended or are alleged to have offended. Despite this, many practitioners in the justice systems in Scotland believe that there is a failure to properly identify all of those with ‘mental disorders’ who come into our systems. One of the main issues in this area relates to awareness.

The first point or points of contact between individuals and justice systems have been identified as crucial, for example, the police coming into contact with those in mental health distress has been identified as a key issue in the Mental Health Strategy 2017-2027, Policing 2026, and Justice in Scotland: Vision and Priorities 2017. It is also a main theme for the Health and Justice Collaboration Improvement Board.

Failings at the first point of contact may be because of lack of awareness, training, time or resources. If first or early opportunities to screen for mental health issues in justice systems are missed, they may not be picked up later and perhaps not at all.

There have been examples of good practice in the forensic field in Scotland (see Scottish Government 2018), for example, pilots involving:

- increased training for police officers
- embedding a mental health nurse in a police control room or custody suite
- greater collaborative working between the police and mental health workers.

Nonetheless, criminal justice practitioners often relate experience of individuals they have encountered in justice systems, including in custody, who have been wrongly assessed not to be suffering from a mental disorder – when the practitioner's experience suggests otherwise – or those who are never assessed, perhaps because of lack of awareness and training, or because some criminal justice practitioners are exposed to so many damaged and distressed individuals that they become inured to it and simply do not see it any more.

Whether an individual is dealt with through the forensic systems or mainstream criminal justice systems can result in significantly different outcomes, depending on the path selected.

Current arrangements for assessment and identification of issues often appear inconsistent in application and outcome. We have wondered if there is a need for a proper system – or even a bespoke service – for the production of pre-trial screening and psychiatric assessments. Otherwise, how are mental and intellectual disabilities (of all forms) to be assessed on entering custody? If this is not done routinely, what are the criteria? Does it depend on prior knowledge of the individual? What about concerning behaviour? How do intoxication and addiction feature in decisions, bearing in mind that intoxication and addiction may be masking, or related to, a deeper underlying disorder? Are duties around screening / referral for mental health services required? If this is not done, do we constantly run the risk of our justice systems breaching human rights at various points in the process with serious consequences (RC v HMA HCJAC 62, the Rome Review section 9.3).

The Barron Review recommended:

> The Scottish Government should bring together the NHS, the Scottish Courts and Tribunals Service and the Crown Office and Procurator Fiscal Service to agree an appropriately funded national framework to ensure the timely provision of court reports by psychiatrists and psychologists for assessment and sentencing purposes.

It further recommended this should be actioned within one year of the publication of that report which was published in February 2021.

Whatever the reasons for not identifying the correct system for individuals, failures at the early stages can be compounded by allowing an individual with mental disability to be processed through systems without proper regard for their mental state. In effect, they may be treated the same as everyone else – superficially, perhaps, an example of non-discrimination but one that often appears wrong, inhuman and potentially traumatising.

On visits to custodial settings, it is not uncommon to speak with staff who say that a particular individual or individuals ‘shouldn’t be here.’ This recognition may be a by-product of greater trauma-informed training, awareness and practice within the Scottish Prison Service. Such awareness is still at an early stage within the legal profession and is not yet widely shared, even though it has been suggested, for example, that representation in some proceedings should be confined to those who have undertaken appropriate trauma-informed training in order to try to avoid re-traumatising victims and survivors (Scottish Courts and Tribunals Service 2021).

An example of the issues around mental health awareness, as well as some of the unfortunate consequences of its absence, can be found in the case of Murphy v HMA [2016] HJCJAC 118:

> [54] The appellant suffers from a mixed form of dementia, a combination of Alzheimer’s and vascular dementia. There is no doubt about that, and equally there is no doubt that he now meets the test for unfitness for trial. The critical question in the case is whether he met that test at the time of his trial. At the commencement of the appeal hearing, the preponderance of the medical evidence was that it was likely that he was so unfit…
>
> [55] …The fact that the appellant appears to have been able to converse with his agents about past events is far from conclusive of his fitness for trial in light of the medical opinions, and in particular in light of the comments by Dr Darjee that the appellant’s long term memory was likely to have been preserved for longer, effectively masking other underlying problems, or at least making it more difficult for a layman to identify the severity of the condition. Dr Campbell was clearly highly sceptical about the suggestion that

> there might have been capacity at trial followed by such rapid deterioration that there was no such capacity by 15 January 2015: it seems much more likely on the evidence that the real extent of his condition was merely made more manifest during this period.

Only three solicitors are accredited by the Law Society of Scotland as mental health specialists and none of them practice in our criminal courts. While there are other able solicitors practising in the area of mental health, not all of them appear in criminal cases either. Most of those who encounter the criminal justice systems are represented by solicitors without specialist knowledge, awareness and training. This can lead to the sort of problems identified in the Murphy case. This raises issues around meaningful access to justice. Such issues can be compounded by the accessibility of the law itself.

One of the wider criticisms of this area of the law is that it is not located in a single piece of legislation. In some situations, it is necessary to cross-refer to different Acts to find the complete answer.

The Senators of the College of Justice brought up this point in response to both our general consultation in 2020, and our specific consultation on our forensic proposals in 2022:

> ‘One area on which the review might wish to focus is the accessibility and comprehensibility of the statute law in this area…It is a feature of the provisions dealing with civil compulsory treatment orders and also of those which amended the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”) that there is a need for a great deal of cross referencing between different statutory provisions in order to understand what the law is.
>
> it is broadly unhelpful (with a mind to clear and accessible legislation) to have provisions for different categories of order, with different names, which use different language, and which are divided between sections in the Act and a schedule, as is currently the case. It would be helpful to have a single set of provisions with a single nomenclature. Distinctions between the different types

> of orders that could competently be made in particular circumstances could be specified within a single, coherent, set of provisions.’

That this criticism of inaccessibility has been made by the legal profession and judiciary underlines the greater issue of accessibility in relation to individuals who are made subject to forensic orders, along with their carers and families.

10.1.3: The Barron Review

Practical consideration of this area in the delivery of forensic mental health services was considered by the Barron Review in its Interim Report in 2020 and its Final Report in 2021.

The Interim Report described the following:

- capacity issues, with particular pressure on community services leading to delays in finding a place with the appropriate level of security.
- unjustified variations in services across the country.
- delays in transfers and transitions to different security levels (higher and lower), including delayed discharges.
- issues with transparency around the role of Scottish Ministers in agreeing progression for those on a compulsion order with a restriction order, including lack of awareness.
- issues around information-sharing, including confidentiality and communication between services.
- problems with involving individuals in decisions about their care and treatment, including issues around lack of continuity in relationships.

Apart from the obvious challenges, there can be human rights implications in these various shortcomings in the current systems.

The final Barron Report made a number of recommendations to address these issues, including issues requiring legislative change.

These include:

- that people in low secure units should be given the right to make an application to the Mental Health Tribunal for Scotland (the Tribunal) where they are being detained in conditions of excessive security, with the Tribunal able to make an order for the discharge process to begin and on the relevant authority to provide the appropriate accommodation and support.
- that people in secure units whose plans for discharge into the community are being delayed as a result of the non-provision of the necessary facilities for a phased move to the community should also be given a right to make an application to the Tribunal for an order that a relevant authority make the necessary provision.
- people should be supported to participate as much as possible in decision-making about their care and treatment. Staff should proactively involve people in both formal and informal conversations about their care and inform them of right to their own information. Staff must communicate in a style that best enables people to understand what is happening and to voice their opinions.
- person's wishes should be added to their healthcare record and staff should endeavour to fulfil them on an ongoing basis so long as that does not conflict with that person's wellbeing.

These recommendations overlap with our work and recommendations.

The rest of this Chapter considers our proposals for the forensic mental health system. We consulted on these in June 2022. People who responded to the proposals in that consultation paper will want to note that three of those proposals are considered elsewhere in this report as they also relate to wider issues. This means that:

- the responses we received and the recommendations we make on **the introduction of intermediaries** are set down in detail in Chapter 5 alongside other aspects of Specialist support in legal and administrative proceedings.
- the responses we received and the recommendations we make **on recorded matters** and **extending the appeals against excessive security**

restrictions can be found in Chapter 11 alongside other aspects of Accountability.

All the other forensic proposals consulted on in June 2022 are discussed below. For each we outline briefly where we started, our proposals for change and what we were told. We then draw conclusions and make recommendations.

10.2: Diversion of those who have offended

This is where we started

We heard concerns that those who have offended may not always be appropriately diagnosed and diverted. Different reasons were given for this. Courts and prosecutors sometimes do not have sufficient information available to them. Defence lawyers may not have sufficient awareness of, or exposure, to such cases to become familiar with them. Often the accused may be unwilling to disclose aspects of their mental health. Delayed, partial or staged disclosure of such information can be the result of trauma the individual has experienced.

When we talk about ‘diversion’ it is important to note there are two types. There is diversion from prosecution and there is diversion into the forensic mental health system.

Diversion from prosecution involves diversion from the criminal justice system, meaning that the courts would generally not be involved at all. For example, rather than being prosecuted for an offence, a person may be referred to appropriate agencies for support and treatment. In general, it is quicker and more person-centred in its response to offending behaviour. If the person has addressed the issues giving rise to the offending behaviour or accepts diversion to an appropriate agency for support in doing so, there may be no prosecution at all.

The accurate and timely identification and assessment of people with a mental or intellectual disability can allow for them to be diverted from prosecution entirely. Only if a referral to a specific diversionary service was then unsuccessful would consideration be necessary as to whether to put the matter through the courts.

Diversion into the forensic mental health system also relies on the identification and assessment of individuals with ‘mental disorder’. It allows for people to be diverted from the criminal justice system into the forensic mental health system. It is primarily this kind of diversion that we discuss here. However we heard that the effectiveness of both types of diversion is often inconsistent, at least in part because of issues around awareness, identification and assessment.

Diversion from prosecution

Diversion from prosecution can avoid the full impact of some fair trial rights. For example, these rights include the right to silence which can be a barrier to suitable assessment and treatment. It should arguably be more widely used in this area.

There were calls for a clearer process of diversion from prosecution, to assist in reduction of both prosecution and use of forensic orders. AdvoCard said:

> ‘It is hard to see at times, why one person has been placed on forensic assessment for trial, becomes a restricted patient, and may have a number of months without liberty, when another person may be diverted from that experience with a similar alleged offence.’

The Law Society felt there needed to be:

> ‘…Specific provision within the legislation to ensure that diversion by way of treatment under the civil mental health procedures has been considered before a person is prosecuted/convicted. There should be an obligation on the Crown to explore this, and the Court to consider it. There should be a requirement for Sheriffs, and defence and prosecution agents to undergo mandatory training if they deal with cases involving mentally disordered.’

The Royal College of Psychiatrists and an individual thought having specific guidance and standards as they do in England and Wales would help. There are national guidelines in Scotland on diversion from prosecution in general.

Diversion into the forensic mental health system

Diversion into the forensic mental health system is linked to the criteria for civil detention. This means only the most unwell will be diverted into the forensic mental health system. This can result in individuals ending up in the prison system who should not be there because they do not meet the high bar required for mental health detention. The Barron Review raised this matter, suggesting that there was a gap in sentencing options for people for whom mental illness, intellectual disability or autism played a part in their offending but for whom long term inpatient care would not be recommended.

We have not been able to consider in detail whether there are different forms of community based disposals which might be a better alternative to either prison or diversion into the forensic mental health system. However, we agree with the Barron review that more should be done to develop these.

This is what people told us

People gave a number of suggestions for how the practice of applying the criteria for diverting a person into the forensic mental health system could be improved.

Some explicitly said this was not about legislative change. Most of the suggestions fell into the themes that are set out below. In addition, people were keen that the threshold for mental health diversion was not raised to the extent that it made diversion more difficult. Others advocated for strengthening the monitoring and reviewing of the progress of people on diversion, to include a review of outcomes and resource issues.

Responses on training and guidance: The Law Society suggested mandatory training for Sheriffs, defence and prosecution agents who deal with cases involving mentally disordered people. An individual felt it important to ensure ‘court staff and police were trained…to recognise common mental health conditions to identify people at an early stage. It won’t catch everyone but should help with the most obvious cases’.

Responses on improving services and inter-agency working: NHS Greater Glasgow & Clyde did not feel legislative change was needed, but that current mental health services and infrastructure do not support diversion. MHOs felt they were excluded from court processes when they hold key information on how diversion could be facilitated. Scottish Association of Social Work agreed they could provide the court with information, but often have not been told that a person is appearing in court. They thought that ‘creating better connections between justice social work and adult service would help’. The Forensic Network pointed to ‘patchy’ court liaison systems, calling for a systematic approach to allow smaller courts to have access to services. South Lanarkshire Council were looking for early and clear communications from courts to allow them to be involved better.

Responses related to resource issues: The Royal College of Psychiatrists said that ‘the resources and wider strategizing underway across mental health services should be inclusive of these patients’. They felt duties already exist to meet the needs of those in forensic settings, but enforceability of the measures is missing. They wanted greater transparency ‘about the effects of beds and staffing shortages’. Families Outside felt people end up in prison because prisons can’t turn people away, but…mental health facilities can’. The Forensic Network said more resources were needed to ‘ensure speedy assessment’ of people in contact with courts.

Responses about systemic reform: The Scottish Commission for People with Learning Disabilities would be concerned if more people (especially people with intellectual disabilities) were to be directed into the mental health system if it remains a place where they may spend more time than they would spend in prison for similar offences. They were looking for systemic reform focused more on social support, education and psychology, and community based sentences. The Mental Welfare Commission (MWC) highlighted the issue in the current system that clinicians providing input into the prison estate have to wait until a bed is available before they can make a transfer for treatment direction. This can cause delays in a person accessing the right care.

Responses looking for better solutions for intoxicated people/people with personality disorder: The Royal College of Psychiatrists and an individual wanted a ‘better solution’ for people with addiction issues who may also be mentally unwell. Edinburgh Health and Social Care Partnership spoke of a ‘fundamental re-setting of societal understanding of culpability’ to challenge the ‘false division’ between personality disorder (“bad”) and mental illness (“mad”)’.

Responses calling for better assessment: The inconsistent availability and quality of expert advice to courts was mentioned. One individual suggested that all offenders should be automatically assessed by an appropriate professional, supported by a mandatory disclosure of medical records. They also thought that everyone with a mental health diagnosis should be considered for diversion by a social worker, independent psychiatrist and independent advocate.

Responses about alternatives to custody: The MWC would like to see greater use of third sector supports as a diversion route – this would need ‘significant investment’. They highlighted current work by the prison service on alternatives to custody or remand where there is evidence of mental health issues through development of a ‘hub’ and dedicated services for women and young offenders. This tends to be in central belt, and the MWC wanted to see this provision extended and courts reflecting these options. People also mentioned the need for third sector alternatives which are relevant to diversion from prosecution.

These are our final recommendations

Diversion from prosecution and from any justice system is often quicker, cheaper and more effective than formal justice processes. It should be used whenever possible, informed by better awareness among practitioners and by increased use of relevant assessments.

We want to support increased and more consistent use of appropriate diversion from criminal justice systems into the mental health system. There is a degree of consensus that some individuals come into our justice systems who would do better if they were diverted. Our systems can traumatise or re-traumatise. This should be avoided whenever possible and diversion is a key option to allow this. Its use should be expanded.

We recommend:

Recommendation 10.1: The Scottish Government should ensure that processes and procedures to identify people with a mental or intellectual disability who come into contact with the criminal justice system are effective in allowing for appropriate diversion to be considered. This should include the Scottish Government:

- **working with the Law Society of Scotland to ensure training programmes that increase solicitors' awareness and confidence in issues relating to representing people with a mental or intellectual disability. Similar training should be developed for other justice practitioners.**
- **reviewing the opportunities for screening and assessing people for a mental or intellectual disability within the criminal justice system, with particular attention paid to the earliest interactions with the person.**
- **overseeing better co-ordination and ethical data-sharing between justice and health partners.**
- **the development of community based interventions for offenders with mental health needs as an alternative to prison or diversion into the forensic mental health system.**

Recommendation 10.2: The Crown Office and Procurator Fiscal Service (COPFS) should develop and publish guidance on the prosecution of those with a mental or intellectual disability who offend.

10.3:Pre-trial/at trial

10.3.1: Intermediaries for accused

In our section on forensic proposals in our consultation in March 2020 we asked people what they thought about introducing intermediaries for the accused and witnesses in criminal proceedings. This issue is considered in Chapter 5 alongside other aspects of specialist support in legal and administrative proceedings.

10.4: Pre-sentence

10.4.1: Changes to pre-sentencing orders

This is where we started

The court can enquire into the mental state of an accused person through assessment or treatment orders before the court process is brought to an end (e.g. by conviction or acquittal). The court can similarly make investigations after conviction by remanding the accused for further enquiry or through an interim compulsion order. All of these orders result in the accused being committed to hospital.

We were concerned to hear of people being remanded to prison while waiting for appropriate mental health provision. The judge may feel they have no option but to remand the person, if they cannot be safely cared for otherwise, and no psychiatric bed is available. However, prison can be hugely traumatic for a person who is mentally unwell, and often lacks suitable support. It is also not possible to administer psychiatric medication without consent in prison.

We think that, apart from any other criticisms, remanding a mentally unwell person to prison should be seen as a failure to respect their human rights. We asked people what they thought about the court being able to require that appropriate medical provision is found for any remanded prisoner. Also, if the issue is caused by a lack of appropriate provision to meet the human rights obligations of the State, we thought that systemic remedies should be available. And that the State must be made to address these problems within a reasonable timeframe.

This is what people told us

Most respondents supported the principle underlying this proposal and several supported the introduction of this power, subject to concerns about the capacity of the current system and possible adverse consequences of the change.

Support for courts to be given this power: A number of responses, including the Scottish Learning Disabilities Lead Nurse Group, Mental Health Network Greater Glasgow & Clyde and the Royal College of GPs felt the courts should be given this power. Families Outside agreed, ‘especially as people are not uncommonly remanded to prison because no space is available for them in a health setting’, AdvoCard said, ‘remanding someone who is unwell to prison should not happen simply because of a lack of bed availability in care settings’

The Care Inspectorate strongly felt that bail should not be refused on welfare grounds or people held in custody to address an unmet need; gaps in provision should be identified and addressed by local and national partners to ensure people’s rights and liberty are protected.

Support in principle but concerns the system is not ready: NHS Greater Glasgow and Clyde seemed to sum up how a number of respondents felt. While they could see that giving courts this power would be helpful in principle, this was set beside ‘concerns about how this would work with service in its present form’. They pointed to the need for ‘considerable improvement in mental health provision and infrastructure that isn’t currently available.’ The issue is in pressures on services and lack of beds. One person feared there could be harmful consequences if a court directed a person to a hospital that ‘was not in a position to accommodate them safely at the time’. Their MHOs also spoke to the lack of proper resourcing meaning delays in getting reports.

Dunfermline Advocacy felt it would take ‘a lot of investment from the Scottish Government’ given the long wait for psychiatric facilities, and they are not aware of ‘any community based services that would be able to accommodate this level of demand’. South Lanarkshire Health and Social Care Partnership felt it was ‘essential’ prisoners receive the treatment they need, with earlier being access positive, but ‘resources are already stretched in prisons’. They felt courts would need to have awareness of local provisions and involve MHOs and clinicians at an early stage to ensure ‘provision being sought is realistic and proportionate’.

The Law Society agreed in principle but had some questions about the practicalities. They felt that this should cover both ‘medical provision and placement’. However, they explained that people are often remanded ‘simply because a psychiatric bed cannot be found and they cannot be safely bailed’, and that it was not always possible to make a hospital-based order in the absence of supporting reports. They felt the focus of any new power needed to be ‘an attributable duty to ensure that remand prisoners are able to access appropriate medical provision’. They wondered whether a ‘short term holding power’ may be required to allow for a person to be transferred within 72 hours.

Support in Mind were concerned that people were remanded ‘in the absence of appropriate mental health provision’. They agreed that remanding an unwell person to prison should be seen as a failure under Article 3 of ECHR because not receiving the appropriate care and treatment breaches respect for their human dignity. So, they welcomed this in theory, but in practice felt that it needed increased resources and staff to ensure the provision is there. The Scottish Association of Social Work felt that care and treatment for the deterioration of a prisoner’s mental health in must be available in prison, but this would need the resources to meet this demand. They felt that when deciding which prison to send someone to, account must be taken of whether that prison can deliver the needed care, support and treatment.

The Care Inspectorate felt that, given that no medical facility may be available and that agencies may need to find alternatives, there would be a consequent need to clarify the status of any alternative premises to ensure they are subject to appropriate scrutiny and inspection.

The Royal College of Psychiatrists said that if there is no hospital space for a section 52 remand or a transfer for treatment direction ‘within a reasonable time the courts should have the ability to eventually place a statutory duty on the Health Board’. They felt that senior managers should be able to be cited to account for what is being done to remedy shortages, and that difficulties should be reported to the MWC and Scottish Ministers.

They also had serious concerns about the proposal:

> ‘There is a real danger if this proposal was put in place that individuals will be sent to hospital without the necessary provision in place leading to serious adverse outcomes – including death…This proposal potentially creates situations whereby unnecessary, substantial and real risk is created in the provision of care without appropriate safeguards, staffing and security.’

They said that the proposal assumed ‘limitless capacity’ in the system and that if it were to drive improvement, it must have ‘teeth’ to ensure provision is available – with expectations not falling on clinicians to leverage resources, but a clear process which brings the Health Board to account.

The Forensic Network and MWC felt ‘services should be designed and resourced to be responsive and admit those who need hospital care to the appropriate level of security at the earlier opportunity’. Pointing to the current requirement for a pre-trial order - that the court must be satisfied that this can happen within 7 days - they both said it was not appropriate for someone who is acutely unwell or suicidal to potentially be in prison for those 7 days or while awaiting court reports. However, they also highlighted that there are circumstances in which a person is less acutely unwell or does not require immediate hospital admission and can remain in prison without harm. That time could be used to assess and plan as appropriate.

Existing powers mean this new power is not needed: Some responses spoke of mechanisms already within the system. The MWC pointed out existing processes which allow the court to direct a mentally unwell person, e.g. court liaison healthcare staff on rotas with specific courts, medical/social work assessments that identify a person as requiring inpatient or hospital care as an appropriate intervention, and the option to use a court direction to a local healthcare facility in a defined time scale. They felt the proposal could then make for a more complicated process. The Forensic Network suggested that the MWCs should monitor when a bed is not found within 7 days, looking for patterns and identifying relevant health boards. They said it could then 'be possible to use the Court of Session Act for Health Boards that consistently fail to provide the necessary beds to meet the needs of these individuals.' The Scottish Association of Social Workers highlighted the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). They pointed to the responsibilities these rules place on the State for health care of prisoner on the State and the obligations it places on prisons to evaluate and care for physical and mental need of prisoners. They also highlighted that relationship between health care providers and prisoners is governed by same ethical considerations as in the community. They concluded that power 'simply should not be required'.

Timescales for Treatment Orders: a separate pre-sentencing issue that was raised with us was the need to introduce timescales for treatment orders.

Treatment orders are pre-sentence orders. They were inserted into sections 52K and 52L of the Criminal Procedure (Scotland) Act 1995 by the Mental Health Act. They can be used when a prosecutor or the court believe a person awaiting trial or sentence may have a mental disorder. Scottish Ministers can also apply for a treatment order for anyone meeting these conditions who is also remanded in custody. They allow for that person to be detained in hospital and given treatment. They can be reviewed on a report by the Responsible Medical Officer to the court. This can lead to revocation. They can also be terminated, for example, on the imposition of a final disposal by the court. The usual time limits apply as in summary and solemn criminal proceedings.

One person had experience of people being on these for 'over a year whilst pre-trial and awaiting final disposal'. They felt that there should be provision for these orders to be reviewed in line with civil orders.

The need to address timescales for these orders has been increased by the effects of the pandemic on court backlogs. For a variety of associated reasons, waiting times for hearings have increased.

The Law Society for Scotland also wanted these orders reviewed. They said that they are often given in error as a final disposal by the Courts. This can result in a ‘procedural irregularity and can cause people to be discharged prematurely due to the incompetence of the order, or be detained disproportionately if this is not identified’. They felt the use of these orders post-conviction should not continue. There was also a call for suspension of treatment to be extended to treatment orders to facilitate rehabilitation.

These are our final recommendations

When a person first comes before a court charged with an offence, they may be remanded in custody or released on bail. Alternatively a court may make an order sending a person to hospital for assessment and treatment. We have heard of people being inappropriately remanded to prison for assessment, as well as difficulties and delays in obtaining psychiatric reports . The Barron Review highlighted a situation where a person could be transferred to prison for up to seven days while waiting for a hospital bed to be sourced for a psychiatric report for the courts. Not only could this be potentially traumatising for the person but admission to prison can also cause DWP benefits to be stopped, potentially leading to rent arrears. Prison may appear to the courts to be a way of keeping people safe when there is no available alternative but it could be a highly distressing and damaging experience for vulnerable individuals, and all the more unacceptable if they are placed in prison merely due to a lack of beds elsewhere.

We continue to think there should be a power to allow a court to require the provision of appropriate mental health provision, including as to placement, for any remanded prisoner. Such a power was welcomed subject mainly to concerns about the capacity of the current systems. These concerns are legitimate but, if prioritised over what **should** happen, may allow current system failings to be perpetuated. Current law and practice is inadequate. Care will be needed to ensure progress towards full implementation of such a power but we recommend that it should be introduced as part of an expected recalibration of resources following implementation of the wider recommendations in this report.

We also think time limits should be introduced for treatment orders to avoid unnecessary delay and uncertainty. We are recommending a time limit of 6 months to bring them in line with civil orders. At that point, it would be necessary to return to court with evidence that the treatment order remained appropriate, if the order is to be renewed. This would also allow for judicial oversight of the timetable and management of any outstanding issues that were causing delay.

We recommend:

Recommendation 10.3: The court should be given the power to require the appropriate provision for the mental or intellectual disability of any remanded prisoner, including as to placement in a medical setting rather than prison.

> **Prior to legislative change existing arrangements and powers should be used to their maximum extent. Data should be kept about remands for inquiry into mental and intellectual disability and the outcomes of such cases.**
>
> **The legislation to introduce such a power should be, subject to an appropriate lead-in period for training, co-ordination between different parts of the justice systems and ensuring that legitimate concerns have been addressed prior to implementation.**

Recommendation 10.4: Time limits should be introduced for treatment orders. We recommend a time limit of six months to bring them in line with compulsory treatment orders.

10.5: Sentencing

There is a significant question as to whether we need mental health law to support a wider range of options for those who require mental health support to address offending behaviour but do not meet the criteria for detention. We have a complex system for around 100 people a year who have offended and very little for anyone else. There is little use of community disposals with a mental health component.

The small number of individuals involved is no excuse for doing things poorly. Greater use should be made of existing options, for example, Community Payback Orders. These orders allow for mental health requirements as well as supervision, unpaid work, programme work, residence requirements, drug and alcohol treatment requirements and conduct requirements. The use of the mental health requirements of such an order could be expanded.

10.5.1: Supervision and treatment order

This is where we started

When someone is acquitted of an offence on the grounds of lack of criminal responsibility - or is found unfit for trial and an examination of facts decides that the person committed the offence - the court may make a supervision and treatment order. Such an order can only be imposed after a partial acquittal (i.e. a finding that a person is unfit to stand trial or not guilty by reason of mental disorder).

A supervision and treatment order requires a person to accept supervision from a social worker and submit to medical treatment. There are no sanctions for non-compliance.

This order cannot be made if it would be appropriate to impose a compulsion order. As such, this is clearly to be seen as a lesser intervention than a compulsion order.

This is what people told us

Almost all respondents felt that, although used rarely, there was at least some justification for these orders to remain an option. The two main reasons given were that, without this option, courts could opt for a more restrictive order (e.g. a compulsion order) or people who continued to pose a risk due to their mental health would return to the community without support or monitoring.

Support for keeping supervision and treatment orders: The Royal College of Psychiatrists explicitly felt that, without supervision and treatment orders, ‘a more restrictive order will be utilised by the courts’. Therefore regardless of how infrequently it is used, there is a ‘small number of cases where a person does not meet the criteria for guardianship or welfare order’. The College felt that, as guardianship orders are likely to change, the potential for more people to fall into current gaps should be minimised. They suggested however that the ‘lack of teeth’ for these orders limited clinicians’ willingness to apply for them, and that retaining the order would require ‘expanded efforts to examine how to ensure they are upheld’.

The Law Society felt this order should ‘remain in force’ as one of the limited options available where someone is found not criminally responsible. They said this order gives an ongoing level of monitoring where the criteria for a compulsion order are not met, arguing this makes it a less restrictive order, offering a level of support and supervision which would not be available if the courts made no order. They did feel that any social worker supervising these orders however should have specialist training: ‘a mental health officer may be more appropriate where ongoing treatment for a mental disorder is part of the disposal’. The Forensic Network felt they ‘may remain necessary for exceptional cases’. They used the example of a person with dementia who does not require inpatient care, and whose risk to others is low.

The MWC spoke of how intellectual disability consultants use these orders when a person has been found unfit for trial/acquitted on the basis of their intellectual disability, if the charge was not serious and they do not need hospitalisation, but do need some support. They highlighted that the decision on which order to propose is almost always made by the medical officer, and were of the view these orders continue to be needed. The MWC also felt that more needed to be done to understand the application of these orders to ‘better understand why they are not well-used’. Agreeing with this last point, South Lanarkshire Council felt that there ‘remains a place’ for these orders, but that they are ‘underused and poorly understood' and training and education on them 'may be of benefit'. NHS Greater Glasgow and Clyde argued there was a continued need for these orders for people who continue have associated risks.

Qualified support for keeping these orders: Another respondent agreed that there may be a need for continued use for these orders if we criteria are changed for compulsion orders (i.e. only for Imprisonable offences), but pointed to the Community Payback Order as an alternative. Edinburgh Health and Social Care Partnership saw their 'potential benefit' as a community order, but only if offending is clearly linked mental health; otherwise there is a risk of 'overreach'. The British Deaf Association Scotland emphasised the need for Deaf BSL users being served these orders to be provided with information in BSL, to empower them to know their rights and make appeals.

Number of orders: The Senators of the College of Justice anticipated that this disposal was only used rarely. They explicitly did not offer a view on the renewed purpose for these orders if there were to be a policy decision to require compulsion orders to be for Imprisonable offences.

The Royal College of Psychiatrists felt that information on the numbers of these orders should be 'called on to inform discussions'. They also said victims' views needed to be taken into account to reflect their experience and any negative consequences to them before making any changes.

These are our final recommendations

We recognise that there will never be large numbers of supervision and treatment orders, given the relatively small number of offenders who are found unable to participate in a criminal trial or acquitted by reason of mental disorder. People felt there was a need to keep these orders. However, there remains the wider issue around the low use of community disposal for people with a mental or intellectual disability, and a lack of understanding the reasons for this.

We accept that this order should remain as one of the wide range of disposals for people with a mental or intellectual disability. We would like to see these orders play more fully the role originally intended for them. This will require greater oversight of the use of these orders, including greater understanding of current barriers to their use.

We recommend:

Recommendation 10.5: The use of supervision and treatment orders should be monitored by the Mental Welfare Commission.

Recommendation 10.6: The Scottish Government should engage with the judiciary and the Judicial Institute to better understand any barriers to the use of these orders.

10.6: Criteria for forensic orders – overarching drive towards standardisation

We looked at the criteria for diverting an individual who has offended into the mental health system. These are largely the same as those for a civil mental health order. In terms of the effects of the orders, these are also largely the same. But differences do remain, mainly that it is not necessary to establish that the person has Significantly Impaired Decision Making Ability (SIDMA) for a forensic order. Also, recorded matters are not available for people on compulsion orders.

The Millan Committee originally proposed having the same criteria between civil and forensic mental health orders. We did not want to create or perpetuate differences between these regimes, except where those differences can be justified. So we asked about the degree to which we can achieve greater standardisation between the regimes. Our aim was to ensure that any differences that remain between these two routes are justified in terms of human rights and with a view to removing or minimising them.

10.6.1: Criteria for forensic orders: mental disorder

This is where we started

We consider in Chapter 2 the continued use of ‘mental disorder’ within our mental health and capacity laws overall, and discuss here its use in a forensic context. There is an argument that any order which can result in a deprivation of liberty has to rely on a diagnostic element, to comply with Article 5(1)(e) of the ECHR. The converse is also true. If a person is going to be detained, they should be detained in an appropriate establishment. This means if a person is going to be detained in a psychiatric hospital, they should have a mental or intellectual disability

At the moment the ‘mental disorder’ diagnostic criterion is fairly significant in a criminal justice context as there is no SIDMA test.

This is what people told us

Responses to this question covered a range of views, including the use of the term ‘mental disorder’ and how to reduce stigma.

Responses supporting certain exclusions from any definition: one individual felt it was important to continue to exclude certain diagnoses from forensic disposals, e.g. paraphilia, substance dependency. Another felt consideration needed to be given to what is included in the term ‘mental disorder’ pointing to the exclusion of people with personality disorders leading to pervasive aggressive or anti-social behaviour. The Royal College of Psychiatrists also want to keep exclusions, which they say can be ‘particularly important in the forensic context’. The Forensic Network also explicitly said that the exclusions should remain.

Responses supporting the need for a diagnosis: The Royal College of Psychiatrist did not support the removal of the criterion of a mental disorder diagnosis from legislation. They felt the diagnostic criteria required by Article 5 was fundamental when considering this issue. They also felt it allows for objective evidence which can be challenged. The Forensic Network similarly felt it was ‘essential the concept of mental disorder and making a diagnosis remains within mental health legislation’. They felt that diagnosis helps to provide consistency and clarity in expectations on treatment, management and likely prognosis. Explaining how the legal terminology is used in practice, they wrote:

> ‘Clinicians convert the legal definition of mental disorder into clinical diagnoses by the use of international classifications of disease. These are wide ranging and it is the other criteria for detention such as necessity, that prevent many of these diagnoses from becoming detainable disorders’

One response pointed out the difficulty in how detention could work consistently if diagnosis was not one of the central aspects.

But AdvoCard argued for a system that applies to everyone equally, and as such, that a diagnostic entry point ‘does not seem to be the best starting point’.

Responses raising issues with term ‘mental disorder’: An individual felt it was important to have a consistent term with declared meaning to clarify who should be included but this was not a term well received by people on orders, despite its continuing legal relevance. They appreciated the difficulty of finding another term that would be more inclusive and less vague. Another felt that this ‘generic term leaves much room for interpretation’. They were looking for it to have a much more focused definition, and argued that‘refinement of the definition may crystallise the need for/or obviation of SIDMA or ADM tests’.

One respondent acknowledged that the term in legislation needs to be reviewed as diagnostic manuals, practice and research into treatability develop over time, and some mental disorders do not result in detention in forensic settings. The Scottish Learning Disabilities Lead Nurse Group fed back that people with learning disability do not like the term, and that ‘intellectual disability’ should be used. MHOs in Greater Glasgow & Clyde felt the term needed ‘further definition, with further clarity about what care and treatment means within these definitions’. South Ayrshire Health and Social Care Partnership found the term to be very specific; not inclusive enough to include ‘lower level’ mental ill health. They felt the definition should be broadened and defined more clearly. The Scottish Association of Social Work felt the term had negative connotations, preferring mental illness or mental health conditions to be more accurate and less negative. Families Outside would also prefer ‘mental ill health'. South Lanarkshire Council acknowledged that 'disorder' may imply a value judgement and that language continues to present 'challenges', but underlined the need for clearly understood terminology and frameworks for reference.

Responses addressing implications of changing the term: One respondent warned that, if changing the term resulted in people formerly covered being excluded, there needed to be consideration of what would happen to people whose support stopped. The individual gave an example of people with intellectual disability having a compulsion order or CORO revoked when no longer meeting criteria, and having support withdrawn. The Royal College of Psychiatrists highlighted that any change in terminology will only have positive outcomes for people if the underlying stigma around this is addressed. One respondent thought that even if we had a different definition it would 'probably mean the same thing'.

One view within Edinburgh Health and Social Care Partnership's response reflected that:

> 'To move towards terminology which better encapsulates the experiential and relational (as opposed to disease/disorder) understanding of distress, while much more fitting, is particularly problematic in the forensic world due to the … implications this would have for current ideas of justice and culpability.'

The MWC advocated for a more inclusive approach in using mental health legislation to ensure marginalised groups get the right treatment. They specifically highlighted groups they considered generally not well managed from a forensic mental health point of view: women, people with intellectual disability, autistic people, people with a diagnosis of personality disorder.

These are our final recommendations

In Chapter 2 we recommend that the law should apply to persons with a mental or intellectual disability whether short or long term. We believe this term can apply equally in the forensic context. The presence of a mental or intellectual disability would, as with mental disorder now, be only one factor in determining whether a forensic mental health disposal is made. We also say in that Chapter that we do not believe it should be necessary to retain a long list of exclusions from the definition under this approach. We accept that there is a particular sensitivity in a criminal context around the exclusion of conditions such as sexual deviancy, dependence on, or use of, alcohol or drugs, or behaving in an anti-social or imprudent way. These exclusions exist in part to avoid the mental health system being expected to accommodate people whose behaviour is felt unacceptable by society but who would not benefit from psychiatric care.

Although, as we discuss above, there are people who would benefit from mental health support who may not fit into current psychiatric services, we accept that it is important to avoid the mental health system becoming a dumping ground for ‘difficult’ people or those perceived as dangerous. We believe that the other criteria should avoid this, particularly the addition of a test of Autonomous decision making (ADM), but we accept that further discussion of this issue is merited.

We are making no specific recommendations in this section.

10.6.2: Criteria for forensic orders: SIDMA (or ADM)

This is where we started

A current difference between civil and forensic orders is the absence in forensic orders of a Significantly Impaired Decision Making Ability (SIDMA) test. The Millan Committee felt that the criteria for compulsion should be the same for these two sets of orders.

However, the Scottish Government did not extend the SIDMA test to the criteria for forensic orders. UNCRPD has since increased our focus on a person’s autonomy and the need not to discriminate. This means we need to consider if there remains a justification for this difference.

The SIDMA test is currently used to justify intervention in the absence of the person’s ability to consent. This test has been subject to some criticism and views were sought in our earlier consultation on whether it should remain or not. In Chapter 8 we have recommended a new test of Autonomous decision making (ADM), which could replace SIDMA as a justification for non-consensual treatment for a mental or intellectual disability.

We suggested that the continuing absence of any test of impairment of decision-making ability from the forensic criteria is likely to be problematic and subject to challenge, especially because a compulsion order can last significantly longer than any conventional criminal disposal.

However we also considered the consequences of extending SIDMA or an ADM test to the criteria for forensic orders. We highlighted that it could mean that a person who is acutely unwell but is able to make treatment decisions might not be able to access the mental health system, and would be placed or remain in prison instead. This is one reason why SIDMA is not part of the test at the moment.

We suggested a number of options:

1. We could keep things as they are. This would mean that the criteria for a compulsion order do not make any reference to decision-making ability.
2. We could make the provisions for a compulsion order the same as for a compulsory treatment order, but allow transfers for treatment or hospital directions to take place without a requirement of impaired decision-making.
3. We could consider the changes made in Northern Ireland. Their Mental Capacity Act contains powers for involuntary admissions of forensic patients to hospital. However, treatment decisions need to be based on capacity to consent.
4. We could provide that prisoners could be treated as voluntary in-patients if this was appropriate to meet their needs.

We favoured the second approach. If compulsion orders only last as long as the equivalent civil order can be justified, it reduces the risk that a person with a mental or intellectual disability may be disadvantaged by being transferred out of the prison system into the mental health system.

This is what people told us

Some responses supported greater alignment around the test of impairment of decision-making ability generally. The Law Society felt that a SIDMA or similar test should be added to forensic orders: ‘the same criterion should be applied as in cases for “civil” patients’. The Scottish Learning Disabilities Lead Nurse Group felt there should be ‘parity across both orders’. AdvoCard felt the provisions for compulsory treatment orders (CTO) and compulsion orders (CO) should be the same:

> ‘We agree with the provisions for a CO and CTO being the same, and would welcome an ADM test as part of that. We understand that someone who is able to make autonomous decisions about their care and treatment, may then be refused access to mental health settings, and removal of this barrier should be considered.’

An individual said:

> ‘My opinion effectively is that there should be a form of SIDMA/ADM within forensic orders, and despite the challenges it may be faced by, it is certainly the best option forward from a medical ethical perspective. I do not believe there is much justification for not extending some degree of autonomous decision to forensic orders.’

They felt this was necessary not just to ‘check a box for UNCRPD’ but to ensure equal treatment for all patients.

One person was opposed to the proposal as they were opposed to the use of the SIDMA test in general.

Other responses specifically responded to the different options we had provided. Most responses related to concerns about making any change.

Responses relating to keeping things as they are (option 1): Responses that supported the status quo raised concerns about introducing any test of impairment of decision-making ability into forensic criteria. These concerns were both concerns relating to public protection, and concerns for the impact for the individual.

Most concerns were on public protection grounds. NHS Greater Glasgow & Clyde were concerned with the addition of SIDMA to compulsion orders with a restriction order (COROs), given the ‘public protection aspect to that order’. Their concern was that a CORO would fall if a person no longer met criteria for impaired decision-making ability The Forensic Network accepted that it may ‘at first glance’ seem desirable to have similar grounds, but the omission of SIDMA was ‘deliberate to ensure that appropriate diversion to mental health services could take place when this criterion was not met’. They said that it allowed courts to also be happy to make such orders without concern that someone’s capacity would return and they would be released, even if ‘there was a risk to the public’. The Forensic Network felt:

> ‘There may be a tension here between the dual role of forensic services to treat mental disorder but also to manage risk of violence and protect the public. If an individual has a treatable mental disorder and poses a risk to others then their decision-making ability is not necessarily the issue that trumps all other issues.’ (Forensic Network)

The MWC said that ‘if an individual has a treatable mental disorder and poses a risk to others then their decision-making ability may not be the primary focus of the services treating or caring for that person’. They highlighted that the addition of SIDMA would result in a number of patients no longer being detained, ‘unless any changes are considered prospectively’. They gave the example of people who are adhering to treatment, have insight, but who continue to pose high risks, and are early in the forensic journey, so have not had adequate ‘testing out’.

Edinburgh Health and Social Care Partnership argued that making the criteria equivalent for forensic and civil orders would result in ‘reduction of public protection powers’. They described people, ‘who have decision-making capacity, choose to disengage with treatment, experience a return to the mental state that was the context of their previous offending and then again cause harm to others’. They felt therefore that any move to adding SIDMA / ADM to forensic orders needs to be considered ‘extremely carefully’.

Alongside public protection concerns, concerns for the impact on the individual of introducing this criteria were also raised. South Lanarkshire Council described this as a ‘contentious area’. They acknowledged the inclusion of SIDMA could act as ‘an additional safeguard and would promote consistency between forensic and civil orders’, but they had concerns. They said the lack of clarity around SIDMA may be unhelpful when the issue of risk is heightened; may inhibit transfer of prisoners; may undermine continuation of COROs; and may undermine existing processes which currently work well (like the low level of reoffending on these orders). All of this, they suggested, would result in worse outcomes for patient and public. NHS Greater Glasgow & Clyde wondered if there was a risk that adding a SIDMA criterion to compulsion orders would increase the number of COROs, given the perception of greater need to protect the public.

Some responses specifically felt that this may impact on individuals accessing the care and treatment they need. The Scottish Association of Social Work explained that if SIDMA was a test for a CORO, ‘someone who presents risks to the public could be taken off a CORO when not ready’. They said this would have implications for the public and ‘the supports the person would receive’. The Royal College of Psychiatrists wanted to remind us that part of the focus of these orders was the risk the person poses to themselves and wider society. They felt that:

> ‘Bringing in a civil test of competence may create scenarios where someone who may still be a risk to themselves and others is no longer able to access potentially essential care in a mental health setting due to them now being “‘competent”.’

They could see that SIDMA being consistently in place would be ‘beneficial to a small number of patients’, but for others their access to care would be ‘inhibited by the inclusion of SIDMA, meaning denial of their care’.

Response relating to adding SIDMA but not for transfer for treatment directions and hospital directions (option 2) and allowing prisoners to be treated as voluntary in-patients (option 4): The Royal College of Psychiatrists felt these options could ‘be a space where SIDMA would increase the likelihood of getting care and establishing the necessity'. They felt it would address a 'population that can consent to treatment but are not getting appropriate support'. AdvoCard said they would prefer the forensic system to be based on a system of consent and voluntary inpatients should be considered for forensic settings. They acknowledged this would also need improved healthcare provisions in prisons, and increased bed availability in forensic care settings.

Responses relating to following Northern Ireland (involuntarily detain but treatment requires consent): Both the Royal College of Psychiatrists and an individual felt that felt 'decoupling detention from treatment' would lead to people staying longer in detention, or people being coerced into treatment to make clinical progress, but 'without the current safeguards'. The Royal College of Psychiatrists spoke of international examples where, 'because of decoupling detention from treatment, people have been kept in forensic detention for lengthy periods because they are considered competent to decline medical treatment'. The individual felt that Northern Ireland's solution of 'a public protection order based on risk rather than capacity, enables the refusal of treatment and 'means patients are entrapped in forensic settings and are unable to access appropriate care'. They felt it would be 'highly problematic' and wanted us to wait to see how it worked out in Northern Ireland.

These are our final recommendations

We had favoured option 2 from the four options on which we consulted. This was the proposal to add SIDMA, or our new ADM test, to forensic orders. People raised concerns around public safety in their responses to this proposal.

In principle, we continue to feel that there is a strong ethical case for aligning the two tests, given the potentially indeterminate nature of the compulsion order. It seems to us wrong and arguably discriminatory that a person can be detained long beyond any likely criminal punishment, on the basis of a test which would not justify their detention as a civil patient.

In a well-functioning system, it should be possible for a person who has mental health needs to be given a criminal sentence, but for them to be transferred to a mental health setting for as much of that sentence as they need, on the basis of their agreement if they are able to give it.

However, we have taken account of the strong expressions of concern from a number of stakeholders that such a change could disadvantage offenders with mental or intellectual disabilities, because it may deter sentencers from making a mental health disposal. We also accept that there is a defensible argument that on public protection grounds, some people who have a mental or intellectual disability which would benefit from treatment should continue to be subject to detention, even if they are able to make an autonomous decision about treatment.

We are not attracted to the Northern Ireland model of detention without treatment in such cases, for the reasons given by stakeholders.

We have concluded that we should not recommend at this stage that lacking the ability to make an autonomous decision about treatment should be one of the criteria for a forensic order. We suggest the matter be revisited once our proposals for reform of the civil procedures are further developed.

We recommend:

Recommendation 10.7: The Scottish Government should consider whether a lack of ability to make an autonomous decision about treatment should be added to the criteria for forensic orders once the Autonomous decision making test proposed by the Review has been suitably embedded within civil orders.

10.6.3: Criteria for forensic orders: harm to self

This is where we started

Part of the test for forensic orders is that, without medical treatment, there is a risk to the health, safety or welfare of the individual who has offended, or to the safety of any other person. This means that a forensic order can be made on the basis of the assessed risk to the person who has offended, even if they pose no risk to others.

This was one area where rather than considering standardisation of the criteria for civil and forensic orders, we were considering whether there needed to be an additional difference. We did not want to prevent a person from receiving the appropriate medical care. But we questioned whether the imposition of an order from a criminal court is appropriate when the person is not a risk to others. This is because criminal law does not typically act to prevent an individual from harming themselves.

We were not considering removal of this from the criteria for transfer for treatment or hospital directions. We wanted to know what people thought about this.

This is what people told us

While most respondents were in favour of this criterion remaining for forensic orders, a significant minority were not. A theme underpinning many of the supportive responses was the concern the person would otherwise not receive the services they needed. There seemed to be an organisational split in opinion between clinical responses and local authority responses.

Support for retaining the ‘harm to self’ criterion: NHS Greater Glasgow & Clyde felt removal would be ‘problematic’ as suicidal patients would need to be detained on a Short Term Detention Certificate when court proceedings ended; and suicidal remand prisoners could have no mechanism to move out of prison.

The British Deaf Association Scotland supported this criterion remaining because the ‘safety of the patient is paramount’. Families Outside similarly felt that the ‘risk of harm to self is sufficient to merit support for mental health illness’ and should be grounds for diversion out of the justice system’. The Forensic Network spoke of needing to take account of ‘all aspects of [an individual’s] wellbeing’. They felt that removal of this criterion would increase the threshold for detention, creating a barrier for diversion of more straightforward cases. The Law Society said:

> ‘Given the individual is within the confines of the criminal justice system and the risk has been brought to the attention of the state, then the state has a duty of care to that individual. The criminal law may not be best suited to supporting these individuals. However if they are receiving no care or support from other sectors then is there not a responsibility on the state to take action and provide that support, from whatever source, rather than allow these people to potentially fall through the gap?’

The MWC felt that, if the person is not fit to fully submit to the criminal justice system, ‘then the individual’s needs would be better met by a forensic disposal, even if they are not deemed a risk to others’. The Royal College of Psychiatrists felt it was important to ensure people are treated in a person-centred way, by explicitly accounting for the person’s own health and wellbeing. However, they did think it was critical to define this risk of harm to self, and how broad the definition should be.

Perth and Kinross Health and Social Care Partnership/Council felt this should remain a criterion but ‘accepted that it could be argued that transfer for treatment directions adequately cover this’.

Organisations supporting removal: Edinburgh Health and Social Care Partnership, South Lanarkshire Council and the Scottish Association of Social Work felt there may be more appropriate avenues outwith the court process for people at risk of harming themselves, e.g. civil orders, Transfer for Treatment Directions or Hospital Directions. The Patients’ Advocacy Service felt that, given these orders can only be imposed in a court setting, it made sense to remove this from the criteria for a compulsion order so that ‘only those who pose a risk to others could be placed on such an order’, but that the criterions should remain for civil orders. AdvoCard agreed it may not be appropriate for an order for the court to relate solely to risk of harm to self. They felt ‘an automatic diversion to care’ could be considered in these circumstances, as they did not want someone not to receive necessary care: ‘…people who may need medical care for risks to themselves and also had other criminal procedures ongoing, not relating to risk to others, could be supported by civil orders during these times’.

These are our final recommendations

Responses here expressed concern about access to services being compromised if the ‘harm to self’ test is removed. Responses were, naturally, based on an understanding of the current law and services. It may be harder for respondents to envisage the new landscape we recommend across all areas of the law.

Where harm to self is a concern, we do not think that it is best addressed in the forensic system. However, we do not want anyone to be deprived of essential services and do not believe that this should happen simply because they are removed from the forensic context.

This is a change that may require more time in order to ensure that there are no gaps and that the primary concern about access to services is addressed.

We recommend:

Recommendation 10.8: The removal of the ‘harm to self’ test from the criteria for forensic orders, excluding transfer for treatment directions and hospital directions. This should be subject to the following careful planning by the Scottish Government:

> **A mapping exercise of existing services for those who are a risk of harm to themselves– what and where they are; what criteria are currently used for access; how they operate.**
>
> **Planning across services to prepare for the recommended change and ensure that there are no gaps.**
>
> **Legislation introduced to remove this test.**

10.6.4: Criteria for forensic orders: seriousness of offence

This is where we started

Currently, a compulsion order can only be made in relation to a conviction for an offence punishable by imprisonment. Given the common law basis of much of Scots law – where any offence can result in imprisonment - this does not amount to much of a restriction. Moreover, these only restrict the post-conviction disposals; other disposals are not so limited.

We thought that if a forensic order can deprive the individual who has offended of their liberty then it should only be imposed in relation to a criminal act that would be punishable by imprisonment. This is the case for people convicted in the criminal courts. If the offence is not punishable by imprisonment, they do not go to prison. However, people who, in relation to the same offences, are found unfit for trial or acquitted by reason of mental disorder under section 57 of the Criminal Procedure (Scotland) Act 1995 can be made subject to a compulsion order. In this way they are deprived of their liberty even if they could not be imprisoned if convicted for the offence. We did not see how this distinction can be justified. We asked people what they thought.

This is what people told us

Respondents were almost equally divided on this question.

Responses in support of reserving forensic orders for offences punishable by imprisonment: Individuals in support of the proposal felt that case not punishable by imprisonment should fall under the civil sections of the Mental Health Act. One person said that to do otherwise was in ‘no way beneficial to the patient or the state’. Another said that:

> ‘If by reason of being unfit to plead an individual is deprived of their liberty, when the offence may not ordinarily result in a custodial sentence, then clearly they are being treated unfairly.’

The British Deaf Association agreed but felt there needed to be ‘a robust system in place to ensure civil assessment where the criminal act does not justify incarceration but mental health needs require hospital treatment.’ They also advocated for greater use of community orders and safeguards against net-widening. Organisations agreeing with this proposal included Dunfermline Advocacy, NHS Greater Glasgow & Clyde, and AdvoCard. AdvoCard said that, ‘given this already applies to people who are convicted, we agree that it should also apply to those who are unfit to plead/or acquitted’. Looking at minimum terms of imprisonment, they suggested lesser sentences could be disposed of under supervision and treatment orders, with more serious offences disposed of to ‘appropriate care’. Their main concern was people subject to a forensic order who are no longer in need of intensive medical care.

Responses not supporting the proposal: a number of responses highlighted the preventative and/or access to necessary treatment aspects of allowing forensic orders for more minor offending. Families Outside felt such orders can ‘prevent escalation of behaviour resulting in imprisonment’, and that ‘people should not have to reach such extremes of behaviour to get the support they need’. The Royal College of Psychiatrists recognised the point we were making but said that flexibility for an order to apply to non-criminal situation should be retained, including community orders, to enable access to support after court proceedings. They were concerned that setting a custodial sentence as a bar, may mean care being denied to people.

The Forensic Network were also worried that this additional criterion would raise the bar, making appropriate diversion to the mental health system less likely. They warned that ‘the opportunity to intervene to treat mental health difficulties and any associated risk may be lost prior to more serious offending being committed’. They also highlighted that compulsion orders can be varied to community compulsion orders when appropriate.

The MWC felt that, if someone commits an offence punishable by any court disposal which has their mental health as a causal factor, then a ‘forensic disposal is appropriate even in the offence is not…punishable by prison’. South Lanarkshire Council advocated for the merits of each case to be looked at. They felt that someone may be unable to comply with a community disposal for a less serious offence due to their mental illness.

The Royal College of Psychiatrists questioned what assumptions we were making around what a non-custodial / custodial sentence indicates. They highlighted that the lack of a custodial sentence does not necessarily mean risk to self or others is lower. They also said that often the severity of a person’s charge is mitigated down because of their mental disorder. As such, they felt the proposal may have the perverse effect of people with a mental disorder not having ‘that pre-trial mitigation in non-custodial cases, or for the court to potentially inflate a charge so that they could access that mitigation.’

The Law Society argued that restrictions of liberty by prison sentence and by forensic order do not seek to achieve the same aims. They could see how it may appear unfair and recognised the merit of supervision and treatment orders as alternatives. They also felt that it was not equitable for someone to be on a restriction order if the offence would not have resulted in imprisonment. They felt it would ‘seem potentially discriminatory, to allow them to be subject to an order of such gravity:

> ‘Arguably if the offence was not so serious that a person not suffering from a mental disorder cannot be deprived of their liberty, then an order further restricting a person’s liberty without limit of time should not be available to the court.’

However, more generally they felt that forensic orders are not about punishment but are a:

> ‘…means of providing the effective medical treatment and support the individual needs: if an order which restricts the person of their liberty is considered the most appropriate measure to take to provide the most suitable treatment for them, then that order should be available to the court.’ (The Law Society)

These are our final recommendations

Responses in this area were split. We accept there can be arguments in favour of mental health disposals for offences not punishable by imprisonment, and there are also arguments that only offences which can be punished by imprisonment should justify detention of any sort. We are talking here only of offences that cannot be the subject of a prison sentence. That is different from than a situation where a person is not sent to prison for an imprisonable offence.

What remains problematic for us is that one approach should operate for offenders who are convicted, and a different approach should operate for people acquitted by reason of ‘mental disorder’ or found unfit for trial. The former are the majority of cases, and we have not seen evidence of difficulties arising from the restriction of these disposals to imprisonable offences. It allows like cases to be treated alike, with no greater likelihood of detention simply because of a mental or intellectual disability. We have concluded that people found unfit for trial or acquitted by reason of mental disorder should not be exposed to detention for the types of relatively minor offences which do not carry even the possibility of a custodial sentence.

We recommend:

Recommendation 10.9: That forensic orders should be reserved to offences punishable by imprisonment.

10.6.5: Criteria for restriction orders

This is where we started

The criteria for a restriction order are in section 59 of the Criminal Procedure (Scotland) Act 1995 Act (CPSA 1995). It can be imposed where it appears to the court that (a) having regard to the nature of the offence with which he is charged; (b) the antecedents of the person; and (c) the risk that as a result of his mental disorder he would commit offences if set at large, that it is necessary for the protection of the public from serious harm to impose this order. The restriction order turns a compulsion order into a compulsion order with a restriction order (CORO). COROs come with additional supervision from Ministers and further constraints on discharge and other freedoms.

The wording for restrictions orders dates from the Mental Health (Scotland) Act 1960 and so could benefit from being expressed in more modern terms. Also, the requirement to consider the risk, as a result of a person's mental disorder, of them committing offences 'if set at large' is not sufficiently clear.

There is no comparable civil order to a CORO. Despite some differences, the nearest comparator appears to be a prisoner subject to an Order for Lifelong Restriction (OLR). Among the differences is the element of a punishment part in an OLR which must be served before the person can be considered for release. There also appears to be a more thorough process of risk assessment before the sentence is imposed.

The criteria for an OLR include:

> 'The risk criteria are that the nature of, or the circumstances of the commission of, the offence of which the convicted person has been found guilty either in themselves or as part of a pattern of behaviour are such as to demonstrate that there is a likelihood that he, if at liberty, will seriously endanger the lives, or physical or psychological well-being, of members of the public at large.' (s210E, CPSA 1995)

We asked people for any suggestions about updating the criteria for imposing a restriction order. In order to stimulate discussion, we asked for their thoughts about a comparison between the test and procedures for imposing an OLR and those for a CORO. We also indicated that we were considering whether to limit the power to impose a restriction order to the High Court.

This is what people told us

Responses about limiting the power to impose to the High Court: Although we did not ask a specific question about this, a small number of responses addressed it. Most agreed with the proposal. AdvoCard agreed that restriction orders should only be allowed to be imposed by the High Court. The Patients' Advocacy Service also felt this was appropriate 'given the additional scrutiny individuals are faced with whilst on a restriction order'. The Scottish Association of Social Work said, 'the High Court should have the power'. However, the Royal College of Psychiatrists did not think it would be helpful to limit the imposition to the High Court. They pointed out that 'the offence may not meet the threshold for the High Court, but the level of harm may nonetheless require a restriction order'.

Responses about updating the criteria: Only a very small number of responses directly addressed this issue. The Forensic Network felt the criteria for a restriction order were 'very clear' but agreed that the word 'antecedents' was old-fashioned and should be updated. The Law Society felt that wording of Section 59 was 'potentially outdated and ambiguous', i.e. it is not clear whether the test is in the context of a person being released with no support, or being released subject to a compulsion order' concluding it could be 'updated and clarified'. An individual also agreed the wording of 'committing offences if set at large' is 'vague and open to interpretation'. Dunfermline Advocacy felt 'words are important and these need to be updated and modernised whenever possible'. They also felt that 'if set at large' sounds like 'police language that is long out of date and needs to be changed'. The Royal College of Psychiatrists had a number of suggestions. This included advocating for the entry and exit criteria to be aligned where possible, and for recovery from mental illness to be a factor considered for removal of such an order.

Responses about processes and procedures: One person said that restriction orders should have a risk management plan.

The Royal College of Psychiatrists said that, if criteria of risk are to be applied across settings, more consistent and simplified criteria would be welcome.

Concerns were also raised more generally about the small numbers of people who have restriction orders revoked. AdvoCard wanted to see, ‘a move towards a realistic prospect of release for those subject to these orders’. An individual felt there was no place for a restriction order because it authorises the measures in the compulsion order without limit of time.

- **Responses in support of change to processes and procedures:** One individual suggested that a Risk Assessment Report should be submitted for a CORO. The Royal College considered that a consistent risk assessment process would be useful. Edinburgh Health and Social Care Partnership felt that COROs are overused, and for offences that would not carry anything like the potential for indefinite detention in the criminal justice system. They cite psychiatrists becoming more risk-averse and sought measures to make the threshold for COROs higher. They also felt that Defence lawyers are not as challenging of recommendations for CORO but said this was an issue of training rather than of law.

  AdvoCard wanted to see the criteria for both reviewed. They fundamentally did not agree that ‘whole life tariffs, without realistic prospect of release or revocation should be put in place.’ (AdvoCard)

  Responses against change to processes and procedures: The Senators of the College of Justice suggested that, post-sentence, a CORO is more regulated than an OLR and can be revoked entirely by the Tribunal. The Law Society felt that, like an OLR, a CORO has the protection of public at heart but also the additional aim of alleviating symptoms, and preventing someone’s condition worsening, i.e. the health and welfare of the person. The Forensic Network felt that a CORO was about care and treatment of an individual, thereby minimising risk to the public.

  The Royal College also pointed to the exit for CORO allowing for complete discharge, for discharge with fewer restrictions, and for a focus on treatment rather than the ‘management of risk’ focus for OLR. They felt that streamlining the difference between the two processes may result in more people placed on COROs inappropriately. They also thought there should be a mechanism to identify whether an OLR or CORO is required.

The MWC did not feel more regulation around COROs would be helpful, or necessary. They were not aware of any systemic problem around inappropriate imposition. They argued however that actually the pre-sentence assessment and number of opinions given for a CORO are more than for an OLR. They thought this ‘may be as a result of a lack of statutory set of requirements or guidelines for risk assessment and supported a ‘standardisation approach in both tests’.

Both the Royal College of Psychiatrists and the Mental Welfare advocated for more data to be collected around these orders before making any changes: ‘more regulation’ may not be providing better care or outcomes (MWC).

These are our final recommendations

We agree that some of the wording of the criteria for restriction orders in Section 59 of the Criminal Procedure (Scotland) Act 1995 is outdated and ambiguous. Although the language needs to be brought up to date and clarified, we do not propose any changes to the criteria for such orders. ‘If set at large’ should be changed to ‘discharged’ or ‘released’. ‘Antecedents’ should be changed to ‘history’. It should be made clear that a restriction order will only be imposed where there would be a risk of serious harm to the public if **no** restriction order was imposed.

Although the most serious offences are prosecuted in the High Court, the jurisdiction of the Sheriff Court extends to the majority of serious crime that is prosecuted on indictment (with a maximum custodial term of five years imprisonment). Therefore, we think that restricting such orders to the High Court of Justiciary could emphasise their significance, and on balance we do not recommend that they be exclusive to that court.

It was the possible lifelong effect of both a CORO and an OLR that made us want to look across these two processes and procedures to identify any potential discriminatory impact on someone diverted into the forensic mental health system. We acknowledge the different aims of these orders but, nonetheless, the effect of both can be lifelong and we think that a more standardised process of risk assessment should be required for COROs as is the case for OLRs.

We recommend:

Recommendation 10.10: The wording of the criteria for imposing a restriction order under Section 57 of the Criminal Procedure (Scotland) Act 1995 should be brought up to date and revised to remove any ambiguity about what these provisions mean.

Recommendation 10.11: Astandardised process of risk assessment should be developed as a requirement for recommending restriction orders. This should be developed by the Scottish Government working alongside the Risk Management Authority, and relevant justice and health partners.

10.7: Ongoing management of people under forensic orders

10.7.1: Standardisation of effect

This is where we started

In our consultation we said that one justification for continued differences from civil mental health orders is that people on forensic orders have committed a criminal act. This can range from the most serious crime to very minor offences. However, the risks posed by, and the clinical needs of, people on forensic and civil order may be the same. It can often be a matter of chance whether a person comes into hospital subject to a compulsory treatment order or a compulsion order.

We wanted to consider whether the consequences of a mental health disposal can be out of proportion to the offence. This was because we had heard that people accused of offences often believe that highlighting a mental disorder may result in a loss of their liberty for a longer period of time.

We highlighted the potential in the current system for disproportionality between offence and consequences. We saw this being an issue particularly at the less serious end of the spectrum. Mental health disposals are largely risk based, so if a person continues to pose a risk, they continue to be detained. In the criminal justice system that sort of indeterminate risk-based detention is reserved for the most serious or dangerous offending (i.e. life sentence and Order for Lifelong Restriction prisoners). Of course, the converse can also be true. Someone on a compulsion order may have committed a very serious act and regain their liberty in fairly short order if the risk that they pose is deemed low enough.

Our concerns around disproportionality centred on the possibility of lengthy and indefinite detention under a compulsion order (with or without restrictions), regardless of the severity of the index offence.

We thought one possibility would be to time limit compulsion orders (as is the case for hospital directions) – so that, after a certain amount of time, the person converts to civil detention or freedom. With restriction orders, there could be time related options for the additional restrictions. These could be applied in relation to the severity of the offence in the same way that is applied for criminal sentences. This could still allow for the equivalent of an indeterminate order where justified, as well as orders that stipulate a set time, or extended time. We asked people what they thought about time limiting compulsion orders, with or without restriction orders.

We also thought there needed to be systematic data collection to proactively identify the ways in which the forensic system may be disproportionately impacting those within it. This was both in terms of comparisons with individuals who have offended in the prison system, but also when comparing different groups within the forensic system, e.g. people with intellectual disability. However, we did not specifically ask about this.

This is what people told us

Slightly more respondents agreed that there should be some time limits for compulsion orders, including COROs.

Responses in support of time limits: AdvoCard wanted measures to time limit restrictions. Dunfermline Advocacy also felt there ‘must be a better process than the current one’. They explained that many people in the forensic mental health system did feel they should have been ‘out by now’. They acknowledged that part of this is due to the ‘delays in finding the most appropriate way to support and supervise a patients who still poses a risk but is fit for discharge, and how to do that in the community’. The Scottish Association of Social Work felt time limits would be an additional safeguard as they would ensure no one is subject to a compulsion order for longer than is necessary.

Some individuals also supported some time limits:

> ‘I would support this [restriction] and compulsion orders with length of time based on risk and closely matched to general sentencing guidance. There should be a seamless process for consideration of civil detention at the end of a forensic disposal as there is at the end of sentence and TTDs [transfer for treatment directions].’

> I would agree with time limiting compulsion orders in the same way that Hospital Directions are limited. At the point of final disposal a 'recommended prison sentence' should be passed and a Compulsion Order should not be able to run beyond this point - an application may be made for a CTO (in the same way as it can be, if required, for a hospital direction or a transfer for treatment direction). If there is to be greater scrutiny prior to the imposition of any Restriction Order then I do not believe it should be ‘time limited’.

Edinburgh Health and Social Care Partnership felt time limits were necessary ‘both in practice and for issues of equivalency’. They highlighted however that thought may be needed around replicating licence conditions for a compulsion orders if additional risk management measures. They were worried that without this there would be an increase in COROs to ensure conditions were available.

Responses against time limits: South Lanarkshire Council, the Forensic Network and the MWC all rejected the need for time limits on the basis that these orders are not comparable with prison sentences. They felt that these orders are about care and treatment not punishment and, length of treatment can vary. The Law Society were concerned about applying time limits along the same lines as criminal sentences, for the same lack of comparability reasons.

The Forensic Network explained:

> Time limited hospital and restriction orders previously existed in Scotland and were removed under 1995 legislation. The logic for removal was that the purpose of these orders was to allow an individual to improve their mental health to such an extent that the risk to others was reduced. Many patients on time limited orders were transferred to civil sections at the end of these. Under our current legislation, this would bring in the issue of the criterion for significantly impaired decision making ability and if this was not met the order would lapse. This may make the courts less likely to use these orders

They felt that regular reviews are kept under review rather than reintroducing time limits. Rather than supporting time limits, they felt that the regular review of all patients by the Tribunal ensures that their rights are protected and the issue of ongoing detention is addressed.

The Royal College of Psychiatrists also referred to the principles of these orders – the balance of risk and ensuring access to care and support. They mentioned MWC data that showed that people were actually coming off compulsion orders too early. They Royal College also thought placing time-limits may exacerbate that. They also felt that data showing lower recidivism rates for CORO patients meant the ‘system does not need to be rebuilt’, rather the focus should be on accurate assessments and further supports.

The MWC’s understanding was that compulsion orders were already time limited, with multiple check and balances within them if they are to allowed to keep running.

One person was wanted reassurances that any time-limited aspect would not leave people who pose a risk without the appropriate supports.

These are our final recommendations

While slightly more respondents were in favour of a time limit on compulsion orders, concerns were expressed by a significant minority. The main risk people identified was that the imposition of a time limit could compromise access to services and public safety.

Our particular concern is for people who are subject to very lengthy detention, whose condition does not change significantly during detention and who may not be discharged for many years. As with OLRs, there may be a few people whose index offence is not at the most serious end, but whose underlying risk is so great that they should be detained until it is reduced to an acceptable level. However, for most offenders with a mental or intellectual disability we feel it should be possible to set an outer limit, beyond which they should only continue to be detained if they meet the civil criteria for detention, including being unable to make an autonomous decision about their treatment.

We recommend:

Recommendation 10.12: That compulsion orders (with or without a restriction order) should routinely be time limited. This time limit should be set by the sentencing judge to reflect the maximum reasonable time to address the risk presented by the offender. It should also take account of the gravity of the offence and ensure a degree of proportionality associated with that factor. For the avoidance of doubt, the order would end earlier than this if the criteria for the order are no longer met.

> **At or shortly before the expiry of the time limit for a compulsion order (with or without a restriction order), the offender could be referred by the Responsible Medical Officer to the Mental Health Tribunal for Scotland for consideration of whether a compulsory treatment order should be imposed**
>
> **A compulsion order should only ever be without limit of time where evidence is provided, under a systematic process of assessment, that the offender is likely to continue to present a serious risk of harm for an indefinite period.**

10.7.2: The ‘Serious Harm’ Test

This is where we started

We explained that section 193(2) of the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the ‘serious harm’ test. In short, the effect of this provision is the prevention of substantive consideration of the criteria for detention of a CORO patient who has a mental disorder if ‘as a result of the patient’s mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment’. If the ‘serious harm’ test is met then the Tribunal has to make no order, and the CORO is retained.

We said that the effect of this is that this group, uniquely in the mental health system, will continue to be detained, often in high security, even if they are not receiving any treatment which will alleviate their mental condition.

We said that the effect of this is that this group, uniquely in the mental health system, will continue to be detained, often in high security, even if they are not receiving any treatment which will alleviate their mental condition.

The test was introduced by emergency legislation in 1999. It was a legislative fix intended only to apply to a very limited number of patients considered untreatable and highly dangerous. It continues to be applied in a number of cases and in more expansive ways than intended. This is despite the court setting out guidance for its use in B v. Scottish Ministers, 2010 SC 472. The Millan Committee recommended it should not be included in the current legislation. It said that, if it had to be retained as a transitional measure for a small group of high risk patients, it should be drawn in precise terms to ensure that it did not extend beyond this group. The Scottish Parliament, however, decided to retain the test.

In Rooman v Belgium (2019), the European Court of Human Rights strongly suggested that treatability should be a requirement for detention in terms of Article 5(1)(e). As such, we are concerned that the arguments accepted in the Reid case (Reid v UK 2003 ECHR 94) for retaining this provision would not be accepted today.

We argued that our system is currently set up on the basis that patients are treatable. Our hospitals are founded on making patients better, not merely keeping them somewhere. We also considered that the availability of hospital directions should mean that people who present a danger even after recovery from any treatable mental disorder can be given a criminal justice disposal but still receive appropriate mental health care.

We recognised some people’s fears that the abolition of the test may result in the release of seriously dangerous individual’s into the community. However, we also felt the test was being applied beyond its intended application. We thought it should be done away with, or significantly restricted. We listed some of the approaches for changes that have been suggested over the years:

- Straightforward abolition
- Abolition for any patients sentenced after the change in the law
- Restricting the test to patients at the State Hospital
- Allowing for a case to be referred back to a court for resentencing if it becomes clear that a compulsion order is not appropriate if, for example, it is established that there is no treatable mental disorder.

We asked people what they thought about this. We also were interested to hear if people had any other alternative proposals to deal with this issue.

This is what we were told

The majority of respondents supported the abolition of the ‘serious harm’ test. Some provided alternatives, for example, referring the matter back to the court. Others had reservations about this, mainly on grounds of risk to public safety.

Ethical concerns with the current test: Responses supporting the need for change around this test often spoke about the ethical issues, the breach of professional obligations and the breach of principles in the MHA in detaining someone without treatment. Individuals wrote:

> ‘I do not see it as ethical for a doctor to recommend continued detention in hospital without treatment. This infringes on multiple pillars of medical ethics, namely beneficence and non-maleficence but certainly has impact on the other two pillars.’

> ‘ …restriction of liberty for the patient who is detained in a hospital for a reason other than to receive beneficial medical treatment may reasonably be construed as inflicting harm upon him [which] reconciled with adherence to GMC ethical obligations and Mental Health Act principles, both of which emphasise the primacy of doctors acting in ways that benefit patients.’

Another individual similarly supported a ‘mechanism for reconsideration of an appropriate sentence’, if the circumstance of the original disposal have changed but a risk remains.

The Royal College of Psychiatrists agreed that the question of whether a person should continue to be detained regardless of whether it appropriate for them to be receiving psychiatric care, is not a psychiatric matter:

> ‘Our member’s clinical duties are that any detention is in the purposes of treatment, and that no one should be held under this test for any other reason. Retrospective efforts to review any cases where this is currently the case would also be necessary to address this.’

They confirmed the ethical dilemma and the uniqueness of the issue in mental health law. If this test was abolished, they felt there were other tests under which they could still provide care in forensic settings. The highlighted an issue around determining what is treatable or not. This issue was also picked up within NHS Greater Glasgow and Clyde’s response with one person highlighting the phrase ‘treatable mental disorder’, given ‘that many mental disorders benefit from treatment, however, the outcome is not a “cure”, e.g. complex trauma, personality disorder’.

The Law Society explained the test was essentially introduced to ‘remedy legal challenges which could lead to perceived unsafe discharges’ which has led to ‘risk of serious harm’ becoming one of the primary considerations for forensic mental health orders. They felt the detention of someone without consideration as to whether they can benefit from treatment is ‘not consistent with the principles of the MHA’.

Responses supporting the need for change: Organisations also spoke in support of change. Independent Advocacy Perth and Kinross supported abolition, ‘or at least the introduction of some mechanism [to] allow the swiftest possible correction of errors by the system’. They knew of people who remained lawfully detained as they meet the current criteria for renewal of a CORO, even though it is questionable whether they should have been placed in the mental health system in the first place. That reflects another criticism, namely that that people are being detained on a test which could not be used to admit them in the first place.

AdvoCard would welcome changes to this test. They thought that hospital directions could be used in some cases, and cases should be allowed to be referred back to courts if compulsion orders are not appropriate. The MWC supported the need for change. The Scottish Association of Social Work, while seeing the serious harm test having continued benefits for ensuring public safety, felt restrictions to the test and the ability to refer back to court for resentencing could be helpful in ensuring human rights are upheld. The group representing NHS Greater Glasgow and Clyde had differences of opinion. One person felt there remained the need for a remedy for people with personality disorder on COROs as they can continue to pose a significant risk. They felt a return to court for review of mental health diagnosis could be a reasonable solution.

An individual supported by SOLD wanted the test abolished but was concerned what options the court would have if returned there, given prison may not be suitable for someone with an intellectual disability. The Forensic Network felt this test was originally brought in for people with a primary diagnosis of personality disorder, and that its use was then more widely interpreted. They supported narrowing the test to apply to those with a primary diagnosis of personality disorder alone.

Support for retention of the test: South Lanarkshire Council felt that while the terminology of the section could be updated, the test itself still had merit. An individual felt that if an offender made threats to the extent it was felt that if released they would be a threat to others, ‘it would be remiss of the judge to not take account of it’.

These are our final recommendations

The serious harm test was introduced in 1999 by emergency legislation to deal with an urgent issue. Despite concerns at the time and subsequently, it remains in place 23 years later. It appears to be being applied to a wider group of people than originally intended, particularly people with intellectual disability. A recent study by one of our Executive Team Members, Professor McKay, and colleagues found that the number of people with intellectual disability who met the ‘serious harm’ test was ‘striking’. They found that 84% of CORO patients with an intellectual disability in the study were covered by this test.

The study reminds us that ‘the Millan Committee was concerned about this test, but reluctantly accepted that it may be necessary ‘as a transitional measure’ for a very small group of patients’. It was only every intended for patients who remain dangerous after their treatable mental illness has resolved (Scottish Executive, 2002). However, this study concluded that it seems to be having a wider impact for patients with intellectual disability who are subject to COROs, and that the question of whether treatment is benefiting the person may not always be assessed at reviews.

> ‘Whilst a similar situation can arise for people with other forms of mental disorder on COROs, LD is usually a lifelong condition with a less dynamic risk assessment than mental illness. This makes people with LD particularly susceptible to the test, as being patients whose condition and risk profile is essentially unchanged, who may not be benefitting in any very tangible way from treatment, but who would be felt to be risky in the community. This raises issues of human rights and discrimination’. (Williams et al., 2020)

We do not believe that we can justify maintaining this temporary ‘emergency’ measure as a long term catch-all provision. We recommend that it should be abolished, although more work is necessary to identify and address any potential “gap” that its abolition might cause.

One of the problems at the moment is that once the ‘serious harm’ test is met, there is no requirement to consider whether the person would still meet the normal tests for maintaining a CORO. Only if this is reviewed would it be possible to ascertain if there are any cases analogous to the case which originally gave rise to the legislation, where serious concern for public safety might override the normal principles of mental health law and care.

For the future, the recommendations we make for improved assessment at sentencing stage should help to ensure that people who may present a continuing risk beyond the duration of any treatable mental health condition are given an appropriate disposal, for example a hospital direction.

To address consistent, increased and justified concerns about the ‘serious harm’ test, we think it should be abolished. There may be perverse outcomes in requiring that only patients in the State Hospital be ‘caught’ by the test, since it may make it harder for some people to move on. We also believe there may be human rights concerns with the option of remitting a convicted person back to court for re-sentencing should it transpire that they no longer can be kept in hospital under a CORO, although it may be a more satisfactory option than what occurs at present.

We agree that data should be collected about the use of this test to inform Government about any gaps and assist in identifying a more satisfactory long-term solution.

Matters that might be considered for data gathering include:

- how many people are affected?
- what are their characteristics?
- how long have they been detained on the basis of the serious harm test?
- How do they compare with the population caught by the criteria for civil orders?

Obviously the eventual solution will depend on the data but, at the moment, we recommend that the area be explored with a view to abolition of this test.

We recommend:

Recommendation 10.13: That Section 193(2) of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be repealed, thereby removing the ‘serious harm’ test.

10.7.3: Restricted Patients – role of Scottish Ministers

This is where we started

A key way that forensic orders differ from civil orders is the role that Scottish Ministers have in the ongoing management of restricted patients. The Millan committee recommended that Ministers should no longer exercise functions related to discharge and the management of patients.

The current Mental Health Act did reduce the role of Scottish Ministers to some extent. The responsibility for discharge decisions was given to the Tribunal. However, Scottish Ministers retain significant roles in respect of restricted patients. They are responsible for approving suspensions of detention and transfers. They have the power to recall and vary the conditions under which someone has been conditionally discharged. Scottish Ministers also have a duty to refer people's cases to the Tribunal if they are satisfied that the detention criteria no longer apply or the order needs to be varied.

We wanted to consider whether a human rights-based approach supports Ministers taking decisions in relation to such individuals who offend other than in cases of recall and conditional discharge. We have received no evidence that Ministers do anything other than take their responsibilities seriously and discharge them with integrity. However, there always remains the risk that their decision-making will be influenced by political considerations or public pressure in a way an independent or judicial body would not.

We felt that involving politicians in the management of individual offenders may no longer be appropriate and sought views on whether this should continue.

We separately asked whether the Tribunal should have a role in the recall of conditionally discharged restricted patients. We were also keen to hear how their role would work alongside the existing role of Scottish Ministers in this.

This is what people told us

Most people supported at least some reduction in the involvement of Scottish Ministers. A smaller number advocated for keeping things as they are.

Responses in favour of reduction of the role of Scottish Ministers: A number of responses supported a reduction in the role of Scottish Ministers but did so to varying degrees.

Some responses advocated for complete separation between the judicial and political realms. One person felt, ‘justice is separate from politics for very good reasons. Allowing Ministers to be involved allows people with mental disorders to be treated as pawns’. They wanted decisions to be made by courts, the Tribunal and appropriate qualified people. The Scottish Association of Social Work’s similarly felt that:

> ‘A progressive society that seeks to advance, protect and uphold human rights cannot risk allowing these decisions to be influenced by politics. On that basis, we would prefer to see an independent or judicial body take these roles on.’

Advocacy responses highlighted the delays that Ministerial involvement can create. Dunfermline Advocacy spoke of there being ‘enough delays for patients’ without adding Ministers into the structure. They were looking to ‘reduce the roles, speed up the process’. AdvoCard felt that multidisciplinary teams, including MAPPA, allowed for quicker management. They wanted decisions around approving suspension of detention moved to clinical teams and public protection agencies. However, they felt Ministers could retain an appeal role, ‘to scrutinise complaints, or contentious decisions’.

The Law Society also spoke of the delays to rehabilitation and discharge that Ministers’ involvement can introduce. They felt that Responsible Medical Officers should be given a higher level of discretion, with the level of Ministerial involvement decided on a case-by-case basis, rather than giving same level of permission and input into every case. They specifically wanted Scottish Ministers to be able to opt out of the 21 day period of appeal against conditional discharge, or intimate they will not attend to appeal to allow for immediate discharge, as can happen in civil cases. Edinburgh Health and Social Care Partnership, while feeling that the role of Scottish Ministers was ‘protective in a lot of ways in terms of an additional layer of scrutiny’, also felt their involvement should be only in the most serious cases.

One person thought an independent body might be established to consider these issues; a body that may be ‘more knowledgeable and compassionate’. Similarly, another felt there should be one person to oversee it all, who was not biased by ‘different departments who may have very different agendas’. One individual wanted disagreements between Responsible Medical Officers and Ministers around suspension of detention to be reviewed by either the MWC or the Tribunal.

Responses in favour of current level of ministerial involvement: South Lanarkshire Council said the role of Scottish Ministers was ‘invaluable’ and provided ‘useful continuity for those high risk patients moving through services’. The Forensic Network spoke of the number of pragmatic, daily tasks that sit with the Scottish Government Restricted Patients Team, such as approval of suspension of detention, and that they have no evidence that this represents any problem. They felt that the Ministers’ involvement in Tribunals (for example giving views on detention and changes to order) can be a good ‘check and balance’ in the systems as they can sometimes oppose the clinicians.

The Royal College of Psychiatrists did not see ‘who is harmed by the Ministers holding this duty’. They felt it was rare for things to be escalated to the Minister but that, when it was, that reflected the seriousness of the case. They did feel, however, that the duties in the Mental Health Act should extend to Scottish Ministers when fulfilling their roles.

Responses addressing an additional role in recall for the Tribunal: Echoing the concerns of the Royal College of Psychiatrists, a number of responses, while supportive of the proposals, raised concerns about the speed at which the Tribunal could respond to issues around recall. Indeed, the Tribunal itself was concerned as to how practically it could meet the needs of urgency often associated with recall.

NHS Greater Glasgow and Clyde felt there could be a tightening of the right to appeal suggesting a ‘tribunal hearing within 21 days of recall’ as a way to introduce a safeguard while keeping the mechanism for emergency returns. The Law Society also supported an automatic review of recall by the Tribunal within a set period of time. The Royal College of Psychiatrists and Edinburgh Health and Social Care Partnership suggested that the roles of Ministers and the Tribunal could mirror those for Government and the Parole Board in cases of life sentence and OLR prisoners. AdvoCard and the Tribunal highlighted the Tribunal’s current appellate role under section 204, and how this may be complicated if they were to be involved in recalls themselves. Families Outside felt the Tribunal was best placed to advise Ministers on discharge and recall.

One person raised the additional problem around the length of time it takes for someone recalled to be conditionally discharged again.

These are our final recommendations

We think the continuing involvement of Scottish Ministers in the progression decisions in forensic cases is anomalous. Some people spoke of the delays caused by the involvement of Scottish Ministers in specific cases. Others worried that removing Scottish Ministers may add to the delay in decisions. Our main concern, however, is why Scottish Ministers continue to be involved in way they are not in criminal cases. Millan wanted this to change. The argument made for retaining their role at that time was that the Tribunal needed time to develop. This argument no longer applies.

We think that this is a human rights issue around independence and impartiality.

We recommend:

Recommendation 10.14: The involvement of Scottish Ministers and the Mental Health Tribunal in the progression management, conditional discharge and recall of restricted patients should mirror the respective involvement of the Scottish Ministers and the Parole Board for Scotland in the management of life sentence and Order for Lifelong Restriction prisoners.

> **Review any data and other evidence on the current role of Scottish Ministers, to include information about delays and the impact on outcomes.**
>
> **Using data and other evidence on the current role of Scottish Ministers, in conjunction with the Mental Health Tribunal for Scotland and other relevant justice partners, examine any gaps that might be caused by reducing the role of Ministers and consider alternative options through the Tribunal.**
>
> **Amend the roles of Scottish Ministers and the Mental Health Tribunal for Scotland.**

10.7.4: Restricted Patients – conditional discharge and recall powers

This is where we started

We did not want to prejudge the outcome of our consultation in the previous section on the role of Scottish Ministers in the ongoing management of restricted patients generally and the impact that could have on the roles and responsibilities of the Tribunal. Therefore we separately proposed two additional powers for Tribunal relating to the conditional discharge of restricted patients in order to address relevant case law. The first was that the Tribunal should have the power to vary the condition under which they had previously discharged a restricted patient. The second was the power to allow them to discharge a restricted patient into conditions that amount to deprivation of liberty.

In 2009, the Court of Session considered decisions which the Tribunal had made in the cases of NG & PF (2009 SC 510). The court concluded that the Tribunal does not have the power to vary the conditions on which they have conditionally discharged a restricted patient. It ruled that, if a patient has been conditionally discharged, any variation to their conditions can be made only by Scottish Ministers (under section 200). People can appeal to the Tribunal about any such change.

In 2008, the UK Supreme Court considered the case of the Secretary of State v MM (2018 UKSC 60). It decided that a patient could not be conditionally discharged when the conditions of discharge amounted to a deprivation of liberty. There is an argument that this case ought not to be followed in Scotland as it relies partly on the specific statutory scheme of the English Mental Health Act 1983. However, there remain unanswered concerns that, if tested in court, the Mental Health Tribunal for Scotland may also not be able to discharge a patient into conditions that amount to a deprivation of liberty. It is not helpful to have doubt or confusion about the position.

We proposed that the Tribunal should have the power to vary the conditions in respect of which a patient has been conditionally discharged. We felt it was appropriate that a judicial body has that power.

We thought there also may be circumstances when it may be appropriate and ECHR compliant, to allow for someone to be discharged into conditions that amount to a deprivation of liberty (e.g. to allow discharge to an intensive community care placement from hospital). This however would need to be legislated for. We therefore proposed that the Tribunal should have the power to conditionally discharge a patient into conditions that amount to a deprivation of liberty if it considers that appropriate and a number of conditions are met. Critically, we said that the Tribunal must be aware, and make explicit, that they are discharging the person into a legislative scheme which meets the requirements for lawful deprivation of liberty. There must also be regular reviews with the Tribunal given sufficient powers to alter the conditions.

We asked people what they thought about these additional powers for the Tribunal around the discharge and recall of restricted patients.

This is what people told us

Most respondents were in support of at least some additional powers. While some addressed one or more of the specific proposals, others commented more generally. A small number of responses were critical of the Tribunal and so did not support additional powers.

Responses supporting additional powers: A number of responses supported additional powers for the Tribunal generally. The Scottish Association of Social Work 'agree[d][with the additional powers'. Dunfermline Advocacy supported the proposals, 'not least because decisions at the Tribunals provide the patient with the opportunity to be part of the process'. The MWC felt strengthening the powers of the Tribunal would be beneficial, and having these powers alongside the powers of Ministers could provide a more 'timely, efficient and effective outcome for the person, and for the services that have supported an application to the Tribunal'. South Lanarkshire felt the Tribunal could have a useful role in these areas, but felt Scottish Ministers' role was also positive.

The Royal College of Psychiatrists supported greater safeguards and so welcomed the proposals but only if they did not become an 'additional layer of bureaucracy', for example, seeing people 'waiting in conditions not of benefit to them'. This would, they felt, require that the Tribunal's timeline would need to change to fit clinical scenarios. They also reported that many of their members thought the Tribunal already had these powers. They felt this indicated the need for greater communication about the Tribunal's role in these matters.

Responses addressing the power to vary conditions: An individual supported the Tribunal getting the power to change conditions, 'given it is the Tribunal that set the conditions'. The Tribunal itself felt this would be 'potentially helpful'. NHS Greater Glasgow and Clyde agreed that the Tribunal should have this power alongside that of Ministers. They had wondered, for speed, if minor changes could just be made by Ministers, but reflected that the 2 year review or appeal process gave more rights to patients. Families Outside felt the Tribunal was best placed to make decisions to vary conditions. The Law Society supported a mechanism for post-conditional discharge to apply to the Tribunal to vary or remove conditions. The Forensic Network thought it ‘seemed sensible’ for the Tribunal to have this power, but for it to only be done with the support of the RMO / clinical team. AdvoCard felt variations should be easier to achieve, suggesting they could be requested at Tribunal by a number of parties.

Response addressing the issues around deprivation of liberty: There were a number of responses that explicitly supported the need for this change. The Senators of the College of Justice felt it was in the interests of clarity and legal certainty to have legislation that is explicit on this issue. Edinburgh Health and Social Care Partnership supported the need to allow for discharge into such conditions. An individual supported this given there are currently patients subject to conditional discharge whose community placement would meet the Cheshire West threshold (i.e. would constitute a deprivation of liberty). (See P v. Cheshire West & Chester Council & another; (2) P & Q v Surrey County Council [2014] UKSC19)

The Forensic Network acknowledged this as a complex area.

> ‘The deprivation of liberty 2018 case is one of those complex, rare cases that we encounter in forensic mental health practice. The Network would be very concerned if this were ever to become part of routine practice. However, we recognise the need to have individual solutions in complex cases and this issue requires further exploration.’

They acknowledged the rare cases where patients can only be in a community setting if they have 24 hour support, but they do not necessarily need to be in a hospital setting. They said this is more common for people with an intellectual disability. For these rare case, they felt there did need to be clarification in legislation: ‘providing relevant criteria are met, 24 hour support can be legally authorised in a community setting. This should address the particular legal point that deprivation of liberty can only be justified with legal authorisation and that it is challengeable’.

Concerns with proposals: There were a small number of responses that did not support additional powers being given to the Tribunal because they did not trust it to work in the interests of people on forensic orders.

One individual doubted that the Tribunal could be relied on to use these powers in a way that ‘would be fair to the patient’, as it is ‘too ready to accept any recommendation by the RMO’. They felt such decisions should be made by a court. An individual being supported by SOLD simply felt the Tribunal always agrees with the psychiatrists.

Other responses emphasised the need for the Tribunal to be more accessible and for patients and their unpaid carers to be involved in all of these decisions.

The role and effectiveness of the Tribunal more generally is considered in Chapter 11.

These are our final recommendations

Concerns expressed In this area related mainly to any increase in bureaucracy and the potential for delays to become lengthier. There was general agreement in responses, however, about these additional powers for the Tribunal, in particular allowing the Tribunal to vary conditions of discharge for restricted patients.

There was also general agreement, although sometimes reluctantly, for the Tribunal to have the power to discharge a person into conditions of deprivation of liberty as that term is now understood. People told us that this was needed in the interests of clarity and legal certainty. However, we agree with concerns that the use of this power should not become routine practice. It is intended for rare cases where a person does not require to be in hospital but could only be discharged into the community with intensive support which may reach the legal threshold of deprivation of liberty. As such, there must be clear criteria that govern its use, an accessible route to legally challenge its use and it must be monitored by the MWC.

We recognise that, to ensure that giving the Tribunal these new powers does not create additional delays, resourcing of the Tribunal will need to reflect the additional work.

We recommend:

Recommendation 10.15: That the Mental Health Tribunal for Scotland should have the power to vary the conditions under which they have previously discharged a restricted patient.

Recommendation 10.16: That the Mental Health Tribunal for Scotland should have the power to discharge a restricted patient into conditions that amount to deprivation of liberty. The use of this power should be:

- **governed by clear criteria that can be understood and are accessible to patients and their unpaid carers and**
- **monitored by the Mental Welfare Commission.**

Duty on Scottish Ministers to ensure appropriate accommodation

Recommendation 10.17: There should be a duty on Scottish Ministers to ensure the safe and appropriate accommodation of prisoners with significant mental health needs.

Voting rights

Recommendation 10.18: That voting rights should be available and the blanket disenfranchisement ended for individuals detained under forensic orders provided for under of the Representation of the People Act 1983 should be

ended. Appropriate legislation should be introduced, together with a comprehensive communications policy to raise awareness of the change.

10.8: Cross-border transfers

This where we started

We asked people if they felt there were any differences in respect of cross-border transfers that we needed to take into account when considering legislative changes. Differences in current legislation across UK jurisdictions already make cross-border transfers difficult. This is the case for transferring people on both civil and forensic orders. We knew that increased divergence between legislative frameworks, which our own proposals may result in, has the potential to further exacerbate this.

What we were told

The responses we received had two main themes. One was that we should be looking to reduce cross-border transfers. The other was that, while improvements are needed to the system for carrying out such transfers, these do not need legislative change.

The Law Society felt cross-border transfers should only be done in ‘exceptional circumstances, as they have the ‘potential to breach the rights of those transferred from their home area and may be discriminatory’. They felt specific criteria may need to be considered ‘to ensure all alternatives have been considered and made available’. Families Outside wanted people held as close to their home location as possible to assist with family contact and eventual reintegration back into the community, working from the principle that, ‘ the appropriate accommodation and support is available for people in the right location at the right time for those who need it’. The British Deaf Association Scotland highlighted:

> ‘It is important that Scottish Ministers and relevant authorities know that there are no specialist residential mental health facilities for Deaf BSL users in Scotland, unlike in England. It may be worth considering making funding available to rectify this gap for Deaf BSL-using patients.’

The Royal College of Psychiatrists raised the issue that people transferred from Northern Ireland ‘cannot come over based on interim orders and may, as a result of a lack of options for appeal, end up unable to return to their home’.

A number of responses spoke to improvements in using administrative rather than legal considerations. One person in NHS Greater Glasgow and Clyde felt there was a need for streamlining process, with better interfaces between relevant authorities, but ‘this did not require changes to the law’. The Royal College of Psychiatrists felt it was not the ‘legal issues that present issues, but communication difficulties with wider UK teams’. As such, they felt that, ‘changing the law will not change those difficulties’.

It was also highlighted that people needed more support to know and understand their rights within this process. The British Deaf Association Scotland highlighted the need for accessible information and resources for Deaf offenders to ‘understand what their rights are in terms to being transferred to another part of the UK and how the different legislation would affect them and their rights.’ The Royal College of Psychiatrists felt the current legalistic language required for forensic orders made it difficult to make the cross border paperwork to be meaningful to patients. They said it was critical that patients are supported and clinicians are enabled to communicate these orders in an accessible language.

These are our final recommendations

We agree that transfers for anyone in our forensic mental health system to elsewhere in the UK for care and treatment should be avoided. However, there may be circumstances in which such transfers are required. We acknowledge that, as some of our recommendations might widen the differences in the law between Scotland and the rest of the United Kingdom, this process may become more problematic. We have, however, not held back from recommending reforms for that reason.

Some respondents suggested that administrative improvements could be made in this area already without the need for legislation. These should be pursued.

We make no recommendation on this issue.

10.9: Duty on Scottish Ministers to ensure appropriate accommodation

This is where we started

While our proposals may see more people diverted out of justice systems entirely and more people diverted into the forensic system, we recognise that they could also see more people supported to be able to participate in mainstream justice. Some of them may be sent to prison. This gives rise to concerns about prison conditions for some individuals with a mental or intellectual disability. It is essential that only appropriate accommodation is used in such cases. Unfortunately, at present, some individuals are placed in accommodation that is inappropriate and potentially damaging to them.

The people affected are often highly vulnerable, with complex histories of abuse and trauma. We believe the State owes a duty to such individuals, and cannot simply stand back if neither hospitals or prisons are able to meet their needs.

This is what people told us

In this section we particularly wanted to address the situation of people who are not seen as suitable for prison by the prison authorities, but also not seen as suitable for hospital by the hospital authorities. A number of reports offered relevant findings and recommendations.

The MWC published a report in 2021 on their concerns about the care of women with mental ill health in prison in Scotland which highlighted some alarming examples of this. This report itself followed a highly critical report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment in 2019 which focused on police and prisons in Scotland.

Neither the Barron Review nor our Review were able to address comprehensively the position of people with mental or intellectual disability in prison and who are therefore not part of the forensic mental health system. Although, the Barron Review highlighted different views on capacity and consistency in the forensic mental health system.

The Barron Review's interim report reflected on some of the evidence it received about mental health provision in prison. It concluded that the issues raised indicated that this was an area which would benefit from further examination. It hoped also that the Scottish Government would identify an appropriate body for such work.

The Scottish Government has since commissioned four national needs assessments in relation to Scotland's prison population. These include social care support, physical and general health, substance use, and mental health needs. As this Review was completing its work, the mental heath needs assessment was published. (Scottish Government 2022). It pointed out the need for robust data on the mental health needs of Scotland's prison population in order to develop services designed to meet the particular needs of this group. The team used quantitative modelling which indicated that over a one-week period, it was likely that that 15% of the prison population had a long-term mental health condition, 17% a history of self-harm, 30% a current alcohol use disorder, 16% symptoms of anxiety and 18% symptoms of depression. They estimated that needs were higher in the remand population in younger age groups, and in women relative to men, except for alcohol use disorder and depression.

They also looked at data on the use of inpatient forensic services by people in prison, relative to Scotland's prison population as a whole. This showed these people were disproportionately female and on remand. The vast majority were transferred for the treatment of a psychotic disorder. They found that professional stakeholders working across justice, health, third sector organisations felt there was the need for a 'cultural shift' or 'a big sea change' before mental health would be more meaningfully supported in Scotland's prisons.

The report concluded that a 'fundamental change in the approach to prison care and prison mental health services is required.' It also emphasised the need for additional prison mental health services resources as well as 'changes in practice at the operational level…to better facilitate cross-agency partnership working and information sharing.

A report by the MWC earlier this year on mental health support in Scotland’s prisons said that there had been little improvement in 10 years in outcomes for prisoners’ mental health. It found that ‘access to, and the delivery of, mental health support across Scotland’s prisons is inconsistent and lacks cohesion’. It also said that ‘prisoners who are seriously and acutely mentally ill are still not being transferred to hospital care without delay’.

The report made nine recommendations for urgent improvement. These covered the co-ordination of services, training, screening, follow-up assessments, review and audits. These recommendations were addressed to the Scottish Prison Service and the NHS. The report also made ‘one overarching recommendation to the Scottish Government, asking that they monitor the delivery of those nine recommendations, and work with the prison service and NHS to deliver better outcomes for people in prison with mental ill health’.

Responses supporting a duty on Scottish Ministers: AdvoCard supported imposing this duty on Scottish Ministers because they were concerned at the level of mental health needs not being met in prisons. Two people felt this was fundamental to protecting human rights. The Forensic Network supported the proposal for a statutory duty on Ministers. They agreed that, ‘under no circumstances should people who require hospital assessment or treatment remain in a prison setting’. They felt what was required was a wholesale reorganisation of mental health care for custodial settings.

The Scottish Association of Social Workers were hopeful that imposing this duty on Scottish Ministers would lead to mental health services in prisons having more resources. South Lanarkshire Council also hoped that this ‘additional accountability may address long-standing resource issues’.

The Law Society wanted to ensure that the duty also applied for remand prisoners who do not have access to longer term therapeutic mental health interventions. The MWC wanted the duty to cover the types of clinical disputes that prevent appropriate care in the setting that meets person's needs. They were aware of times when a person had been unable to access the care and treatment they needed due to such conflicts because resolution had been 'slow and discriminatory to the person'.

One individual supporting the proposal wondered if it could create difficult situations across the system. For example, they could envisage a unit being required to accept a prisoner against their clinical judgement, or the prison service being required to continue care for someone whom they did not feel they could care for.

Responses that did not support this duty: Edinburgh Health and Social Care Partnership felt that the way distress is currently conceptualised would be a barrier to this duty being effective. They wanted the focus to be on improving the prison experience in terms of safety and the ability to meet prisoners' needs. NHS Greater Glasgow and Clyde, the Royal College of Psychiatrists and one other respondent all felt the proposal was too vague to meaningfully comment. NHS Greater Glasgow & Clyde felt if the proposal was meant to target the underlying resource issues, this would be better done without changes to the law. They pointed to the existing issue of securing appropriate places for CORO patients. The Royal College of Psychiatrists questioned whether the duty would leverage resources and had concerns that it would create demands on care that could not be met. They felt that the complexity of prison transfers would need to be looked at first.

These are our final recommendations

This proposal received support from most respondents. Objections were largely that the proposal was too vague. Even those against the proposal, however, agreed that the prison experience should be improved in terms of safety and the ability to meet the needs of those in custody.

There were concerns also about the capacity of the system to cope with enforcing such a duty.

In some ways, the proposed duty simply reflects the ultimate responsibility of the State at the moment to individuals within our justice systems. In terms of ECHR, such a responsibility already exists. It is likely to be extended by the Human Rights Bill which is expected from the Scottish Government. We want to ensure that there are enough levers in the right places in our systems. We want individuals and practitioners to know that this ultimate responsibility can be relied on to ensure that what is needed actually happens. We see this as a recommendation that sits within the longer term implementation of our recommendations to ensure that the mental health system is recalibrated and ready to respond to new methods of ensuring proper recognition of human rights.

Alongside our own recommendation, we have noted the findings and recommendations in the Scottish Government's 2022 report on understanding the mental health needs of Scotland's Prison Population. We also note the findings and recommendations of the Mental Welfare Commission in their 2021 report about mental health support in Scotland's prisons**. We endorse the recommendations in both of these reports. Addressing these recommendations would be a positive step towards acknowledgement and performance of a duty such as we recommend here.**

We recommend:

Recommendation 10.19: There should be a duty on Scottish Ministers to ensure the safe and appropriate accommodation of prisoners with significant mental health needs.

10.10: Mental Health Tribunal for Scotland powers

We have considered extended powers and roles for the Tribunal in relation to restricted patients earlier. Here, we set out some further proposals for changes to the powers of the Tribunal.

Recorded matters

In our section on forensic proposals in our consultation in June 2020 we asked people what they thought about extending recorded matters to forensic patients. The evidence we received on this is considered in Chapter 11 where we are recommending extending recorded matters to cover people on forensic orders, and in other ways.

Appeals against conditions of excessive security

In the section on forensic proposals in our consultation in June 2020 we asked people whether they thought the current right of appeal against conditions of excessive security should be extended to all people subject to compulsion orders. We also asked what people thought about removing the need for these appeals to be supported by a medical report by an approved medical practitioner. The evidence that we received on this is considered in Chapter 11 where we are recommending extending excessive security appeals and removing the need for a supporting report.

10.11: Voting rights

This is where we started

Advocacy groups who responded to the Barron Review had called for an end to restrictions on voting rights for people in the forensic mental health system. We asked people what they thought about giving voting rights to people in this system.

This is what people told us

There was widespread support for ending the blanket disenfranchisement of people detained under forensic orders. A couple of responses suggested there should be a capacity test.

Responses supporting the right to vote: Responses that supported the right to vote being given to people in the forensic mental health system tended to do so whole-heartedly. Individuals questioned why this was not the case already. They said voting rights should be available to everyone ‘to maintain democratic rights’, that it was ‘not obvious why voting rights should be denied to them’, and pointed to the discrepancy that people on compulsory treatment orders can vote. Organisational responses included:

> ‘People in the forensic mental health system should have the right to vote. They remain citizens and part of the Scottish community. Disenfranchising them is unequal and unfair’. (Scottish Association of Social Work)
>
> ‘If people in the forensic mental health system are to be recognised as responsible, contributing citizens and right-bearers, their disenfranchisement via a ban on voting rights is counterproductive.’ (Families Outside)
>
> ‘Currently, an individual who is acquitted due to their mental health does not have the right to vote. This is a conflict as on one hand they are being treated as a criminal and losing the right to vote but on the other hand are treated as someone who did not have the capacity to understand the consequences of their actions. If an individual has been acquitted due to their mental health they should have the ability to vote should they wish. (Patients’ Advocacy Service)

Other organisations including NHS Greater Glasgow and Clyde and the MWC were also in support. The Law Society felt there should be ‘no differentiation from other persons in the criminal justice system’. South Lanarkshire Council said that ‘continued exclusion feels anachronistic’.

The Royal College of Psychiatrists said:

> ‘As part of a system that move towards being least restrictive, we cannot see any legitimate reasons to deny those in forensic settings the vote. This would also ensure that Scotland is compliant with the ECHR’s rulings in this regard.’

The Forensic Network said that part of their ‘role is to encourage people to join positively in civil society and voting is clearly a part of this’. Another respondent felt the proposal ‘fits with a human rights-based approach’.

Responses also highlighted however that people would need to have the appropriate support to exercise this right if they wished. Families Outside specifically felt people may benefit from support and protection to ensure others do not abuse this through coercion (either informally or via power of attorney / proxy voting).

Responses that suggested the need for a capacity test: A small number of responses, while supporting the right to vote, suggested that there should be an assessment of capacity attached to it.

The British Deaf Association felt people should be given the vote, if ‘they have the capacity to understand the information in relation to voting’. One person felt it should be all given to all ‘competent patients’. Another said that given these individuals are ‘within a clearly defined mental health system, then the test must be whether the individual has capacity to make sound decisions’. They suggested a SIDMA or ADM test to show the person is capable of making such decision. However, Families Outside argued specifically against this need:

> ‘In the general public, there is no test to ensure people have the capacity to cast an informed vote: they only have to be of voting age. People receiving support from the forensic mental health system should not be discriminated against because they have a diagnosis.’

One individual felt the vote should not be extended to those who had deliberately taken a life.

These are our final recommendations

The ‘civil death’ of forensic patients originally mirrored that of all those convicted and sentenced to imprisonment for any length of time.

The disenfranchisement of people detained by ‘virtue’ of a mental disorder is currently provided for in Section 3A of the Representation of the People Act 1983. It was introduced into this Act by the Representation of the People Act 2000, and amendments were then made to take into account the changes made by the Mental Health (Care and Treatment) (Scotland) Act 2003. Similar provisions disenfranchising prisoners were set down in Section 3 of the same Act.

This ban has been challenged in the European Court of Human Rights since 2005 and has been the subject of discussion, litigation and legislation since then.

The issue was considered by the Scottish Parliament and Scottish Government and resulted in the Scottish Elections (Franchise and Representation) Act 2020 which allowed people sentenced to 12 months' imprisonment or less the right to vote. No such modification was made for people detained on a forensic order.

We think that voting rights should be extended to be people detained under mental health legislation. This is part of the necessary cultural change required to recognise individuals as rights-bearers and tackle the stigma too often associated with mental ill-health.

We recommend:

Recommendation 10.20: That voting rights should be available and the blanket disenfranchisement ended for individuals detained under forensic orders provided for under of the Representation of the People Act 1983 should be ended.

> **Within 3 - 5 years – appropriate legislation should be introduced, together with a comprehensive communications policy to raise awareness of the change.**

10.12: Additional proposals for change

We received additional suggestions for change in response to a general question on this. Many of these have been integrated into the sections above. However, below are three issues which we felt required further consideration, but on which we did not have the time to consult on. As such, we are not in a position to reach any conclusions about them. We think these should be further considered by the Scottish Government.

A consultation on transfer for treatment directions (TTD): A number of issues were raised about transfer for treatment directions which we have not addressed. People raised a wide range of issues, with one person highlighting that there are issues around, 'consent, SIDMA, delayed transfer, discrimination, equivalence of health provision'. The National Forensic Allied Health Professions Leads Group used transfer for treatment directions as an example of the way in which resources are not equitable for people in services:

> 'People within the forensic mental health services across Scotland experience disparity in their financial situations. People subject to TTD transferred from prison to hospital can remain in healthcare settings for many years and progress through the levels of security until discharge. These people are amongst the most marginalised in society and due to the way that they originally accessed forensic mental health services, their income is greatly reduced and not equal to others who are treated within the same service. People on a TTD live on £20 a fortnight. This puts them at a great disadvantage during their progression, with rehabilitation activities significantly reduced due to the financial constraints they experience.'

The Law Society wanted there to be a mechanism for the Tribunal to make an interim order when an application for a compulsory treatment order is made upon the expiry of a transfer for treatment or hospital direction, when a custodial sentence is due to end. They highlighted that currently only a full compulsory treatment order can be granted. The issue is that this means neither the patient nor any other party can seek an interim order if further investigations require to be made.

Application of legal tests by psychiatrists providing reports in proceedings: The Senators of the College of Justice highlighted possible deficiencies in either the precision of instruction given to psychiatrists preparing reports for court, or possibly their understanding of those instructions and the relevant law. They gave the example of one judge deciding that the accused was unfit for trial on the basis of the usual psychiatric evidence. A second judge when presiding at the Examination of Facts, on finding the facts established and obtaining reports about disposal, noted that one of the psychiatrists had misunderstood their instruction. The judge found that the accused was fit for trial.

They also suggested that as a matter of practice, it might be desirable if psychiatrists instructed regarding fitness for trial were instructed as a matter of routine to advise at the same time as to whether or not the tests for the making of a compulsion order were met.

Examination of Facts: The Senators of the College of Justice suggested that due to the gravity of allegations heard and potential consequences a panel of judges, or a judge and jury should determine the facts in such hearings rather than a single judge. They said that this would bring more equivalence with those who are criminally accused but not mentally disordered.

Chapter 10 recommendations

Diversion of those who have offended

Recommendation 10.21: The Scottish Government should ensure that processes and procedures to identify people with mental or intellectual disability who come into contact with the criminal justice system are effective in allowing for appropriate diversion to be considered. This should include the Scottish Government:

- **working with the Law Society of Scotland to ensure training programmes that increase solicitors' awareness and confidence in issues relating to representing people with a mental or intellectual disability. Similar training should be developed for other justice practitioners.**
- **reviewing the opportunities for screening and assessing people for a mental or intellectual disability within the criminal justice system, with particular attention paid to the earliest interactions with the person.**
- **overseeing better co-ordination and ethical data-sharing between justice and health partners.**
- **the development of community based interventions for offenders with mental health needs as an alternative to prison or diversion into the forensic mental health system.**

Recommendation 10.22: The Crown Office and Procurator Fiscal Service (COPFS) should develop and publish guidance on the prosecution of those with mental or intellectual disability who offend.

Pre-sentence

Changes to pre-sentencing orders

Recommendation 10.23: he court should be given the power to require the appropriate provision for the mental or intellectual disability of any remanded prisoner, including as to placement in a medical setting rather than prison.

> **Prior to legislative change existing arrangements and powers should be used to their maximum extent. Data should be kept about remands for inquiry into mental and intellectual disability and the outcomes of such cases.**
>
> **The legislation to introduce such a power should be, subject to an appropriate lead-in period for training, co-ordination between different parts of the justice systems and ensuring that legitimate concerns have been addressed prior to implementation.**

Recommendation 10.24: Time limits should be introduced for treatment orders. We recommend a time limit of six months to bring them in line with compulsory treatment orders.

Sentencing

Supervision and treatment order

Recommendation 10.25: The use of supervision and treatment orders should be monitored by the Mental Welfare Commission.

Recommendation 10.26: The Scottish Government should engage with the judiciary and the Judicial Institute to better understand any barriers to the use of these orders.

Criteria for forensic orders – overarching drive towards standardisation

Criteria for forensic orders: SIDMA (or ADM)

Recommendation 10.27: The Scottish Government should consider whether a lack of ability to make an autonomous decision about treatment should be added to the criteria for forensic orders once the Autonomous decision making test proposed by the Review has been suitably embedded within civil orders.

Criteria for forensic orders: harm to self

Recommendation 10.28: The removal of the 'harm to self' test from the criteria for forensic orders, excluding transfer for treatment directions and hospital directions. This should be subject to the following careful planning by the Scottish Government:

> **A mapping exercise of existing services for those who are at risk of harm to themselves – what and where they are; what criteria are currently used for access; how they operate.**
>
> **Planning across services to prepare for the recommended change and ensure that there are no gaps.**
>
> **Legislation introduced to remove this test.**

Criteria for forensic orders: seriousness of offence

Recommendation 10.29: That forensic orders should be reserved to offences punishable by imprisonment.

Criteria for restriction orders

Recommendation 10.30: The wording of the criteria for imposing a restriction order under Section 57 of the Criminal Procedure (Scotland) Act 1995 should be brought up to date and revised to remove any ambiguity about what these provisions mean.

Recommendation 10.31: A standardised process of risk assessment should be developed as a requirement for recommending restriction orders. This should be developed by the Scottish Government working alongside the Risk Management Authority, and relevant justice and health partners.

Ongoing management of people under forensic orders

Standardisation of effect

Recommendation 10.32: That compulsion orders (with or without a restriction order) should routinely be time limited. This time limit should be set by the sentencing judge to reflect the maximum reasonable time to address the risk presented by the offender. It should also take account of the gravity of the offence and ensure a degree of proportionality associated with that factor. For

the avoidance of doubt, the order would end earlier than this if the criteria for the order are no longer met.

> **At or shortly before the expiry of the time limit for a compulsion order (with or without a restriction order), the offender could be referred by the Responsible Medical Officer to the Mental Health Tribunal for Scotland for consideration of whether a compulsory treatment order should be imposed**
>
> **A compulsion order should only ever be without limit of time where evidence is provided, under a systematic process of assessment, that the offender is likely to continue to present a serious risk of harm for an indefinite period.**

The 'Serious Harm' Test

Recommendation 10.33: That Section 193(2) of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be repealed, thereby removing the 'serious harm' test.

Restricted Patients – role of Scottish Ministers

Recommendation 10.34: The involvement of Scottish Ministers and the Mental Health Tribunal in the progression management, conditional discharge and recall of restricted patients should mirror the respective involvement of the Scottish Ministers and the Parole Board for Scotland in the management of life sentence and Order for Lifelong Restriction prisoners. This should include:

Review any data and other evidence on the current role of Scottish Ministers, to include information about delays and the impact on outcomes.

Using data and other evidence on the current role of Scottish Ministers, in conjunction with the Mental Health Tribunal for Scotland and other relevant justice partners, examine any gaps that might be caused by reducing the role of Ministers and consider alternative options through the Tribunal.

Amend the roles of Scottish Ministers and the Mental health Tribunal for Scotland.

Restricted Patients – conditional discharge and recall powers

Recommendation 10.35: That the Mental Health Tribunal for Scotland should have the power to vary the conditions under which they have previously discharged a restricted patient.

Recommendation 10.36: That the Mental Health Tribunal for Scotland should have the power to discharge a restricted patient into conditions that amount to deprivation of liberty. The use of this power should be:

- **governed by clear criteria that can be understood and are accessible to patients and their unpaid carers and**
- **monitored by the Mental Welfare Commission.**

Duty on Scottish Ministers to ensure appropriate accommodation

Recommendation 10.37: There should be a duty on Scottish Ministers to ensure the safe and appropriate accommodation of prisoners with significant mental health needs.

Voting rights

Recommendation 10.38: That voting rights should be available and the blanket disenfranchisement ended for individuals detained under forensic orders provided for under of the Representation of the People Act 1983 should be ended. Appropriate legislation should be introduced, together with a comprehensive communications policy to raise awareness of the change.

Chapter 11: Accountability

11.1:Introduction

In 2008, the then United Nations (UN) Special Rapporteur on the right to health, Paul Hunt, described accountability as one of the most important features of human rights. He also said it was one of the least understood (United Nations 2008). In 2017, the UN Special Rapporteur on the right to health at that time, Dainius Pūras, explained:

> ‘Accountability provides an opportunity for rights holders to understand how duty bearers have discharged their duties and claim redress where rights are violated. It also provides an opportunity for duty bearers to explain their actions and make amendments if required’ (United Nations 2017b).

In our consultation we agreed that a strong accountability framework is a vital element of a human rights approach. The foundation to this is that people first need to know what their rights are. Then, they need to know what they can do and where they can go if they feel these rights have been violated. We call these **routes to remedy**. These are the ways that people can challenge violations to their rights and seek a remedy or solution. These remedies can take different forms. The UN Committee on Economic, Social and Cultural Rights expects us to ensure that all remedies are ‘accessible, affordable, timely and effective’ (United Nations 1998).

We are clear that mental health and capacity laws should not just regulate what can be ‘done to’ people covered by these laws, they should also remove barriers that stop them from realising all of their rights. This includes their economic, social and cultural rights. Consequently, the accountability framework for these laws must also cover all our rights. It must promote, protect and fulfil our civil and political rights and our economic, cultural and social rights. We need to pay special attention to how the accountability framework can be more effective and person-centred.

People need to be empowered and supported to use these routes to claim their human rights. In this way, we hope that people will ultimately become the best protectors of their human rights (Sunkel and Shekhar 2019). However, even if individuals are aware of their rights and the route they can use to challenge any violations, they may still need help to do that. In addition, it should not fall on the shoulders of an individual to challenge systemic issues that are breaching their rights. Systemic issue are issues that affect more than one person. This indicates that the issues are part of the system rather than the result of someone's individual circumstances.

It is not enough to have accessible, affordable, timely and effective remedies for individuals. We must also have oversight of the systems and services for people with a mental disability or intellectual impairment to allow us to identify breaches of human rights and ways to address them. We need bodies that are responsible for ensuring our rights are respected, protected and fulfilled in different settings. There need to be plans, monitoring and meaningful assessment of how well people's rights are being realised and protected. This will let people know how well, or not, their rights are being promoted, protected and realised.

These principles and requirements go beyond issues in within our remit. Clear, effective accountability systems – or 'frameworks' – are needed to protect everyone's human rights. The Scottish Government is preparing a Human Rights Bill based on the recommendations of the National Taskforce for Human Rights Leadership. This should strengthen human rights accountability across Scotland. Within the health and social care sector, there are other proposals to change and improve accountability mechanisms. As we conclude our Review, the Scottish Government has announced an independent review of inspection, scrutiny and regulation. This will look at how social care services are regulated and inspected across social care support services in Scotland. Its remit includes to consider how the regulation and inspection of social care and related services can deliver improved outcomes for people within a regulatory framework that meets the needs of the planned National Care Service. There are proposals for a Patient Safety Commissioner and a new Learning Disability, Autism and Neurodiversity Bill and Commissioner.

The Scottish Government is also considering recommendations from previous Reviews. This includes the inquiry into mental health services in NHS Tayside which called for a national review of assurance and scrutiny of mental health services across Scotland.

Our Review is aware that any of these may significantly affect the accountability framework currently in place for our mental health and capacity legislation. We were unable to anticipate changes that have not yet happened. Our focus has been to identify what is required from a human rights-based accountability framework for the people under our remit. This includes identifying the specific barriers they may face when trying to access justice.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) sets out what is needed for full accountability within a human rights-based approach. It stresses the need for disabled people to be able to take part fully in public life. People with disabilities need to be actively involved in all decision-making processes on issues which affect their rights. They need to have equal access to justice. There needs to be independent monitoring of services for disabled people. The right information must be collected to make sure the right policies are developed to support the realisation of people’s rights.

Many of the responses to our consultation, and in our engagement meetings, acknowledged the importance of effective accountability within the system. Before, or sometimes instead of, responding to each of our proposals, some responses endorsed the general direction of travel we had outlined. These included:

> ‘We support the need for proper accountability and scrutiny in all matters.’ (People First Scotland)
>
> ‘We are broadly supportive of what we see to be the underlying ‘driver’ of everything that is proposed here, which is to improve accountability by threading human rights more effectively through a variety of processes, some of which may also usefully be strengthened in favour of those seeking to hold others (including organisations) to account.’ (Royal College of Nursing)

> ‘As the proposals identify, accountability is a fundamental component of a system that respects, protects and fulfils human rights. Incorporation of human rights standards throughout legislation, policy and practice is essential to providing accountability for those standards. The proposals consider a range of forms of accountability, all of which are essential components.’ (Scottish Human Rights Commission)

> ‘A strong accountability framework is essential, not just as an important element of a human rights approach, but in order to ensure protections under equality law for those affected by incapacity, mental health and adult support and protection legislation. Decisions covered by existing mental health, incapacity and adult support legislation have a serious impact on the lives of many people who share protected characteristics. It is important that such decisions can be effectively challenged where individuals feel they have not received the right care or support.’ (Equality and Human Rights Commission)

Some respondents had wanted us to take fuller account of the potential changes to the wider scrutiny landscape.

Organisations representing autistic people and people with intellectual disabilities were concerned that our proposals did not take into account the recommendation of the independent review of learning disability and autism in the Mental Health Act (the Rome Review) to remove learning disability from mental health legislation.

> ‘[This] means that proposals do not account for or fully explore the potential of a new multi-institutional approach to accountability and justice being proposed as part of the new Human Rights Bill for Scotland and the potential role a Learning Disability, Autism and Neurodiversity Commissioner can play in this . . . We are concerned that when no agreement has been reached on removing learning disability from ‘mental disorder’ that proposals have been made regarding extending powers to issues such as employment, education, housing and social connections. Scottish Commission for Learning Disability sees this as an overstep of the review given its failure to listen to the views of people with learning disabilities expressed in the Rome Review. Instead, we

> believe conversations on the developing multi-institutional scrutiny landscape sits firmly within the new Human Rights Bill for Scotland.' (Scottish Commission for Learning Disability)
>
> 'We would urge those involved in broader work on mental health legislation to engage with Scottish Government officials preparing the proposed Learning Disability, Autism, and Neurodiversity Bill, given the potential for a considerable overlap in responsibilities and the role the future Commissioner might play.' (National Autistic Society Scotland).

We do now address the Rome Review's recommendations in relation to our overarching approach in Chapter 1.

We were also asked to take account of the work underway to establish the National Care Service. The Scottish Human Rights Commission highlighted a 'significant crossover' between our principles and proposals, and the work of the Human Rights Bill. They felt it would be helpful if our ideas were developed in tandem. The Royal College of Nursing also felt we needed to provide 'much greater clarity' about how both our work and that of the Human Rights Bill would 'marry up'.

This chapter considers the scrutiny landscape for mental health services and the routes to remedy within it to ensure the accountability framework for mental health services is human rights compliant. We agree that there will be an important task for Government in aligning the various reforms. We have tried to set out what needs to be in the accountability framework – exactly how that is organised will need further consideration once the wider landscape is clearer.

11.2: Scrutiny and the regulatory landscape

11.2.1: The scrutiny landscape

This is where we started

There is no one body with oversight and accountability for our mental health and incapacity legislation. Our health and social care scrutiny landscape is made up of a number of bodies. Together they have responsibility for overseeing mental health services. This is a form of ‘networked governance’. This is a model which involves many organisations, with no one body having all the knowledge, responsibility or influence. (Healy 2011) The organisations include the Mental Welfare Commission, Healthcare Improvement Scotland, the Care Inspectorate, the Scottish Public Services Ombudsman, Audit Scotland, NHS Education for Scotland, the Public Guardian for Scotland. There is also the Mental Health Tribunal for Scotland, and professional bodies for people who work in the health and social care sector, like the General Medical Council and the Scottish Social Services Council.

People told us that it can be good to have more than one set of eyes across a system. It brings different perspectives. However, successful ‘networked governance’ relies on effective co-ordination. Without this, such networks can become too confusing or fragmented. It can become difficult to know who is responsible for what, and how to take action to address systemic problems rather than failures in individual services. There can be unnecessary overlap and duplication, but there can also be gaps in oversight.

A human rights approach also requires us to recognise the need for, and value of, involving people with lived experience in the oversight, monitoring and evaluation of services. UNCRPD’s General Comment 7 calls for this level of participation. However, people with lived experience need to feel ownership of scrutiny bodies. They need equal roles in the governance, monitoring and evaluation of services, including inspection. This includes roles for families and unpaid carers.

Involving people with lived experience in the regulation and scrutiny of services has another benefit. It decreases the risk of ‘regulatory capture’. This is when people who are meant to be scrutinising services begin to identify more with the services than the people using them. People using services often have different ideas about what makes a service of good quality. The value lies in having these different perspectives within the process (Care Quality Commission 2020).

We identified a number of gaps in the current system.

- No one organisation has an overview of the system as a whole and how it is working for people. Scrutiny bodies themselves commented that the scope for joint working is not being realised to its full potential.
- There is no comprehensive inspection regime for mental health services. The Mental Welfare Commission visits hospitals but is not an inspection body. The Care Inspectorate inspects social care, but not NHS services. Healthcare Improvement Scotland does not routinely inspect NHS services and has a focus on improvement.
- Mental Welfare Commission visits and Care Inspectorate inspections can only assess the quality of what is there. It is harder for them to identify things that are not there which should be.
- There appear to be few clear design standards, even for common provisions, such as acute admission wards.
- Despite a duty in the Public Services Reform (Scotland) Act 2010 to ‘secure continuous improvement in … the involvement of users of scrutinised services in the design and delivery of scrutiny functions’(Section 112), the user voice in scrutiny appears weak.

We are not the first Review to point out weaknesses in the current system. The inquiry into mental health services in NHS Tayside said in 2020 that there is ‘only limited scrutiny and oversight of mental health services in Scotland’. It said there was ‘no system of assurance’ either. It highlighted that the Mental Welfare Commission and Healthcare Improvement Scotland cannot enforce the recommendations they make. It recommended a national review. The Scottish Government has responsibility for delivering this recommendation. It is being supported by the Mental Health Quality and Safety Board to do this.

We raised questions about what could be introduced or developed within the existing system to fill some of these gaps. We questioned if the existing Sharing Intelligence for Health and Care Group role and remit could be developed or extended. This is a group of seven of the national scrutiny bodies. It was set up in 2014 and is co-ordinated by Healthcare Improvement Scotland. It is a forum for sharing and making good use of data and intelligence to improve the quality of care. People involved in the Group recognised that its ability to focus on mental health can be limited by their responsibilities for the wider health system.

We also asked whether people felt we need a new system of universal inspection and regulation, as other countries have chosen to do. This could involve introducing duties and responsibilities into our accountability framework similar to those of the Care Quality Commission in England, which regulates all health and social care, whether provided by the NHS, local authorities or independently.

We had an initial proposal which was:

- the Scottish Government should develop a comprehensive and effective improvement and assurance framework for mental health services. This should be developed with the Sharing Intelligence Network bodies and collective advocacy organisations.

In our consultation paper, we asked people what they thought was needed to make the scrutiny landscape for mental health services more effective in order to make this proposal more concrete. We organised a roundtable with key scrutiny bodies to seek their views. We also spoke with the Scottish Government's Mental Health Quality and Safety Board and international mental health commissions.

This is what people told us

Responses recognised our description of the current scrutiny landscape for mental health and adults with incapacity. People accepted there was room for improvement, but views differed as to how to achieve this. Some people said there were benefits in moving towards one regulatory body. Others warned about adding another regulatory body, or other changes into the already complex landscape. Most suggestions were about improving the existing model of networked governance. Better collaboration, co-ordination, clarity of roles and leadership among the different scrutiny bodies were all seen as crucial. Human rights was suggested as a framework which could bring better cohesion across the landscape.

Reponses about one regulatory body: A small number of responses supported one body with accountability and oversight of the new legislation. One individual felt users would appreciate just ‘one port of call’.

> ‘The establishment of one body solely responsible for this would be more effective than the fragmented service that exists currently.’ (British Deaf Association Scotland)

Social Work Services Dumfries and Galloway advocated for one overarching body focused on quality of in-patient and community services, with authority to grade and make recommendations. They argued such a body would be able to develop the breadth of knowledge and specialisms needed to understand and support the ‘safe, proportionate and person-centred care’ of mental health service users.

Responses about improving the current networked model: A number of responses, including those from scrutiny and regulatory bodies, recognised the limitations of the current landscape. However, they favoured a continuation of the networked or nodal models of scrutiny, alongside improved joint working.

Social Work Scotland and Scottish Association of Social Work said the existing powers for scrutiny and regulatory bodies are sufficient. They recommended joint working across them rather than increasing the powers of any one body. Advocacy groups agreed.

> ‘We would suggest that the existing powers for current scrutiny and regulatory bodies are sufficient. We would recommend that joint working across the regulatory bodies would be preferable, reducing the tendency toward silo approaches and strengthening a human rights-based approach to advocacy ... Care Inspectorate, Mental Welfare Commission, Scottish Social Services Council and Health Improvement Scotland, working closely together would be preferable rather than increasing the powers on any one group.’ (AdvoCard)

The Care Inspectorate recognised that there is no one organisation with oversight of the system. They want ‘better multi-agency scrutiny and assurance work’ across mental health. They suggested this needed to include proportionate mechanisms for the collation and analysis of multi-agency information. They also want to see service providers risk assessed and subject to proportionate scrutiny and improvement plans.

The Mental Welfare Commission acknowledged that the landscape can appear ‘cluttered and disjointed’. They feel clarity of leadership and intelligence is required. They said scrutiny should be based on ‘agreed standards’. Then, when a body identifies deficiencies, that body should undertake work (if needed in partnership with others). They proposed that, ‘this scrutiny and resultant action be fed back by the Mental Welfare Commission to the Scottish Parliament’.

Health Improvement Scotland felt this was an opportunity to ‘establish more formal and networked governance arrangement for external assurance’. They would welcome existing bodies working collaboratively with their ‘respective skills and experience’. To work effectively they said there would need to be ‘clear alignment’ between bodies where there is potential for overlap of roles and responsibilities.

See Me highlighted the lack of ‘a comprehensive inspection regime across mental health services’. Families Outside pointed out that health and prison mental health services tend to work independently of each other. They wanted prison mental health services to be subject to the same level of scrutiny.

Promoting and protecting equality and human rights: An underlying theme in responses was that scrutiny bodies should have a greater role in promoting and protecting equality and human rights. The Scottish Human Rights Commission feels the essential role that regulators and scrutiny bodies have to play in monitoring and regulating human rights ‘has not yet been fully harnessed’. They want a duty on these bodies to fulfil their responsibilities in a way that is consistent with, and gives effect to, human rights. They also argue for enhanced enforcement powers for these bodies.

People told us there seemed to be a lack of understanding, knowledge or accountability around the existing Public Sector Equality duty. This duty is in section 149 of the Equality Act 2010. It requires public bodies to look to eliminate discrimination, advance equality and foster good relationships with different groups of people. Public bodies need to consider how their functions may affect different groups differently if they are to avoid creating greater inequality in the system. The Equality and Human Rights Commission is responsible for regulating this duty. They said any accountability framework must take account of this duty. They want scrutiny bodies to play a central role in promoting equality and monitoring progress against standards and duties. The Patient and Carer Race Equality Framework was recommended by some of the groups we spoke with. This framework was developed by the National Collaborating Centre for Mental Health. It guides services towards ‘a system which provides equitable mental health care regardless of race/ethnicity’ and provides ways to measure and monitor this.

The UNCRPD requirement for lived experience to be a ‘core party to any future scrutiny framework’ was also raised (Mental Health Network Greater Glasgow). People with lived experience should have a role in reviewing services and ensuring quality (Carr Gomm National Involvement Group). Their ideas and expertise would make the system more effective (Support in Mind). Our practitioner reference group also called for carers to be involved in scrutiny.

In our lived experience reference group it was suggested that the voice of service users is often not accurately captured during inspection. They pointed to two reasons. One, was that people in the services being inspected are oppressed in a way ‘only people with lived experience would understand’. Therefore, the ability to speak out truthfully is hindered. Two, if asked to nominate people to speak to inspectors, services will put forward people who are more quiet or amenable.

Avoid adding more complexity*:* A number of responses warned against introducing any changes that added further complexity into the scrutiny landscape.

> ‘As the consultation recognises, the regulatory landscape is wide ranging, complex and has areas of overlap. We need to take care to make sure that

> new scrutiny and regulatory bodies don’t increase on this overlap and result in a bigger, more complex and harder environment for the individual to navigate.’ (Scottish Social Services Council)

Responses also pointed out potential overlap with the work being done for the Human Rights Bill, the Scottish Government’s Mental Health Quality and Standards Board and the development of the National Care Service. The Scottish Commission for People with Learning Disabilities were especially concerned. They believe ‘conversations on the developing multi-institutional scrutiny landscape sit firmly within the new Human Rights Bill’.

Our final recommendations

We are conscious of the many changes and work going on which may impact on the existing scrutiny of services for people with mental or intellectual disabilities. However, we believe there is an urgent need to develop a more holistic, rights based and effective framework for scrutiny in this sector.

The National Human Rights Leadership Advisory Group has already recommended specific duties be considered for ‘front-line complaint handling mechanisms and scrutiny bodies to enhance access to justice and ensure human rights obligations are given effect by public authorities.’ It also wanted these bodies to be supported to build their capacity to do this. We agree. We believe that bodies involved in the scrutiny of services for people with mental or intellectual disabilities can play a critical role in the cultural shift in awareness and respect for human rights across these services in Scotland. They need to be able, willing, confident and supported enough to model and hold others accountable for embedding human rights-based approaches.

We are aware of the work the Scottish Government’s Ministerial Mental Health and Quality Standards and Safety Board is doing to meet the Tayside Inquiry recommendation for a review of the scrutiny landscape across mental health. Since our consultation paper was published the Scottish Government has been meeting with the Care Inspectorate, Healthcare Improvement Scotland, the Mental Welfare Commission and the Forensic Network to consider how to improve the collective scrutiny of these services. A Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group has been set up to provide scrutiny organisations the platform to share, discuss and act upon emerging themes and issues from their on-going scrutiny activity. The Group will meet bimonthly and aims to ensure a cohesive approach across the organisations and reduce the burden on mental health and intellectual disability services.

This Board is also overseeing the development of standards and specifications for different aspects of mental health delivery including adult mental health and psychological therapies.

We anticipate that the Scottish Government commitments to Commissioners for both Patient Safety and Learning Disability, Autism and Neurodiversity will be additions to this landscape in the near future. And, of course, there is the ongoing development of a National Care Service which may cover some or all mental health services. Its accountability framework is therefore also likely to have repercussions for the existing network of scrutiny.

We have not found widespread support for radical structural change to the existing scrutiny landscape for mental health, and we do not believe this would be the best way forward. We recognise that structural reform can be hugely disruptive and can often promise more than it delivers, and it would be difficult to do this for mental health services if the regulatory system for other health and social care services was unchanged.

What people were looking for was greater co-ordination, clarity and focus among the different scrutiny bodies. There needs to be a more structured approach to overall responsibility across the system. Our recommendations seek to ensure, whatever the outcome of both the Scottish Government’s Human Rights Bill and its review of the assurance framework for mental health service, that human rights and accountability are embedded in it.

We have already said it is critical for scrutiny bodies to have expertise in human rights. We feel that the protection, promotion and realisation of human rights should be a common language and goal through which all scrutiny bodies frame their work and interactions.

A key part of achieving this is to ensure that people with lived experience, including unpaid carers are participating in and undertaking scrutiny rather than having scrutiny **done to** them. They should be involved in all aspects of scrutiny including within the governance of scrutiny bodies and monitoring, evaluating and inspecting the quality of services. There is already an existing duty on scrutiny bodies under section 112 of the Public Services Reform (Scotland) Act 2010 to secure and demonstrate continuous improvement in user focus. They must also take into account the guidance that has been issued on this by the Scottish Government.

The networked approach to scrutiny and regulation can only be justified if it does not confuse the people who need to seek remedy from it. People must be able to navigate the system to get access to the appropriate, available routes of remedy. There was consistent support for a ‘no wrong door’ or ‘single gateway’ for the public to seek remedy. This means that the first body a person approaches will take the issue and match it to the appropriate assistance.

> ‘We have anecdotal feedback that members of the public including at times those represented legally and by independent advocacy services can find the landscape confusing. Consideration should be given to a single gateway for mental health complaints which would be far easier for the individual and families to recognise and access.’ (SOLAR)

There also needs to be more formalised dialogue and sharing of information and agreed aims across scrutiny bodies. In some cases this may require legislative change to allow information to be shared. Scrutiny bodies must have mechanisms to identify and report systemic issues within their own area.

However, within this, there also needs to be system leadership to drive change and ensure responses to issues that fall across organisational responsibilities are considered, reported and addressed. We have considered options for this.

Ministers play a vital leadership role in driving improvement, as has been demonstrated by the Quality and Safety Board. However, Ministers also ultimately run large parts of the system, including the NHS and the planned National Care Service. It is vital that we also have an independent scrutiny framework.

There was support for building upon the example of the Sharing Intelligence for Health and Care group. This group currently comes together to share intelligence about all the care systems. However, we believe that there needs to be a more formalised network with a specific focus on mental and intellectual disability. It should not only co-ordinate scrutiny of particular services, but should be able to assess whether the system overall is delivering the outcomes for people that it should, and whether their human rights, including to the highest attainable standard of mental health, are being secured. The Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group set up by the Scottish Government could provide the nucleus for this formalised network we are recommending.

This network needs to have a lead organisation, with responsibility for co-ordination and reporting. We believe the Mental Welfare Commission, as an independent body which has a focus on human rights and mental health, and a locus across the full range of health and care services, would be well placed to take this role. The changes to the governance and responsibilities of the Mental Welfare Commission which we propose in the next section should support them in this role.

We recommend:

Recommendation 11.1: There should be a duty on scrutiny bodies and complaint handling bodies to enhance access to justice and ensure human rights obligations are given effect by all public authorities involved in the provision of services for people with mental or intellectual disability. The Scottish Government should ensure these bodies are fully supported to build their capacity and confidence to play this part.

Recommendation 11.2: There should be a formalised network of bodies involved in the scrutiny of mental health services. This should include Healthcare Improvement Scotland, the Care Inspectorate, Audit Scotland, the Mental Welfare Commission, the Office of the Public Guardian, Public Health Scotland, the Scottish Public Services Ombudsman and collective advocacy organisations. Other members may include professional regulatory and training bodies.

Recommendation 11.3: The network should work with the Scottish Government to identify and remove any legislative barriers to this approach, such as unnecessary constraints on sharing information, or restrictions on the full involvement of people with lived experience, or their unpaid carers.

Recommendation 11.4: The Mental Welfare Commission should be the lead organisation for this network, with responsibility for co-ordination and reporting to Ministers and the Scottish Parliament.

Recommendation 11.5: This network should develop a cross-agency framework for monitoring outcomes in mental health and should ensure that:

- **the promotion, protection and realisation of people's human rights is a common aim for scrutiny bodies across the mental health landscape.**
- **there is development and support for sufficient human rights expertise within all scrutiny bodies.**
- **there are mechanisms to identify, report and address systemic issues across the work they do.**
- **people with lived experience play a leading role in determining what defines 'quality' in services as the foundation for each scrutiny body's monitoring, evaluation and inspection processes.**
- **effective monitoring of the extent to which scrutiny bodies are meaningfully fulfilling their duties under section 112 to 113 of the Public Services Reform Act 2010 in relation to user focus.**
- **there is a single entry point for the public to access the appropriate scrutiny body for any information, support or issue they want to raise.**

11.2.2: The Mental Welfare Commission for Scotland

This is where we started

The Mental Welfare Commission (MWC) has functions and duties under both the Mental Health and the Adult's with Incapacity (Scotland) Act. (the AWI Act). Its stated purpose is to 'protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions'. To carry out its statutory roles, it focuses on five areas of work. These are 'visiting people; monitoring the Acts; investigations; information and advice; and influencing and challenging'.

It visits people in hospitals, prisons and, to a lesser extent, the community, and reports on what it finds. It provides advice to other bodies, professionals, service users and families. It investigates situations where there may be unlawful detention or a deficiency in care, and issues guidance on best practice. It can highlight issues of concern publicly, to services, or to Scottish Ministers. The MWC also monitors and reports on the use of the Mental Health Act and the AWI Act, and oversees treatment safeguards under both Acts. It does not regulate services and has few powers to order changes to happen, but its reports and guidance can have significant influence.

The MWC is a member of the UK National Preventive Mechanism, established under the Optional Protocol of the Convention against Torture, because of its role in visiting people in places of detention.

In 2020 the MWC did some research to explore what people thought of it. There were generally positive results in relation to perceptions of the MWC's trustworthiness, approachability, efficiency, effectiveness, and overall impact. However, the research highlighted lower levels of awareness and satisfaction with the MWC from service users with lived experience, families and carers, compared with professionals. It was suggested that the MWC could do more to challenge service providers, and be firmer and bolder in its dealings with services. It was suggested that the MWC should apply more pressure on services to implement recommendations and/or be granted greater powers to enforce change. However some professionals felt enforcement powers could change its relationship with professionals, and that the strength of the MWC lay in its approachability (Mental Welfare Commission, 2020b).

We wanted to explore ways in which the MWC's role could be extended to more effectively reflect our human rights framework. We discussed the way this should be done with our practitioner and lived-experience advisory groups, as well as with the MWC. We made preliminary proposals in our consultation.

These included making human rights more explicit as MWC's core remit.

As discussed in Chapter 6 part of a human rights framework is the possibility of judicial scrutiny of systemic failures to deliver on human rights. It is unrealistic to expect individuals to litigate such systemic issues and we felt the MWC could play a role in identifying such issues and taking them to court if necessary.

We also believe the Scottish Parliament has an important role in overseeing human rights and suggested strengthening the links between the MWC and the Parliament.

(Unlike the Scottish Human Rights Commission and the Commissioner for Children and Young People, the MWC is formally accountable to Scottish Ministers rather than to the Parliament.)

We also felt it was important that, like other scrutiny bodies, the MWC should do more to include people with lived experience in their work and governance, which may require changes to its legislation.

Whilst the MWC has always had a remit in relation to people in the community (including people on guardianship), much of its work focuses on hospitals. We suggested increasing its work in community settings was important.

This is what people told us

Most of the individuals and organisations who responded gave overall support for extending the MWC’s role in these ways. Some expressed support for specific proposals, with the most support given to increasing the involvement of people with lived experience. People asked that any changes be done alongside the wider review of the scrutiny landscape. Others voiced concerns about aspects of our proposals.

Support for the proposals: There was support from individuals and organisations for these proposals:

> ‘The role of regulators, scrutiny bodies and ombudspersons could be significantly enhanced by powers to provide consequences for non-enforcement. We support the proposals to extend the role of the Mental Welfare Commission in particular’ (Scottish Human Rights Commission).
>
> ‘The MWC has a unique, independent role in safeguarding and supporting the human rights of adults with mental or cognitive disabilities; its role should be extended and strengthened as proposed’ (Individual).

> ‘We would support the expansion of the Commission’s role and would urge it be given more substantive powers when it comes to compelling responses to its findings’ (Royal College of Psychiatrists)

Some responses focused on specific proposals. The most repeated support was for increased involvement of lived experience within the MWC’s work.

> ‘They should strengthen the requirement to include people with lived experience in the work and governance of the Mental Welfare Commission and engage with organisations representing people with lived experience. This would be an improvement.’ (Edinburgh Community Voices)

> ‘We strongly welcome the proposed strengthening of the requirement for greater lived experience in our work and governance as a means to ensure that the Commission remains focussed on what matters to the people who use services.’ (Mental Welfare Commission)

The need for more people with disabilities to be involved was specifically highlighted.

In addition to increasing lived experience involvement, people wanted to see a more diverse range of professional backgrounds involved in its work. An individual felt they currently appeared ‘quite heavy with both NHS and social work professionals’. The Law Society felt that in-house legal expertise would be necessary.

There was specific support for extending the work the MWC do in the community and for them to report to the Scottish Parliament.

A small number of responses suggested areas where the MWC’s roles could be strengthened further. A couple of responses said the MWC should be given powers similar to those of the Care Inspectorate. One person said giving similar power may give people using services more confidence in the MWC as people were well aware of the current differences between MWC visits and Care Inspectorate inspections.

Concerns about the proposals: A number of individuals were unable to support the proposals because of their opinion of the current effectiveness of the MWC. In the view of these respondents, the MWC does not do enough to challenge health professionals, and it was suggested that more powers were of little value because they did not use the powers they had.

Some organisations involved in social work and social care did not feel all these proposals were necessary. They felt some were already the responsibility of other regulators. There were also concerns if the proposals were to imply that the MWC would be able to direct local authority staff or interfere with the local authority’s role to determine local priorities. Social Work Scotland preferred a ‘joint approach to regulation and scrutiny . . . to increasing the scope and powers of anyone’.

People pointed out that any changes would take place within an already complex scrutiny landscape, and suggested that greater detail was needed on roles and responsibilities to avoid any potential duplication. While recognising the value of the proposals, SOLAR queried:

> ‘given the earlier comments about the crowded and fragmented landscape, whether it is premature to consider this, outside a more holistic review of the landscape in order to identify where indeed the aspects of the proposed extended remit should best sit.’

Inclusion Scotland did not think the MWC (or the Mental Health Tribunal for Scotland) should be monitoring whether neuro-diverse people or people with a learning disability are getting the support they need, unless they have mental health issues.

Some professionals were supportive of the proposals but would be concerned if they resulted in a change of relationship with the MWC.

> ‘As long as [the proposals don’t] affect the approachability of MWC. One of their strengths is they are there to help us (psychiatrists) get it right for our patients.’ (Individual)

> ‘The proposals for extending the remit of the MWC would support better governance and oversight of mental health services. The identified caveat of

> erosion of approachability for professional guidance is one that would be echoed, this is a current strength of the MWC that is highly valued by practitioners. The expansion of remit should not come while sacrificing what it currently does well'. (Social Work Services Dumfries and Galloway)

Moray Council did not want to see the Commission 'become a scrutiny body'. It said its current role 'in providing expert guidance' was 'highly valuable and practitioners would not like to see their function change'.

These are our final recommendations

The role of the Mental Welfare Commission

Our vision of a human rights-based legal and policy framework for mental or intellectual disability calls for a body which has the powers, expertise and credibility to safeguard the rights of individuals and influence the wider system. With some changes to its powers and operation, the MWC is well placed to undertake that role. It is already an influential and important body in the system with a focus on human rights. It is independent of services, and works across health and social care, and sometimes beyond.

The MWC has defined its purpose as being to 'protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions'. However, this is not set out explicitly in the Mental Health Act. Section 4 of that Act defines the MWC in terms of 'seeking to protect the welfare of persons who have a mental disorder' and promoting best practice in relation to the principles of the Act. We recommend that a human rights focus should be explicit in the founding legislation.

The MWC has always seen itself as having a focus on the individual person. At the same time, it has access to a huge amount of information about how the wider system operates, and many individual problems highlight wider systemic failings. Again, we think this role of influencing the wider system needs to be a clear and explicit function of the MWC.

We believe the MWC should continue to provide expert guidance and support to professionals. Ultimately, though, the MWC is ‘for’ people with mental or intellectual disabilities. It is important that it is seen by them as a trusted ally, while maintaining its independence, credibility and expertise.

The MWC has always played an important role in the AWI Act, including monitoring the operation of welfare guardianship. However, its statutory monitoring function only relates to the Mental Health Act. We think its role in relation to adults with incapacity should be made clear.

In the previous section we have discussed how we see the MWC playing a leadership role in a stronger and better co-ordinated scrutiny network. We are also making proposals related to the MWC in other parts of this report. For example, in Chapter 8 we discuss responsibilities for them within the legislative framework we are proposing for situations where a person may be deprived of their liberty. In Chapter 9 we set out proposals to broaden the safeguards operated by the MWC to review medical treatment of people subject to compulsory care as well as additional responsibilities to support the reduction of coercion. In chapter 13 we make recommendations for strengthening part 5 of the AWI Act and for fundamental reform of the current guardianship process, both of which will impact on the remit of the MWC.

The Mental Welfare Commission’s place in the system

As we set out above, we see the MWC as having a system leadership role in the network of scrutiny, with a particular focus on human rights. We do not believe it should become a regulator or inspectorate; those roles sit elsewhere in the system.

It does, however, need more ‘teeth’. Our model for this is closer to bodies such as the Scottish Human Rights Commission and Scottish Commissioner for Children and Young People than an inspectorate. It includes a new power to take public bodies to court where they have failed to observe human rights requirements, and other attempts to resolve these failures have not succeeded. We anticipate this should be developed on the model outlined in Recommendations 23 to 26 of the Human Rights Taskforce.

In some situations, the MWC escalates concerns about the actions of local services to Ministers, and this will remain an important tool, particularly with the development of the National Care Service. However, we believe it should be supplemented by a formal power to submit a report to the Scottish Parliament for the consideration of a relevant committee. This might include situations where its recommendations have not been implemented by services.

We believe reform may also include how the MWC uses some of its existing powers. We think there are opportunities to use powers of visiting, investigation and data collection creatively to interrogate and highlight a range of systemic issues. This may benefit from some reframing of the legislation which currently implies that the focus is always on an individual patient.

We also note that the MWC has never used its power in section 12 of the Mental Health Act to hold a formal inquiry with the power to take evidence on oath. We understand that this has never been felt to be necessary because witnesses in investigations have co-operated with the MWC. However, it may be a useful tool to highlight any areas of serious concern in future.

We make recommendation in the next section which include how the MWC should play a key role in improving the collection and sharing of data across the system to monitor outcomes for people.

Greater involvement of lived experience

We note and agree with the wide support for more involvement of lived experience in the work of the Commission. We note the changes the Commission has made in recent years to involve lived experience but believe these should go further.

Currently there is a requirement for one service user and one carer to be on the Board of the Commission. We believe this should be increased. We also believe the organisation should be moving to a position where the voice of lived experience has equal status to other relevant experience at a management level and in its engagement with other groups. The recommendations for supporting and developing collective advocacy later in this chapter should help with this.

Implications for the operation of the Mental Welfare Commission

We endorse the view that the MWC should increase its focus on community services. This is where the majority of people with mental or intellectual disabilities live, and a large proportion of those are subject to compulsory care. However, we do not believe it should reduce its regular visiting to hospitals, since no other independent organisation regularly visits people in detention in hospital.

We are clear that the MWC cannot fulfil the role we envisage on its current budget and with its current staff complement. It will require additional resources, and a planned evolution to a new model. The current cost of the MWC is around £4 million per year. We believe the additional resource can be justified.

We are sympathetic to views expressed that, as well as greater lived experience involvement, the MWC may need a wider range of professional expertise to discharge its new role, including legal and human rights expertise, and a wider range of professionals. This is an operational decision for the MWC so we have not made any specific recommendation.

We also feel that consideration should be given to a change of name. The MWC has existed under that name for 60 years, and it has recognition within the system, but it is less familiar to others, and does not give a clear sense of its role.

We recommend:

Recommendation 11.6: The powers and responsibilities of the Mental Welfare Commission should be strengthened in legislation. The changes we recommend are:

- **Its core remit should be to protect and promote the human rights of people with mental or intellectual disabilities. This should include both protection of the rights of individuals and promoting systemic change.**
- **The MWC should have a statutory responsibility to monitor the operation of the adults with incapacity legislation.**
- **There should be a substantial increase in the statutory requirement to include people with lived experience as service users, or family carers on the Board of the MWC.**
- **The MWC should strengthen the involvement of people with lived experience in their management, staffing and wider engagement, and should have a responsibility to co-operate with collective advocacy organisations.**
- **The MWC should increase its work in community settings.**
- **The legislation should include a level of accountability directly to the Scottish Parliament. This would include the power to make a report to Parliament if there is a serious failure by a public body, including the Scottish Government, to follow a recommendation.**
- **The MWC should have the power to initiate legal proceedings to protect the human rights of any person or group covered by mental health and capacity law.**
- **Consideration should be given to a change of name for the MWC to reflect its focus on human rights**.

11.2.3: Data Collection

This is where we started

Throughout our report, we make specific recommendations to improve the collection, analysis and use of meaningful data. This section looks at the overarching obligations we have to ensure we know whether and in what ways the legislation is working, or not, to respect, protect and fulfil our human rights.

The UNCRPD has already asked the United Kingdom to increase the availability of high quality, timely and reliable disaggregated data in respect of UNCRPD (United Nations 2017a).

The disaggregation of data allows us to understand the experiences and situations of different groups of people better. So, we need to be collecting the right level of data on relevant characteristics. The UN highlighted the specific need for data disaggregated by: income, sex, age, gender, race, ethnic origin, migratory, asylum-seeking and refugee status, disability, and geographic location. Having such data available and appropriately scrutinised is critical to identifying discrimination within our systems which can otherwise be hidden.

We said we were considering the need for additional proposals around this. We did not ask a specific question. A small number of responses addressed it though.

This is what people told us

People agreed that datasets should be disaggregated. Disaggregation needs to include nationality, asylum status, carers, disability and address intersectionality. Also the Scottish Government should be required to show how datasets are being used.

> ‘Data collection should be transparent. It must be efficiently processed and made available through services like the Equality Evidence Finder . . . it should Identify which groups are particularly affected and allow for better analysis and action on the underlying inequalities contributing to the disparities for BME people in mental health settings.’ (Commission for Racial Equality and Rights)

> ‘The need for equality data and more meaningful monitoring is extremely important in fulfilling PSED (Public Sector Equality Duty) requirements and in order to clearly understand how the system is working for all of its patients,

> and what improvements can be made.' (Equality and Human Rights Commission)

The Forensic Network supported the need for further data to provide clear evidence for service improvements, and to understand how different groups may be affected by mental health practices. Autism Rights wanted transparently available data on what 'what is happening to autistic people treated under the Act'.

Our practitioner reference group were supportive of robust monitoring of mortality of people with mental illness. They recognised the need for this to be disaggregated to capture the different impact on different groups, like people with learning disabilities. This is because of the known data around people with mental illness dying significantly earlier than the general population.

Our final recommendations

We consider that, to deliver a human rights-based approach, we need to gather information that allows us to do three key things.

- We need data to evidence the extent to which our mental health and capacity legislation and services do, or do not, ensure people's human rights are protected, promoted and realised and effecting positive change. This includes knowing how and why specific aspects are working, or not.
- We need to collect information which allows us to report meaningfully (and act) on how well we are doing in terms of the progressive realisation of rights for people with mental health issues and meeting minimum core obligations.
- We need data that routinely allows us to identify any discriminatory impact of our mental health and capacity law and services on different groups. This will allow us to address such impacts in timely and transparent ways.

This is because the Scottish Government's planned direct incorporation of the UNCRPD into Scots law will place legal requirements on the Scottish Government and public authorities to 'collect appropriate information, including statistical and research data, to enable them to formulate and implement policies'. This is what is required of States by Article 31 of the UNCRPD. Article 31 also requires this information is to be used to help assess the implementation of our obligations under the UNCRPD and to 'identify and address the barriers faced by persons with disabilities in exercising their rights'. It also includes a duty to ensure the accessibility of these statistics to persons with disabilities and others.

The UNCRPD and other treaties can be interpreted with reference to General Comments and to Concluding Observations on the UK and other states, documents which often provide guidance on requirements for the collection and use of data. As we said above, the UN Committee on the Rights of Persons with Disabilities has already asked the United Kingdom to improve the extent to which the data we do collect can be disaggregated to identify discrimination in the system (United Nations 2017a).

The Scottish Government has set up the Equality Data Improvement Project Board that is looking at the challenges and gaps in collecting, analysing and reporting intersectional equality data. This disaggregation by equality characteristics helps us to understand who the system is working for and for whom it is not. It will uncover unconscious biases within the care and treatment people receive. It would also be useful to be able to combine datasets to identify intersectional impacts.

We need to avoid an increasing number of indicators and measures developed by different bodies with no central organising principle or links to outcomes. We need to move away from simply collecting what is easy to collect, or what is important for the services, to what is important for the people who use the services. The value of qualitative data needs to be recognised in this.

We also need to be clear what we should be collecting disaggregated data about. We need to be monitoring and collecting data on things that are meaningful to people. It needs to reflect outcomes that people value. We also need a framework to monitor the effectiveness of the new legislation. There were calls for greater leadership around this area. The MWC wanted a duty that went beyond only monitoring. They want to be able to determine what actually needs to be monitored and require organisations to work together to provide data needed to make changes to the system. We agree this should happen.

The way data is gathered also needs to be more accessible, transparent and consistent. We heard that different bodies across the system are sitting on large pockets of data that cannot be accessed easily and are not routinely published or analysed; as such, data can remain locked in systems. There is a lack of consistency in definitions being used across public sector datasets for mental health. People are measuring different things, and the same things in different ways. There are also issues around assuring the quality of data collected. There is work already underway to try to improve accessibility, including work being done by Research Data Scotland. The structured datasets of Public Health Scotland provide an example of how data can be collected and made available in a way that allows it to be analysed.

There are legitimate concerns among the public about collection, sharing and general use of their personal and sensitive data. There is a need to build public confidence in the way that data is to be used. This requires us to have answers to the questions about why we are collecting what we are collecting. What do bodies that collect this type of data do with it? It is of no use to value to collect data if it cannot be then used by some body to effect change.

We have specific data collection, monitoring, and research related recommendations within relevant sections of other Chapters in this Report. One of our first recommendations is for the Scottish Government to enforce the existing duty [on public bodies] to collect appropriately disaggregated data on protected characteristics (see Chapter 1). Other recommendations are about whole system changes. For example in chapter 6, where our recommendations support the realisation of our economic, social and cultural rights and ensure systematic processes to monitor whether our obligations around core minimum obligations, progressive realisation and non-regression are being met.

We also have specific data collection, monitoring, and research related recommendations to make sure we can understand and scrutinise particular aspects of the legislation better. We are recommending ways in which the scrutiny, collection, recording and reflection on coercive treatment and practice must be strengthened. This includes setting up a national register of restraint. We also consider that the continued use of community-based compulsory treatment orders must be supported by enhanced research, monitoring, inspection and individual scrutiny of these orders (see Chapter 9). The need for additional research to ensure ongoing understanding and support continued innovation is also reflected in a number of our recommendations.

Here we recommend two overarching statutory duties to further support the degree of oversight needed to fulfil our human rights obligations in respect of monitoring, understanding and transparently reporting on the impact of our legislation. These build on the Section 114 duty in the Public Services Reform (Scotland) Act 2010. This is the duty on scrutiny bodies to co-operate and co-ordinate activity to improve their scrutiny functions.

We suggest work to improve data collection generally should be led by Public Health Scotland, working with the MWC and others. We are clear that there needs to be leadership to drive the necessary collaborative working. We think Public Health Scotland seem well placed to undertake this role. However, the question of leadership is more important than who it is, and we would be comfortable with the MWC or another body having the lead role.

We recommend:

Recommendation 11.7: There should be a duty on Public Health Scotland to actively lead work with the Mental Welfare Commission, groups representing people with lived experience, other agencies holding data and the research community to determine what needs to be monitored across mental health services to ensure human rights obligations are being met.

Recommendation 11.8: There should be a duty on organisations holding data, including Public Health Scotland, the Mental Welfare Commission, the Care Inspectorate, Health Improvement Scotland, the NHS, the Office of the Public Guardian, local authorities, Police Scotland, the Scottish Prison Service and any other relevant organisations to work together to gather and make available the structured, disaggregated, researchable data needed to monitor mental health services effectively and drive change.

11.2.4: The Mental Health Tribunal for Scotland

The Mental Health Tribunal for Scotland (the Tribunal) is a judicial body. It was created under section 21 and Schedule 2 of the Mental Health Act. It is responsible for making decisions about compulsory treatment under that Act. The Tribunal decides whether compulsory measures are justified or not and considers appeals. It has seen a year on year increase in applications over the last ten years. In 2020/21, it received over 5000 applications (Mental Health Tribunal for Scotland 2021). It will move from being a stand-alone Tribunal soon, as it is due to become the Mental Health Chamber of the First-Tier Tribunal for Scotland within the Scottish Courts and Tribunals Service.

The United Nations has issued warnings about assuming mental health tribunals are effective accountability mechanisms for protecting human rights. In his report in 2017, the Special Rapporteur for the right to health was concerned about:

> ‘The growing prevalence of mental health tribunals, which instead of providing a mechanism for accountability, legitimize coercion and further isolate people within mental health systems from access to justice.’ (United Nations 2017b)

We are recommending extensions to the role and powers of the Tribunal throughout our report. In Chapter 3 we are proposing ultimately to expand its jurisdiction to include Adults with Incapacity Act cases. The Tribunal is identified as a key accountability mechanism for some of our new processes around Human Rights

Enablement, Supported Decision Making (SDM) and Autonomous Decision Making (ADM) (see Chapters 4 and 8). We propose the strengthening of existing powers in our Forensic recommendations in Chapter 10 and later in this Chapter. As such, we need to be confident that it is, and will continue to be, an effective accountability mechanism for protecting human rights.

This is what people told us

Our Executive Team Member, Professor Stavert was one of the authors of a review of international literature on research into experiences of mental health tribunals. (McGregor, Brown & Stavert 2019). This review suggested that Mental Health Tribunals generally may need to do more to safeguard legislative principles and human rights standards that promote a person's autonomy. This work was part of a wider project to capture the views and experiences of people involved in the Mental Health Tribunal in Scotland (the project). This included the voices of patients, named persons, practitioners and Tribunal panel members. Its findings and recommendations were published in September 2022 (Stavert, Brown & McDonald 2022).

The project found a determination on the part of members of the Tribunal and professionals to give effect the Mental Health Act principles and rights of patients. However, there were also frustrations relating to the way that resourcing issues across the mental health system could weaken their ability to do this. It also identified some key barriers to meaningful participation. These included power imbalances within the Tribunal, the power of the medical domain, and feelings of powerlessness on the part of those whose Tribunal it was. The project report provided a number of recommendations for the Tribunal and the Scottish Government. It also recommended that this Review include a number of recommendations for subsequent legislative and policy reforms.

Across our consultations we asked a number of questions about extending or changing some of the functions and powers of the Tribunal. We did not ask specifically for people to tell us what they thought about the Tribunal itself. The majority of responses welcomed strengthening the powers of the Tribunal. However, a small number of responses were reluctant to trust this body with more powers.

The main concerns echoed those of the project around the ability of people to meaningfully participate and be heard in Tribunals. The Royal Society of Edinburgh's response was from a group of people with varied perspectives. If the Tribunals powers were to be increased, they sought reassurance about the Tribunal's culture:

> 'It was argued that the tribunals do not always get it 'right,' and users have reported a failure to understand the views of those who access their service . . There is therefore a need for reassurance that the Tribunal's culture will not impede effective decision-making nor infringe on service users' rights.'

The ALLIANCE felt Tribunals, while meant to be more informal, often 'operate at the "sharp" end of the law'. They felt Tribunals were often treated as a 'tick box' exercise, rather than listening meaningfully to both the person receiving treatment, and the practitioners. The Challenging Behaviour Foundation described the Tribunal process as 'difficult and deeply flawed'.

> 'The Tribunal process is difficult and deeply flawed. Those working with the Tribunal often lack the necessary expertise around learning disability and autism and are often risk-averse.' (Challenging Behaviour Foundation)
>
> 'Processes are inevitably set up on the assumption a person can hear and speak, and not from the perspective of a Deaf sign language user.' (British Deaf Association Scotland)

A small number of responses spoke about the composition of the Tribunal Panel. Each Tribunal sits as a three-person panel. There is a legal member who chairs the Tribunal, a medical member and a general member. The medical member is a psychiatrist. The general member can be a person with lived experience, a carer, or other professionals with mental health experience.

Thrive felt the composition of the Tribunal panel should be reconsidered. They were looking for a more 'holistic skill mix'. They suggested a four-member panel: legal, medical; carer/lived experience; and another health or social care professional. One individual quoting the Special Rapporteur criticised the presence of a medical member on each panel. They said this meant the Tribunal ‘could not be impartial and so patients cannot be guaranteed a fair hearing’. The Royal College of Psychiatrists also addressed this issue. They were looking for greater participation of general and lived experience members. They also argued strongly for psychiatrists be retained as members.

Autism Rights pointed out the lack of ‘consistent panels’ can lead to ‘them overturning their own decisions’. They also did not think the Tribunal should be given more powers over autistic people, ‘in light of parents’ experience of the system’.

Our final recommendations

The Mental Health Tribunal for Scotland is one of the routes that protects our human rights. As with all these routes, we should not become complacent about its effectiveness to achieve this. The participation of the Tribunal in the recent project on the views and experiences of it by those who attend and sit on Tribunals indicates its own commitment to this.

The project conclusions mirrored the concerns raised by a small number of respondents to our consultation around increasing meaningful and inclusive participation for patients, their unpaid carers and other representatives. Their recommendations to the Tribunal reflect improvements that can be made in this area. They align with the human rights approach that underpins this Review and would further support our recommendations, for example around independent advocacy and specialist support in legal and administrative proceedings. The project recommended that the following be included in our recommendations:

- The reinforcement of UNCRPD requirements in legislation.
- The review of the status and position of recorded matters by placing a statutory enforceable duty on NHS Boards and local authorities for compliance.

- Establish a statutory mechanism to raise, monitor and respond to general issues other than recorded matters arising during the Tribunal processes and hearings.
- Evaluation of existing and alternative measures for supporting participation in the Tribunal processes by patients and named persons, including the role of advance statements.
- The review the role of named persons and the availability of legal representation.
- The review the role and efficacy of curators ad litem.
- A statutory duty on clinical teams to consider alternatives to compulsory psychiatric care and treatment.

They further recommended that these should be reflected by the Scottish Government in subsequent legislation and policy reforms.

The project reported with its recommendations after the consultative phases of our Review were over. We have however considered them in light of the conclusions we had reached separately as a result of the engagement processes we undertook and the further evidence this project's work has provided. We consider that:

- All our recommendations seek to reinforce UNCRPD within our legislation.
- We are recommending changes to recorded matters later in this Chapter including an additional accountability mechanism for compliance.
- The introduction of the Human rights enablement approach in Chapter 8 and our recommendations about recorded matters both extend the matters which the Tribunal can raise, monitor and respond to.
- In our Supported Decision Making (SDM) Chapter (see Chapter 4), we make recommendations to reform the advance statements model.
- We make recommendations on specialist support in legal and administrative proceedings for improving the experiences and clarifying the role of named persons and curators ad litem (see Chapter 5).

We also support the report's recommendations for the Scottish Government to reflect these recommendations in subsequent legislation and policy reforms.

As with the recommendations for the Tribunal, these align with the human rights approach that underpins this Review. They would complement and support our recommendations, for example, around increased community based services, independent advocacy, access to effective legal representation and informed participation.

We recommend:

Recommendation 11.9: The Scottish Government and the Mental Health Tribunal for Scotland consider and respond to the recommendations of the research project: Mental Health Tribunal for Scotland: the views and experiences of Patients, Named Persons, Practitioners and Mental Health Tribunal for Scotland members.

11.3: Remedies and access to justice

As we said above, international human rights instruments require routes to remedy for breaches of human rights to be accessible, affordable, timely and effective. As part of this, it is important that people do not always have to go to court to seek redress. But there needs to be an ultimate right to access to the courts which equally meets these human rights standards.

A report by the Mental Welfare Commission in 2019 explored the difficulties people with mental ill health have getting legal representation. The biggest barrier is a person's mental health condition itself. It can impact on the ability to organise, understand or participate in legal processes. Other barriers included lack of solicitors with adequate understanding of mental health legislation. This was an issue especially in remote and rural areas. In their response to our consultation, the Medical and Dental Defence Union of Scotland felt it highlighted the need for improved education of all professionals involved in mental health care, including solicitors.

The Law Society for Scotland also pointed to the general ‘lack of proper access to justice in terms of funding arrangements’. Although legal aid is available on a non-means tested basis for most mental health hearings, and for applications for welfare guardianship, we understand there are gaps in the system, particularly where the more restrictive provisions of Legal Advice and Assistance apply. The Law Society has also raised concerns about a restrictive approach in legal aid regulations and practice to necessary work, particularly in cases under the Adults with Incapacity Act. We are also aware of concerns that expert legal representation under the legal aid scheme may not be easily available across Scotland.

The National Taskforce for Human Rights Leadership recommended a new statutory framework to ensure our judicial remedies meet the human rights standards. We anticipate that will be part of the Scottish Government’s new Human Rights Bill. The framework should work for everyone. Within that, account should be taken to address the specific barriers faced by people with mental or intellectual disability.

We recommend various new legal remedies in this report. We believe the principle of non-means tested legal aid representation should apply to all of them.

These are our final recommendations

We recommend:

Recommendation 11.10: Individuals who are subject to or wish to initiate legal proceedings under our proposals, or their carers or representatives, should have access to non-means tested expert legal representation. The Scottish Government, working with the Scottish Legal Aid Board and the Law Society of Scotland, should ensure that there is an adequate supply across the country of expert legal advice and representation.

11.3.2: Investigating Deaths

This is where we started

In 2018, the Scottish Government completed its review of the arrangements in place to investigate the death of people who are under compulsory care and treatment at the time of their death. It covered people who died in hospital and the community. Its report found that investigations were not carried out in a consistent way. Investigations were not guaranteed to be independent. Carers and families spoke about the unacceptable time it took for these investigations to be carried out.

These investigations are about protecting our right to life (Article 6 of the International Covenant on Civil and Political Rights , and Article 2 of the European Convention on Human Rights. This right is incorporated into UK law by the Human Rights Act (1998). Public authorities are required to protect life, especially for people whose liberty is restricted. Deaths of people whose liberty is restricted at the time of their death must be subject to a proportionate level of scrutiny. An effective investigation must also take place where it is possible the State was responsible. The Equality and Human Rights Commission has provided a framework to help organisations meet this obligation. It set out the human rights-based requirements based on judgments from the European Court of Human Rights. It also provides a checklist for how effective investigations into these deaths should be carried out.

The MWC was asked by the Scottish Government to develop a system for investigating these deaths. They consulted on their proposals earlier this year. Since our own consultation, they have now submitted their final report to the Scottish Government. It sets out their proposals for these investigations. The MWC has also set out proposals for improved investigations of mental health homicides and is awaiting the Government's response.

Alongside this, HM Inspector of Prisons for Scotland, the Chief Executive of Families Outside and the Chair of the Scottish Human Rights Commission concluded a review of responses to deaths in prison custody. The investigation of these deaths is already treated differently. There must be a Fatal Accident inquiry into the death of anyone in custody. Their final report recommended a new independent body to conduct timely reviews of every death in custody.

We said we would consider the MWC's proposals to ensure they meet the human rights requirements for such investigations. We did not ask a specific question about investigating deaths. A small number of responses did, however, address this issue.

This is what people told us

The Scottish Human Rights Commission and INQUEST both highlighted the responses they had made to the MWC consultation, feeling that the MWC proposals needed to be strengthened. They felt this was needed to fulfil the procedural requirements of Article 2 ECHR. In particular, the proposal that the majority of investigations would still be carried out by the local service was not felt to meet Article 2 requirements of independence.

The Scottish Human Rights Commission felt that the MWC 'appeared to have the necessary degree of institutional and practical independence' to meet these requirements if it was the MWC itself doing the investigations. However, to meet the Article 2 requirement they would need to be the body carrying out more of the investigations. INQUEST however queried whether - even if they were doing the investigation - they would be 'seen to be sufficiently independent'. They described the MWC's close working relationship with the NHS and having staff drawn from the NHS. They felt this would make it difficult for them to take an independent objective view.

The Scottish Human Rights Commission wanted as far as possible the same level of scrutiny recommended by the review into deaths in prison custody to be applied to deaths in mental health detention. If the MWC is to be the independent body investigating these deaths, they felt it must have the same functions and remit as the new investigatory body being proposed for deaths in custody. This would include, for example, the timescales for investigation, the parties that must be involved in an investigation, and related complaints/appeals processes. They state that all these should be set out in statute and explicitly linked to human rights standards. INQUEST were of the view that an independent investigatory body should be set up. They felt it ‘iniquitous that the death of those in mental health detentions should not receive the same independent scrutiny as deaths in prison’.

Alongside independence, the requirement for carers and families of people who have died to be able to participate meaningfully in these investigations was also emphasised. Transparency, compassion and empowerment were critical to this process. There is a need for more data and transparency around these deaths to allow for greater public scrutiny. This data needs to be appropriately disaggregated by age, gender, disability, cause and place of death. INQUEST also called for the duty to investigate to be extended to voluntary patients.

The MWC reported that they are waiting for a response from the Scottish Government on its proposals. They feel these proposals are proportionate, human rights compliant and offer the opportunity for learning and improvement. They feel they already have a wide range of investigatory powers under section 11 and section 12 of the Mental Health Act to support the proposals. They wanted the Review to consider some additional ways in which their role could be strengthened.

They wanted greater clarity that their power to request information and co-operation from other authorities extends to many organisations including the police and Crown Office and Procurator Fiscal Service. They felt the language around these sections needed to be updated to take into account the changes in the health and social care landscape in recent years.

Healthcare Improvement Scotland said arrangements must be in place to avoid duplication or overlap of investigations, and to be mindful of the impact on families and other individuals involved. They pointed to their role alongside the Care Inspectorate in co-hosting the National Hub for Reviewing and Learning from the Deaths of Children and Young People. Since October 2021, reviews are conducted into the deaths of all live born children (up to aged 18, or 26 for care leavers who are in receipt of continuing care or aftercare at the time of their death). Some deaths while under compulsory care and treatment may also fall within the review criteria for the National Hub.

These are our final recommendations

We want to be sure that any new arrangements put in place to investigate the death of people who are under compulsory care and treatment at the time of their death meet the human rights-based requirements for such investigations. However, we do not want to hinder the improvements to the system currently being proposed by the MWC and considered by the Scottish Government. In their report to the Scottish Government the MWC consider these human rights requirements and offer responses to the challenges people have made around these.

We believe the MWC's proposals are a considerable advance on the current system. The only alternative would appear to be a greater use of Fatal Accident Inquiries (FAI) for deaths while a person is detained under mental health law. Although this would meet the requirement of independence, we are aware of the problems already faced by the FAI system, including in investigating deaths in custody.

However, we are not convinced that the MWC proposals are the last word, particularly with respect to the requirement for independence. We are guided by the European Court of Human Rights that these investigations should be independent of 'those implicated in the events' (European Court of Human Rights 2022). Our concerns do not relate to the independence of the MWC but to the proposal that many of the investigations will still be carried out by services. We also feel that while the MWC may have the necessary powers to investigate the deaths of people under compulsory care and treatment, the role for them to do so should be explicitly set out in law. Key indicators of the success of the new proposals will be the degree to which the families of those who have died are involved and experience the process as being independent and effective. The timeliness of these investigations must also be closely monitored.

We therefore believe it will be important to review the operation of the new system. We appreciate in 2013, the court in England ruled that having different standards for the investigations of deaths of people in custody and people who are under compulsory care and treatment is not discriminatory under European Convention on Human Rights (R (Antoniou) v Central and North West London NHS 2013). However, it may be that case law will begin to move more towards compliance with UNCRPD. This may make having two separate systems not only problematic but arguably not compliant with human rights standards. Therefore, in due course, if the proposed new system for investigating deaths in custody does more fully and effectively meet human rights standards, there would be merit in considering how the two systems could be aligned.

We recommend:

Recommendation 11.11: The Scottish Government make a timely response to the Mental Welfare Commission's proposals to allow improvements to be made to the investigation of deaths of people under compulsory care and treatment as soon as is practical.

Recommendation 11.12: The Scottish Government should ensure that the role of the Mental Welfare Commission in investigating these deaths is explicitly placed in legislation.

Recommendation 11.13: The Scottish Government should ensure there is a mechanism to monitor and review the investigations into these deaths using the experiences of the families of those who have died as a key measure.

Recommendation 11.14: The Scottish Government should ensure that the development of any independent body to investigate deaths of people in custody and the development of the proposals for investigating deaths of people under compulsory care and treatment progress together to ensure

opportunities for further alignment and equity between the two processes are not missed.

Recommendation 11.15: The Mental Welfare Commission's powers to request information and co-operation from other authorities should be amended explicitly to cover any organisation with which it needs to collaborate for the purpose of these investigations.

11.3.3: Recorded Matters

This is where we started

As explained earlier in this Chapter, the Mental Health Tribunal for Scotland (the Tribunal) is the judicial body responsible for making decisions about compulsory treatment under the Mental Health Act. One of the things it can do is make something called a 'recorded matter'. This power to make recorded matters is in Section 64(4)(a)(ii) of the 2003 Act.

Recorded matters are intended to support the Mental Health's Act's principle of 'reciprocity'. This is about making sure that someone who is required to accept treatment gets the services they need in return. If a part of someone's care or treatment is a 'recorded matter' and it is not being provided, then their Responsible Medical Officer must let the Tribunal know about this. The MWC also has a general power to refer a situation like this to the Tribunal (Mental Welfare Commission, 2009).

In 2020, the MWC raised concerns about how effective this power was (Mental Welfare Commission, 2020a). When looking at the experience of people with learning disabilities in hospital they found a lot of people whose discharge was delayed. They also found a small number of examples where the Tribunal had made a 'recorded matter' about this. However, it did not always make a difference. A

Tribunal in 2014 made a ‘recorded matter’ to identify accommodation and support for someone within six months. This had still not been done when they checked on it six years later.

We want to strengthen this power. In our consultation paper in March 2022, we asked for people’s views on our proposal that:

> The Tribunal should be able to require NHS boards, local authorities and integration authorities to provide such care and support as may be required to:
>
> - avoid the need for an individual’s compulsion; or
> - ensure that compulsion respects the human rights of the patient.

At the moment the Tribunal can only make recorded matters in civil cases. This is one of main differences between a compulsory treatment order and a compulsion order. As well as proposing strengthening this power, we also thought that it should be available when considering the cases of people on criminal mental health orders (forensic orders). We asked what people thought of this in our consultation paper in June 2022.

This is what people told us

There was support for strengthening recorded matters in the ways we proposed. Some supportive responses also pointed out additional requirements to make it more effective. Concerns were also raised about the proposal. There was wide support for recorded matters to be available when considering the cases of people on forensic orders.

Support for the proposal: Individuals supporting these proposals said they were ‘long overdue and much needed’, ‘would reinforce reciprocity’ and ‘give people more confidence in the Tribunal’. Others pointed out how recorded matters can be helpful in brokering care, planning for discharge, and ensuring progress for people who are ready to leave hospital.

Advocacy groups supporting the proposals called for the powers to go wider than they do now. This is because recorded matters are only available to people under civil orders at the moment. They are not available to anyone on a criminal order, e.g. a compulsion order.

> ‘We agree that recorded matters should be strengthened and welcome the possibility that the tribunal could require public bodies to provide such care and support. They should be extended to all orders, including those that originate from criminal justice.’ (AdvoCard).

The Law Society for Scotland wanted an equivalent process to be introduced for people under Adults with Incapacity law. They also highlighted that recorded matters which had not been complied with may not be looked at again by the Tribunal for two years. An example of this would be when the Responsible Medical Officer does not bring it back before the two year review, and a person cannot instruct a solicitor to do so. They felt this was not human rights compliant. To meet this gap they recommend the creation of a role in Scotland equivalent to the Official Solicitor in England, applicable across civil process in Scotland.

See Me agreed these proposals were a ‘way of strengthening an individual’s right to access specific care’.

Support alongside calls for further action to make the power effective: There were individuals and organisations who supported the proposals but pointed to additional things that would be needed if they were to really be effective.

The first main suggestion was that any strengthening of recorded matters powers should include a clear way to enforce them. Currently there is no sanction if a recorded matter is not complied with. We proposed allowing the Tribunal to require a relevant body to provide what is needed for an individual. However, responses called for more clarity on what would happen if this was not complied with. There needed to be enforcement and appeal mechanisms.

> ‘The power to require the provision of care and support to avoid the need for compulsion could provide an enforceable right to voluntary treatment, where

> that has been unreasonably denied. This could guarantee the right of people with a mental illness to access services in the least restrictive environment, to be actively engaged in determining their treatment, and to be assisted in social reintegration. We would, however, like to see clarity on the consequences for non-enforcement of an order of the Tribunal.' (Scottish Human Rights Commission).

While supporting the proposal, the Royal College of Psychiatrists added that it was critical there were also 'duties about what happens when a recorded matter is not fulfilled [and] and an escalation process … to address why this has not happened.' The Mental Welfare similarly highlighted the need to know what would happen if a recorded matter was not actioned. They used the example of excessive security appeals which can remain unresolved for a long time, and lead to additional costs and protracted legal challenges.

People also wanted to know where responsibility for non-compliance would lie. While it can be the Responsible Medical Officer who is facing the Tribunal, people were keen it should not necessarily be them who should be responsible for meeting the requirement. This is because the power to authorise what needs to be done often lies with others. People also felt there needed to be an appeal process against any direction by the Tribunal.

The second main issue people raised was about the need for increased funding.

> 'Additional resource must be available for this proposal to be most effective and ensure that individuals get the resource they need. However even if additional resources are not available, the proposal could at least result in improved transparency and accountability of decision-making by authorities regarding allocation of resources (however an improvement in the rights of the individual would not be achieved).' (Midlothian Health and Social Care Partnership).

The Care Inspectorate agreed that a human rights-based approach should allow people subject to compulsory orders, or at risk of them, to access necessary treatment and support. But they highlighted consideration of ‘increased resources to support availability’ would be needed. They also wanted recorded matters to remain in place for as long as they are necessary. They currently only remain in place as long as any compulsory measures remain in place. The Challenging Behaviour Foundation welcomed these extended powers but wanted some guarantee they would be strong enough ‘to operate in the face of local authority pushback/excuses’.

The support of some responses was dependent on making improvements to allow people to participate more meaningfully in the process.

> ‘All service users should be able to participate in their own tribunal and should be involved in the discussion of what recorded matters are being considered by the tribunal for them and why ... [we] call for all service users, their carers, or people that support to be able to access information on what a recorded matter is and what it means for them.’ (Support in Mind)

> ‘[There is a] need to provide an appropriate level of additional support such as advocacy and carer support to help a person to submit evidence and make the best possible argument for their case.’ (Mental Health Network Greater Glasgow)

> ‘We would like to see the Mental Health Tribunal have increased powers to order that specific care and/or support be provided for a person. However this is set against the need to provide an appropriate level of additional support such as advocacy and carer support to help a person to submit evidence and make the best possible argument for their case.’ (Mental Health Network Greater Glasgow)

The Royal College of Physicians wanted the process simplified. They wanted it to be accessible ‘in a timely way’. Some of the professionals needing to use these provisions also said they were not easy to find in the legislation.

Concerns about the proposals: A number of responses were concerned about the impact that this new duty would have on an already complex and resource-limited landscape. Responses highlighted that currently professionals often support the need for the care and treatment needs set out in recorded matters. This issue that needed to be addressed therefore was the significant gaps in provision. Without addressing resources, people were concerned the proposal would at best be ineffective.

> ‘There are occasions where resources are limited and despite best efforts, there is little that practitioners or services can do to provide specific care and/or support for patients; increasing powers within legislation will not solve issues relating to resource and service provision in the short-term.’ (Forensic Network)

At worst, some argued the proposals could lead to unintended negative consequences. One such consequence was the creation of a perverse incentive to seek compulsion to gain resources through this route.

> ‘While a legal mechanism to ensure the care specified in an order is delivered could be critical to ensuring a patient could realise their rights, without wider increase in resources available to services, it is unlikely to be effective . . . Provision of a route to ‘guaranteed’ service provision for detained patients, if not available to voluntary patients, could also provide a ‘perverse incentive’ to encourage patients to place themselves under formal measures.’ (Royal College of Psychiatrists)

Another concern was the potential impact of these proposals on limited local authority resources. Respondents from this sector spoke about the realities of having to balance the rights of one individual’s needs against the rights of others when allocating resources. They were concerned about the redirection of services. They fear it could introduce or exacerbate inequalities among different vulnerable groups.

> ‘Granting powers to direct the provision of services for one vulnerable group over others creates competition, prioritisation of resources toward one group, and may result in increased unmet need in other areas where local authorities should be promoting welfare. We would suggest that there is little point in legislating for increased powers to order specific care provision without also providing additional finance and other resource to improve community-based support.’ (Social Work Scotland)

> ‘That the Tribunal be able to require such care and support to prevent the need for compulsion [would] require such a huge mobilisation of resource to support an individual that it might jeopardise the care and treatment of many others who are not subject to the safeguard of a tribunal adjudicating on what resources ought to be committed to prevent compulsion.’ (Mental Welfare Commission)

People questioned the effectiveness of an additional layer of bureaucracy and administration on an already stretched workforce. They said it could create ‘requirements’ that ‘were simply unattainable’. We were told that a greater impact would be made by better resourcing services and the workforce (Social Work Services, Dumfries and Galloway). SOLAR suggested the need for a national strategy to identify the level of need and resources required and to then provide this level of resource. The MWC suggested that giving people a sense of what they can expect from services through core minimum obligations and standards would be more appropriate. Social Work Scotland suggested the Equality and Human Rights Commission’s Human Rights Framework for Adults in Detention as a basis for both good practice and to outline quality standards that individuals who are detained can expect.

Other concerns were that services may rush to satisfy the recorded matter to the detriment of an individuals needs or that recorded matters may reduce the flexibility of services to respond innovatively at a local level.

Responses on limits to what can be directed: We asked whether there should be any limits placed on what the Tribunal can direct. Only a small number of responses directly addressed this. There was agreement between the Royal College of Psychiatrists and the Forensic Network that the Tribunal should not be able to direct specific treatments or care for people. Mental Health Network Greater Glasgow felt the determining factor in any limits should be, ‘the harm relating to not receiving the service’.

Responses on extending recorded matters to forensic orders: Almost all respondents agreed with the proposal that recorded matters should be available when considering people on forensic orders.

Alongside the support of individuals, one person said this is what, ‘should always have been’. The Forensic Network agreed these would be ‘particularly helpful in establishing and recording efforts of local authorities to find appropriate accommodation in the community’. Other organisations supporting this proposal included the MWC, Royal College of Psychiatrists, the Scottish Association of Social Work, Edinburgh Health and Social Care Partnership and the Law Society of Scotland.

Advocacy groups also agreed:

> ‘Recorded matters should absolutely be extended to allow for inclusion of forensic orders. Given a recorded matter is often used to gather further information or to ensure answers are provided to vital questions, there seems to be no reason why this should not be available to all individuals who approach the mental health tribunal system.’ (Patients’ Advocacy Service)
>
> ‘Recorded matters can be very helpful in progressing someone's care and treatment. To have them for some patients, and not others seems discriminatory and unfair.’ (AdvoCard).
>
> ‘Forensic patients have long expressed a frustration at the differences between the civil and forensic orders such as the lack of SIDMA test (see chapter 8) and the lack of recorded matters. Any move towards removing these disparities would be welcomed.’ (Independent Advocacy Perth & Kinross).

These are our final recommendations

Most responses recognised the need for, and intention, behind these proposals. The key issue raised was whether they would make any difference in the face of current resource constraints.

We know that constraints on resources mean services cannot always delivers what they would like to. When proposing the strengthening of recorded matters, our Practitioner reference group explained how care and treatment options are necessarily limited by resources. They highlighted a tension between what is required to deliver the most appropriate option and what can be resourced or delivered. As such, the ‘least restrictive option’ set out in the Mental Health Act often means in practice ‘the least restrictive option available’.

We know that resources and services will be key to the success of many of the changes we are proposing. However, these proposals do not stand alone. They are part of the wider aim of ensuring that the full rights of people with mental disabilities are realised. A system which guarantees procedural rights around compulsory care but does not secure appropriate care and support for those required to accept care which they have not chosen is not a human rights-based system. The principle of reciprocity as we discuss in Chapter 3 must be more than a vague aspiration – ultimately it needs to be enforceable.

We were also struck by the fact that in many cases the cost of the service which would meet the person’s needs - and may reduce the need for compulsion - is not greater than the cost of continued detention in hospital. Resources are already being spent on these patients – just on the wrong things. This was highlighted, for example, in the Coming Home Implementation Report in relation to people with learning disabilities and complex needs.

We understand the concerns people have about the potential for perverse incentives and increasing inequality by bolstering the system for this particular group of people. We know professionals are put in the difficult position of having to balance the rights of different people on a daily basis. But the state cannot have it both ways – once it takes on responsibility for decisions about someone’s life, it owes a particular duty to respect and fulfil their rights.

In any system however, of course, resources are finite. As such, there must be yardsticks against which the Tribunal can measure any use of its power to direct services in the way we propose. These should provide people with a clear idea of what they can reasonably expect.

This will be linked to the way in which we propose economic, social and cultural rights can be evaluated more generally. As now, the power to make a recorded matter may initially be to ensure that services are focused on what they need to do and working together to promote recovery and end compulsion. But the power will be strengthened to require that services can be directed to act:

- to address any threat that the continued lack of service could have to a person’s Article 3 or Article 5 rights: for example, when the lack of services may result in unnecessarily detaining someone, or in inhumane or undignified treatment.
- where a service has been identified as necessary within the Human rights enablement approach.
- where the person would be entitled to the service under agreed minimum core obligations or national service standards.

We envisage that the direction could create an obligation for the NHS, a local authority, an integration authority or, in time, the National Care Service.

The direction will be made to the body with the authority to authorise what needs to be done. And it would not extend to directing any professional to deliver care and treatment which they do not believe is clinically justified.

We have modelled the enforcement mechanism on the existing procedure for excessive security appeals (discussed below). The tribunal would identify what needs to be done and set out a time period which they believe would be reasonable for this to be achieved. If this is not done, the matter would revert to the tribunal who may make a final direction or give one further opportunity for the issue to be resolved before issuing this direction.

This would create an enforceable duty on the body subject to the direction. If this duty is not fulfilled, the patient, their representative or the MWC would be entitled to raise proceedings in the Court of Session for a breach of statutory duty.

If new procedures to remedy human rights breaches are introduced as part of the planned Human Rights Bill, these could also be available.

Of course, the Tribunal could also refuse to authorise the compulsory care if the necessary supports were not delivered, but this new remedy should avoid compulsion being necessary to make up for a failure to provide support.

We propose that a similar remedy should be available in relation to adult incapacity act interventions, at least where a deprivation of liberty or regulated restrictive practice is authorised.

In line with the principle of reciprocity, we intend that the power of direction should be restricted to situations where non-consensual care or detention is authorised. This is a separate and additional safeguard to the general rights we discuss in chapter 6 for anyone to seek a remedy where ESC rights have not been upheld.

We recommend:

Recommendation 11.16: The existing powers of the Mental Health Tribunal for Scotland to make recorded matters under Section 64(4)(a)(ii) of the 2003 Act should be strengthened as follows:

> **The Mental Health Tribunal, in the event of non-compliance with a recorded matter should be given powers to direct the relevant provider to provide within a specified time such care and support as may be required to:**

- **avoid the need for an individual's compulsion; or**
- **ensure that compulsion respects the human rights of the patient.**

In reaching a decision as whether to issue such a direction, the Mental Health Tribunal will have due regard to:

- **the core minimum obligations and any other relevant standards in place for the provision of mental health services,**
- **the Human Rights Enablement approach taken with the individual,**
- **and the wishes of the individual.**

The service provider will have an appeal to the Upper Tribunal against such a direction.

Continued non-compliance with a direction will be a breach of a statutory duty which is justiciable in the Court of Session.

11.3.4: Excessive security appeals

This is where we started

People held in high and medium secure hospitals have the right to appeal against the level of security in which they are being held. This is set out in Sections 264 to 273 of the 2003 Act. These appeals are heard by the Mental Health Tribunal for Scotland. The Barron Review into forensic mental health services (2021) recommended that low secure patients should also have this right. (Recommendation 13).

In our consultation in March 2022, we proposed that right to appeal against conditions of excessive security should be extended as Barron envisaged. But we went further.

We asked people what they thought of our proposals that:

> All patients subject to compulsion should have a right to appeal against being subjected to unjustified restrictions.

We intended this to extend beyond a person’s right to move to a less restrictive care or treatment setting. People would also have the right to challenge the level of restrictions while staying in the same place. This could include restrictions as to whom the person should see, any restrictions on their movements in and outside a ward, or access to technology. It also means someone could challenge ‘blanket’ restrictions on a ward. ‘Blanket’ restrictions are when the same set of restrictions are applied to everyone on a ward, even though they may not be necessary for everyone.

In some cases, it may also extend to restrictions imposed by a community-based Compulsory Treatment Order.

In 2015, amendments were made to the existing excessive security appeal provisions. These included introducing the need for any appeal to be supported by a medical report by an approved medical practitioner. This was proposed by the Scottish Government to ensure that the appeals could operate effectively. We questioned whether an individual’s right to make an application against excessive security appeals should continue to be linked to a medical professional’s opinion in this way. In our consultation in June 2022 we asked people what they thought about this requirement.

This is what people told us

Most responses to the consultation welcomed and supported our proposal that patients subject to compulsion should have a right to appeal against being subjected to unjustified restrictions. They recognised it as increasing the accountability within the system. The need for additional resources was often mentioned alongside supportive responses. A smaller number of responses were cautious of these proposals and their potential consequences.

Support for the proposals: These proposals were widely welcomed by individuals, advocacy groups and professional organisations.

> ‘We support this; it is a basic Human Right that individuals should have the right to appeal decisions that directly impact on their wellbeing and personal life. Consideration of how this might also apply to children is suggested.’
> (Social Work Scotland)

> ‘All individuals who are detained by legislation should have the ability to challenge their position, especially if they are in a place whereby they no longer need to and are simply in the setting due to structural issues such as a lack of beds. Depriving someone of their liberty or imposing restrictions which individuals in the community would not be subject to, for a length of time longer than necessary, should not be acceptable for any length of time. Therefore, individuals should have a right to challenge their position.’
> (Patients' Advocacy Service)

Organisations supporting this also included the British Deaf Association (Scotland), Psychiatric Rights Scotland, Dunfermline Advocacy, Support in Mind, Families Outside, AdvoCard, the Mental Welfare Commission, Forensic Network, the Law Society of Scotland, Royal College of Psychiatrists, South Lanarkshire Council and the Scottish Association of Social Work. An individual felt they would bring, ‘more openness and accountability into the system’. A number of responses considered it to be a ‘matter of human rights’.

Some said this right of appeal against unjustified restrictions should be extended to children. The Law Society of Scotland said it should apply to all situations of non-voluntary intervention, including those under adults with incapacity legislation.

Support alongside recognition of resource implications: Support for the proposal was however often stated alongside recognition of its resource implications.

The Forensic Network cautioned the proposals may ‘create a significant caseload initially’. They pointed out that the extension of appeals to people in medium secure in 2015 had not yet resulted in new provision in health or community settings. They felt that the outcome of these appeals needed to be monitored and managed to ‘ensure action is taken’.

Thrive Edinburgh felt the proposals were ‘fair, equitable and a fundamental human right that should be available to all who are subject to compulsion’. However, they said there was an outstanding need for more, less restrictive supportive environments. They also highlighted how long it can take to get new services like this in place given the ‘complex planning, commissioning and financial systems’. Independent Advocacy Perth & Kinross described the current right to appeal in medium security as ‘to some extent a right in name only for many’. They said some people do not appeal because the lack of services means they may be placed ‘even further away from their home area’, or that they would ‘simply be “gazumping” another deserving individual’.

Support in Mind called for more and reallocated funding in the community to ‘ensure excessive security appeals are successful’. The Royal College of Psychiatrists ‘absolutely’ supported the proposals in ‘principle; but wanted more details. They warned that, in the context of limited resources, it may simply ‘lead to diversion of resources from other areas of provision’. They advocated for ‘much clearer criteria’ for what constitutes a ground of appeal, to give ‘clarity to all involved and ensure that appeals are taken up on a clear understanding of what would constitute successful grounds’. For example ‘excessive security’ would need to be defined to avoid services being ‘overwhelmed by appeals regardless of their relevance or merit’.

Concerns about the proposals: Glasgow City Council had concerns about the ‘wide reaching use of these appeals’. They felt they made sense in hospital. However, they warned that if people were ‘to appeal around all aspects of any perceived restriction [in the community] it would significantly impact on day-to-day care planning’, and consequently resources. Edinburgh Health and Social Care Partnership, while seeing the sense of the proposal from a ‘legal rights’ perspective, were concerned appeals in this area would clog the system if not matched with resources to resolve issues. They felt addressing the wider economic, social and cultural rights needed to be done at population level, rather than through mental health legislation.

Both COSLA and SOLAR felt this area of practice was more complex than recognised by these proposals. They highlighted that supporting people to claim their rights must be done in a person-centred and trauma informed way.

One individual wanted these appeals to be heard by a Sheriff.

Responses on appeals against blanket restrictions: Only a small number of responses explicitly mentioned the extension to appeal against restriction in the same setting/blanket restrictions. Most of those supported the proposal including AdvoCard and the Scottish Association of Social Work. The Equality and Human Rights Commission gave it particular support given that ‘consideration for patients’ individual needs is imperative in tackling disproportionality and possible discrimination.

> ‘Blanket restrictions are not always necessary for everyone they affect, this can impede a service user’s independence and recovery, and has the potential to breach their human rights that are meant to be protected by reformed Scottish mental health law. Blanket restrictions can have several side effects, including loss of identity and being dehumanising. [We] believe that appeals in this scenario would be important to allow service users to be considered as individuals with their own human rights and needs.’ (Support in Mind)

The MWC spoke of how it has had to challenge services for ‘blanket’ restrictions that serve ‘operational needs but not individual patient needs’. They asked that any direction for improvement be aimed at a management level rather on any individual member of the clinical team.

A few responses highlighted the need for these proposals to be seen in the context of balancing the rights of one person against the safety of all.

> ‘Public safety as well as the safety of vulnerable patients are very much intertwined with the rights of those patients who wish to challenge levels of security.’ (Individual).

We were told that risk must be a critical factor when considering how these appeals may work. This was important particularly when considering the security settings.

The Forensic Network said any legislative change around this would ‘need to balance the potential outcomes for an individual against the need to safely run a unit for the wellbeing and safety of patients and staff.’ This was because they felt some of the environmental and procedural elements of security need to be done on a unit wide, rather than an individual basis. They gave the example of allowing an individual to keep possession of their own metal cutlery in a high secure setting would pose a risk if other patients took it. The MWC also wondered what impact these proposals would have on the day to day running of secure services.

> ‘In principle we support the concept of appeals against the level of restrictions in place in an appropriate setting, however the grounds and criteria for appeals would need to be carefully defined, recognising the need to balance issues of individual rights and safety, with organisational risk and the needs, safety and welfare of other patients, and staff.’ (Perth and Kinross Health and Social Care Partnership).

Dumfries and Galloway Council’s Social Work Services felt that there needed to be adequate staffing levels on wards and in services before ‘personalised restrictions could be managed’. This was because they felt current use of ‘blanket restrictions’ could be a way for short-staffed teams to continue to manage risk safely. Some respondents from NHS Greater Glasgow and Clyde felt that allowing appeals in this smaller area of practice would lead to a ‘deluge of appeals for trivial reasons’. They felt this risked placing an increased burden on staff. They felt it could see services spending time defending their actions in tribunals in a way that would detract from clinical time. They suggested an alternative approach of introducing greater challenges at organisational level through MWC inspections and peer review to ensure human rights compliance.

Responses on the need for a medical report by an approved practitioner to support appeals: The Forensic Network explained that the requirement for excessive security appeals to be supported by a medical report came in at the same time that the right to appeal was extended to people in medium secure settings. Its intention had been to ‘prevent multiple appeals being heard that had little chance of succeeding but had a huge opportunity cost in terms of staff time for the health and wellbeing of patients.’

Most respondents were in favour of this proposal. South Lanarkshire Council thought the current requirement was ‘a barrier to legal rights and should be reversed’. A number of responses including those from the Law Society of Scotland and AdvoCard felt it should be removed because it was not a requirement for any other appeal.

> ‘Where deprivation of liberty is at the heart of an appeal, there should be minimal restrictions on the appeal right. It is for parties to present all available evidence to the Tribunal and for the Tribunal to make a judgement on the merits of the appeal.’ (Law Society of Scotland).

The Law Society also highlighted barriers to instructing and receiving such reports given the small pool of forensic psychiatrists, which can create conflicts of interest. As well as restraints on legal aid funding for such reports.

The MWC argued:

> ‘The appeal process necessarily relies on medical evidence; arguably, an appeal may not be upheld without supportive medical evidence. The right for patients to have an appeal heard is important enough that it should not depend solely on the existence of medical evidence, supportive or otherwise. The time bar on appeals will limit questionable appeals to some extent.’

An individual supporting the removal, also highlighted that there would be an ongoing need for factual and objective evidence to support it. They argued ‘all risk to the public cannot be eliminated’.

Concerns were raised however about an ‘uptick in appeals unlikely to be successful’ if the requirement for such a report was removed. A small number of responses suggested ways to reduce this threat of speculative appeals. The idea of a ‘duty convenor’ to scrutinise applications before going to tribunal was suggested as an alternative.

Both NHS Greater Glasgow & Clyde and the Royal College of Psychiatrists were opposed to the removal of this requirement.

> ‘One of the issues is the vast majority of appeals of any mental health act order, which do not have a supportive professional report, are not upheld. So if excessive security appeals also go down this route, the possibility of a far greater number of appeals with no discernible benefits would need to be given careful consideration. Respondents felt this touched on one of their main reservations about the Scott Review in that many of the proposals will increase workload and burden on a very over-stretched service. Therefore they felt that this requires very careful consideration, and it was also felt that workforce planning ought to be a consideration for the Review.’ (NHS Greater Glasgow and Clyde).

The Royal College of Psychiatrists could not see how this could proposal could be ‘acceptable’. They felt that safeguards and protections needed to be in place for this group of people and ensuring medical expertise to inform such decisions was part of this.

These are our final recommendations

There was widespread support for people under compulsory measures to be able to appeal against excessive restrictions including, but not confined to, people in secure settings moving to lower levels of security.

We believe this is consistent with the developing approach to human rights. The European Court of Human Rights and the UK courts have previously held that Article

5 of ECHR only protects against the fact of deprivation of liberty, not the degree of deprivation. However, in the case of *Rooman v Belgium* the European Court went beyond this, saying ‘the assessment of whether a specific facility is "appropriate" must include an examination of the specific conditions of detention prevailing in it’. (Para 210).

There are two main practical concerns. One is around resourcing. The other is about ensuring the system of appeals is not overwhelmed.

We recognise that there are already strains around the existing right of appeal to be moved from medium secure units to lower security. It appears that, for some, this has only been achieved once litigation reaches the Court of Session. We accept that widening this appeal right may highlight similar strains elsewhere in the system. But this is not new, and nor is it confined to the mental health system. Slopping out in prisons was only ended once a court determined that it was incompatible with human rights. Before then, political choices had been made to prioritise other things. We believe that holding someone in a setting which is more restrictive than is needed is also a significant human rights breach which needs an enforceable remedy.

We accept however, that there could be problems if people were repeatedly to appeal against more trivial restrictions. There may need to be provision in regulations to spell out what level of severity and duration of restriction would give rise to the possibility of an appeal to the Tribunal.

We also understand the concern about removing the requirement for a supportive medical report leading to an unmanageable number of hopeless appeals. We accept that there may need to be some further check, in addition to the time limits which prevent multiple appeals on the same issue within a short period.

We propose a sift mechanism within the Tribunal itself, based on a wider evidential test than medical support. Before an appeal could proceed, a convenor would check that it contained a stateable case – that it concerned restrictions which the tribunal could adjudicate on, and that there was some evidence for why the restrictions should be lifted. For legally aided cases, it may be that the Scottish Legal Aid Board might also consider whether the appeal contained a stateable case, for example, adopting the test used for civil legal aid which requires an applicant to demonstrate that they have a plausible case and that it is reasonable in all circumstances that civil legal aid is made available.

For restrictions which fall short of the level of severity to warrant an appeal, it would be possible to ask the MWC to review their justification, and make recommendations to the service if they saw fit to do so. The patient would also be able to seek an MWC view of more serious restrictions as an alternative to an appeal to the Tribunal.

We have also considered the existing provisions in sections 281-286 of the Mental Health Act which relate to access to phones, technology, post and searches. These include a process of designating someone a ‘specified person’ who may be subject to security restrictions, and a complex set of provisions regarding oversight by the MWC. The MWC has published information for patients on these and more detailed practice guidance.

There is already a recognition that these provisions have not kept up to date with advances in technology and no longer reflect how people interact with the world. They do not adequately cover many of the devices that people now rely on, and there is no proper basis to regulate ‘virtual’ rather than physical searches – i.e. monitoring of use of the internet and communication devices.

We also understand that the judgment of the UK Supreme Court in the case of McCann v The State Hospitals Board for Scotland [2017] UKSC 31 has created operational difficulties, particularly in the secure estate, because of the way it expects restrictions to be individually justified.

The Scottish Government asked the Forensic Network to carry out a review of the use of communication and technology. It originally reported in November 2018. They were subsequently asked to update it following the rapid development in the use of technology as a result of the coronavirus pandemic. This had not been completed prior to the publication of the Barron Review. The Barron Review recommended that the Scottish Government respond timeously to the updated report. It also hoped that report itself would reflect ‘an enabling, rather than a risk adverse approach’.

The Senators of the College of Justice highlighted to us that the compatibility of these provisions with ECHR has been questioned. The provisions regulate potentially severe infringements on the human rights of patients, raising significant questions under Article 8 of the ECHR. The fact that the review procedure does not involve a judicial body may raise concerns under Article 6 of the ECHR. Even the review by the MWC is limited – for example, they cannot override the decision to make someone a specified person.

In the medium to longer term, we propose that these regulations would be largely replaced by our new proposals for appeals on excessive restrictions. However, we believe they need to be urgently updated before this can happen.

We recommend:

Recommendation 11.17: All patients subject to compulsion should have a right to appeal against being subjected to unjustified restrictions.

- **This right should extend beyond a person’s right to move to a less restrictive care or treatment setting. People would also have the right to challenge the level of restrictions while staying in the same place.**

- **This right should extend to restrictions imposed by a Community-based Compulsory Treatment Order, or a Deprivation of Liberty under the AWI Act, as well as detention in hospital under the Mental Health Act or Criminal Procedure (Scotland) Act.**

- **The appeal procedures would be modelled on sections 264 to 273 of the Mental Health Act. However, there should be no need for the appeal to be supported by a medical report by an approved**

practitioner. Instead, there should be a sift process to ensure that groundless appeals are not pursued.

- **Regulations should set out the nature, severity and duration of restrictions which would potentially be subject to an appeal.**

- **The use and outcome of these provisions should be monitored by the Mental Welfare Commission to identify whether there are any systemic issues giving rise to appeals which require wider investigation or action**.

Recommendation 11.18: The appeal process should ultimately replace the 'specified person' procedures in sections 281-286 of the Mental Health Act. Before then, the Scottish Government should urgently progress reforms to the specified person procedures to ensure they appropriately cover modern technology and better reflect human rights.

11.3.5: Complaints

This is where we started

Previous reviews of services for people with mental or intellectual disability have found that existing complaint procedures do not work well for people wishing to raise issues about their care and treatment. The inquiry into mental health services in NHS Tayside said the complaint system did not appear to be designed around the needs of complainants. The review of forensic mental health services identified the need for transparent and trusted ways (both formal and informal) in which people and their families could raise concerns they have about their care and treatment.

We heard the same issues. Specifically, we found that the current complaints handling process seems to assume an equity of access for people with aterm mental or intellectual disability which in reality does not exist. There are specific barriers for them within a universal system to the extent that some will just not complain.

People fear repercussions for their ongoing care and treatment. They can have their concerns dismissed as part of, or used as further evidence of, their illness. They fear not being believed. This experience of not being believed can be particularly harmful for people who have already experienced trauma. The process is felt to be too complex and time-consuming especially for people who are often in distress. The process itself can also lead to the person's mental health worsening.

People said they would often rather not complain. People suggested better communication and meaningful involvement in decisions about their care and treatment could prevent many complaints. Others just want to make a suggestion or ask a question, rather than complain. Mediation might be quicker, more accessible and more effective for some people. For those who want to complain, some will need more support to do so in a way that works for them. People also felt more could be done to learn from complaints. There was also an acknowledgement that most services were trying their best to provide a high quality service.

There is a need for complaint handling bodies to understand the rights of complainants. But there was little evidence that human rights are routinely considered as part of complaints handling processes. We said there was a need for a complaints system firmly based within a human rights approach. This would place complainants as active, trusted and valued participants in a dialogue about the decisions that affect them. Our proposal was that:

- the ways a person can raise a concern or complain about their care and treatment should be reformed.

We set out our ideas for how this reform may look based on what people had told us. The ideas were:

- the ways for someone to be able to challenge their care and treatment needs to be equitable, accessible, co-ordinated and effective.
- the system should be designed around the needs of the complainant. Complainants and their families, and complaint handling bodies should be equal partners in the development of the reformed system.
- the formality and purpose of the complaint process needs to be challenged. The idea of a ‘remedy panel’ rather than a complaint handling process captures the solution-focused and collaborative aspects people said they would like.
- more meaningful monitoring and reporting on complaints is needed. The content of complaints need to be analysed to identify and address patterns or themes which may indicate systemic issues. Equality data needs to be collected about who is using the system to help us understood who the system is working for and who it is excluding. The learning and improvement that can be gained from complaints needs to be tapped into.
- there needs to be a way of checking that appropriate actions from a complaint decision are taken and whether these actions made any difference to the person, or resulted in any changes to the service.
- people handling complaints must have a high level of awareness about people’s different communication needs. They need to be supported to help people share their experience in ways that work for them. This could mean additional training or having access to specialist clinicians, like occupational health therapists.

We asked people what they thought about our ideas for reforming the way people can raise a concern or complain about their care and treatment. We also sought any other ideas that would make this process equitable and effective.

This is what people told us

The majority of responses recognised the issues we described and supported reform. Many provided ideas about what that reform should look like.

However some responses said that the existing system was adequate or raised concerns about developing a separate system for people with mental or intellectual disability. In this context they thought that additional advocacy support for people would be more beneficial than legislative change.

Responses questioning the need for reform: Most of the responses that questioned the need for the reform we proposed highlighted the existing processes and legislative provisions of the Scottish Public Services Ombudsman (SPSO). They raised concerns about the impact of introducing a new system for mental health or incapacity complaints alongside this. It was felt this had the potential to introduce further delays and complexity. Some also said it could be stigmatising or discriminatory. A few responses queried whether complaints fell within the remit of this Review.

> ‘The SPSO Act 2002 provides a legislative basis from which public services should take forward complaints, and we suggest this process would apply in relation to raising concerns or complaint about care and treatment.’ (Social Work Scotland)

> ‘We query the inclusion of this within this legislation as there are other clearly detailed and established processes for this within other legislation (including complaints legislation in the NHS). Given the complexity of current complaints processes across agencies and organisations, we do not think it would be helpful to add yet another process to these.’ (Forensic Network)

COSLA said the SPSO’s standard complaints handling procedure ‘provides a strong platform for tackling inequity and ensuring consistency’. They pointed to the wider reform underway across human rights to ensure ‘wide ranging human rights, as recommended by the human rights taskforce, are embedded into legislation. This will require a means to complain and seek redress to be in place’.

A small number of responses suggested that some of the weaknesses in the current system were more about a lack of resources than inadequacies in the system itself.

> ‘The current approach does, in places, work well, where there are sufficient social care staff to execute the complaint review.’ (Individual)

> ‘A quicker response is dependent on having enough staff to deal with complaints.’ (Moray Council)

Responses in support of reform: Nearly three times as many responses spoke either in favour of the need for reform and/or confirmed the issues we had been told about the current system.

> ‘Complaints processes are currently too difficult – people give up because it’s too hard and too stressful. We think many of the recommendations will improve our ability to speak up individually and collectively’. (Lothian Voices)

> ‘The system is made so complex so you just give up, that suits the service but doesn’t change anything for us.’ (Carers Trust quoting an individual carer)

> ‘The experience of families we support is often that the complaints processes are time-consuming, stressful, take a long time and do not deliver good outcomes.’ (Challenging Behaviour Foundation)

> ‘People receiving mental health support (whether formally or informally) require to be empowered to ensure equity of access to complaint investigations without fear of repercussion.’ (Mental Welfare Commission)

> ‘We strongly agree that the complaints systems should be firmly based within a human rights approach which places complainants as active, trusted and valued participants in a dialogue about the decisions that affect them. We therefore agree with all the suggestions in the review around how to reform the complaints process along these lines. Fundamentally, the complaints process needs to be open, accessible, trusted and robust in its handling of complaints and well resourced.’ (Scottish Association of Social Work)

The Carers Trust emphasised the need to design the system around the complainant. The Royal Society of Edinburgh agreed that the barriers to pursue complaints for people have mental health difficulties were ‘significant’.

The fear of ‘retaliation’ or ‘repercussions as a barrier to complaining’ was confirmed by individuals, the Carers Trust, Parkinson’s UK and the Mental Health Network Greater Glasgow.

> ‘The main problem is that any sane or insane patient does not want to rock the boat and risk retaliation. And once they are out of hospital they want to forget the whole sorry episode.’ (Individual)

Advocating Together (Dundee) SCIO said people would not ‘risk upsetting the care team or being seen as ‘challenging’ so would not raise legitimate concerns’.

Raising a complaint or concern should be as ‘easy and painless’ as possible (SAMH). However, we heard it took time and resources to make a complaint. AdvoCard welcomed anything that would allow for ‘faster resolution because:

> ‘The system is broken, most people will abandon their complaints long before they receive a fully investigated response, and, if they persist, the waiting often causes its own trauma and mistrust of the system.’

The ALLIANCE indicated that the lengthy waiting times for complaints has a significant impact on an individual’s rights and their care and treatment. SOLAR suggested that a single gateway would be ‘far easier for individuals and families to recognise across a confused landscape’.

What reform should look like: A number of responses also told us what they wanted the reform to look like.

There was wide support for more solution-based, collaborative ways to deal with issues. Individuals supported ‘non-confrontational’ approaches and ways to give ‘feedback as well as complaints’. The Mental Health Network Greater Glasgow highlighted there was ‘little alternative to enable a person to make a comments or suggestions on their treatment, other than a formal complaint'. The Law Society supported greater use of mediation, especially when resolving issues between a person and their care team.

Importance was placed on the need for the complaint system to be independent and transparent. The Royal Society of Edinburgh noted complaints are often addressed internally in the first instance. ENABLE ACE emphasised independence 'because people may be scared to complain to people who are in charge of their care'. The Care Inspectorate advocated for a system independent of both services and the new National Care Service.

There was a focus on more meaningful consideration, monitoring and reporting of complaints to support the learning and development of services. Alongside this were calls for a more joined up mechanism to allow the system to identify and address systemic issues and feed learning back into the system. The Equality and Human Rights Commission, the Law Society of Scotland, Support in Mind, Forensic Network, Care Inspectorate, Royal College of Psychiatrists and the MWC all spoke to these issues.

> 'There is a need for a joined up mechanism to ensure that the outcomes of complaints are scrutinised and fed into the wider system to improve outcomes for all.' (MWC)
>
> 'Current systems enable a team to respond to a complaint but this does mean perhaps recurrent themes get missed that could help collective learning.' (Individual)

The National Forensic Allied Professionals Leads Group highlighted that scrutiny of the actions and outcomes following complaints needed to be part of this.

SAMH wanted the development of 'growth mindset' within organisations. This means viewing complaints and concerns as opportunities to learn and grow rather than as threats. One individual felt organisations did not want to 'learn anything from mistakes'. A couple of individual responses emphasised the need for people with lived experience to be involved in the scrutiny and handling of complaints.

People expect the process to be fully accessible. The Royal College of Psychiatrists acknowledged the current system was underused by particular groups. This included people with the most severe needs. ENABLE ACE wanted to be asked which way of communicating their complaint ‘would work for us’. They wanted a range of options – meeting, call, letter, email. Advocating Together had a preference for meeting in person to discuss any concern. Translators needed to be available. The British Deaf Association of Scotland explained the additional barriers Deaf people can face when trying to navigate universal procedures:

> ‘Deaf people have not enjoyed the ‘incidental learning’ that hearing people glean from older people, colleagues, radio and television, overheard conversations, etc., because this information is not accessible to Deaf BSL users. With this in mind, consideration must be given to extending the offer of a Deaf Advocate to assist the Deaf patient in understanding the choices available to them. Deaf service users typically don’t currently enjoy this extra support.’

The Equality and Human Rights Commission said the system must take account of digital exclusion and have anticipatory reasonable adjustments.

People also wanted greater advocacy to support people through any complaint process. SAMH wanted advocacy included in the complaints process. Thrive Edinburgh felt strengthening advocacy would help people to navigate the process and so contribute to ‘a more accessible and efficient system’. ENABLE ACE and Advocating Together (Dundee) SCIO both spoke of the importance of advocacy to help them ‘speak out’ and ‘make sense of what I have to do’.

Complainants need to be at the heart of designing any reform. The Royal Society of Edinburgh and Support in mind said that understanding the complainant’s lived experience and perspective was needed to design a more effective process.

> ‘To ensure everyone can engage fully with any complaints system, it is vital to work with individuals sharing protected characteristics and their representative

> organisations to identify needs, potential barriers and solutions.' (Equality and Human Rights Commission).

COSLA warned against a return to individual local procedures. They felt that had 'previously created greater inequity'.

Responses to the idea of a remedy panel: a small number of responses spoke directly to our suggestion of a 'remedy panel'. A couple of individuals as well as See Me, the ALLIANCE and SOLAR explicitly supported them.

> 'The idea of reframing as 'remedy panels' is good. This seems a more constructive mindset and with appropriate training, helpful towards minimising an adversarial and defensive process.' (SOLAR)

> 'Solutions reached by agreement are more likely to be implemented than those imposed.' (Individual)

The SPSO did not support the idea. They said these had previously been discontinued 'because they caused delays and were felt to be intimidating'.

The SPSO is the final stage of complaints for public services in Scotland. They can take complaints about NHS Boards, local authorities, the Office of the Public Guardian, the MWC and the Care Inspectorate. They also have a role in monitoring and promoting good complaint handling practice in organisations. They have established Model Complaint Handling Procedures to improve consistency and outcomes across complaints. These were revised in 2021 for most of the public sector. The NHS model however was last revised in 2016.

They pointed to improvement and best practice within the system but also:

> 'Recognise[d] the concerns within the consultation that there remain barriers for those who may be most reliant and dependant on services. Our own experience is that they face the greatest challenges to accessing complaints systems . . . The underlying legal structure for complaints is complex and can be confusing. It is built around organisations and not users . . . Complaints

> processes, in our experience, work best, when procedures are simplified so that the focus can be on culture and practice change.' (Scottish Public Services Ombudsman)

They thought that that much of the reform can be done without changes to legislation. For them, they feel what is needed 'commitment from organisations and resources for SPSO to drive improvement work and monitor complaint handling more effectively'.

However, they did identify current barriers within their legislation to letting them drive the type of reform we had outlined. First, the focus of the legislation is 'maladministration'. They explained that this means that the focus is on the complaint process rather than its content. They support shifting from this narrow focus to a broader, holistic consideration of the service provided and whether rights have been respected. A change in legislation may be required if they were to be able to 'drive a shift towards more rights-based focus'. Second, on accessibility, they can only accept complaints in alternative formats 'in special circumstances'. Third, the law limits the information they can share about cases resolved without the need for investigation. They cannot share information about actions taken post-investigation either. This prevents them sharing learning across the system. It also inhibits best practice development.

These are our final recommendations

We think that the informal routes to remedy are the foundation for the protection, promotion and realisation of people's rights. We believe that, if these foundations can be strengthened, the need for people to go to court or tribunal will be reduced. Like all remedies though, they need to be accessible, affordable, timely and effective. The evidence we have heard is that the complaints system does not meet these standards for people in the mental health system. There are barriers for people who continue to depend on the services they wish to raise an issue about. This includes the fear of repercussions or not being believed. This inherent power imbalance characterises the interactions of people with mental health and capacity issues with professionals they rely on for their care and treatment; an imbalance which is increased for people with intersecting marginalised identities. The process can also be complex and time-consuming, during a time people are in already in distress.

We agree that advocacy is critical to support people to navigate through systems, like complaint procedures. People wanting to complain about the NHS can already be supported by the Patient Advice and Support Service to do this. However, strengthening provision of such support should not be seen as an alternative to ensuring that a complaints system is built around and continues to meet the needs of the complainants.

We agree that not all the changes need legislation. However, the SPSO has highlighted current legislative barriers to driving forward a more holistic and human-rights based complaints process. We also now know that the National Care Service (Scotland) Bill will be co-designing and developing a complaints system for this new service. It will be part of a Charter of Responsibilities, with the potential to create penalties. Earlier in this Chapter, we recommended a statutory duty on complaint handling bodies to enhance access to justice and ensure human rights are given effect by public bodies, and that support should be given to these bodies to build their capacity and confidence to do this.

We have not sought at this stage to set out a definitive set of proposals as to what a reformed system should look like. That would be part of the design of the system. However what we set out here is what this design must ensure if it is to both meet human rights requirements and reflect what people have consistently told us and others that they need. We do not underestimate the difficulties in creating a system in which people with mental health difficulties and their unpaid carers can feel confident and safe to raise concerns. Trust cannot be bought or designed into a system. It must be won.

We recommend:

Recommendation 11.19: The Scottish Public Services Ombudsman remit should be extended to allow it to:

- **Oversee and drive a more holistic and human rights-based approach to considering complaints for people with mental or intellectual disability across health, social care and other public services.**

- **Share learning and best practice on complaint resolution and handling across Scotland.**

Recommendation 11.20: The legislative restriction whereby the Scottish Public Services Ombudsman can only accept complaints in alternative formats 'in exceptional circumstances' should be removed.

Recommendation 11.21: The Scottish Public Services Ombudsman should work with provider organisations, the Care Inspectorate, Healthcare Improvement Scotland, the Mental Welfare Commission and the Office of the Public Guardian, to support a lived-experience led change project to design a complaints system that better meets the needs of people with mental health and capacity issues and which is based in human rights. To support this:

> **We recommend an improvement methodology for testing this new model.**

Our work has shown that to be based within a human rights approach and to address barriers people experience in the current system, it should:

- **Have complainants as active, trusted and valued participants in a dialogue about the decisions that affect them.**
- **Be developed by complainants and their families, with complaint handling bodies as partners.**
- **Look towards more solution-focused and collaborative ways to share concerns without necessarily having to escalate them to complaints.**
- **Have meaningful processes to monitor, follow-up and report on issues raised which allow us to:**
    - **Know the outcomes in terms of what difference was made to the individual or what changes were made to the services.**
    - **Identify patterns or themes which may indicate systemic issues and be fed back into the system for learning and development.**
    - **Gather equality data to understand and monitor who the system is working for and who it is excluding.**
- **Support people to share their experiences in the way that works best for them. This could include the involvement of peer workers, having access to specialist clinicians, or providing people with additional training on communication methods, mental illness or anti-racism.**
- **Have a single point of access for the system.**

11.3.6: Independent collective advocacy

In Chapter 4 we considered the ways in which independent advocacy should be supported, with an emphasis on the independent individual advocacy that is important for supported decision-making. Here we look consider independent collective advocacy.

This is where we started

Collective advocacy groups are a group of people with shared experiences who come together to try to improve issues that affect their lives. They are independent and run by and for their members. These groups play a critical role in both realising and promoting people's rights. They raise awareness of rights among their members as well as with organisations. They provide a safe and supportive space for people to raise issues that affect them. They do not take on individuals' issues but identify and seek remedies to issues that are affecting more than one person, including influencing policy and practice in their area.

The UNCRPD Committee's General Comment No. 7 emphasises the importance of groups like these. It says governments need to strengthen the capacity of these groups to allow them to participate in all phases of policy making. It also says resources should be prioritised for those groups that focus on advocacy for disability rights. It also encourages each country to establish 'a single, united and diverse representative coalition' of the organisations of people with disabilities. One of its roles would be to participate in the monitoring of the UNCRPD.

We looked at whether collective advocacy needed to be strengthened across Scotland. We ran a targeted consultation among collective advocacy groups and other representative groups last year. We published a summary of the responses we received. These informed our initial proposals for strengthening collective advocacy.

The right to advocacy for people treated under the Mental Health Act does not specify collective advocacy. We were told this means that collective advocacy provision can be overlooked in favour of funding individual advocacy. Collective advocacy provision is not consistent across Scotland with only a few local advocacy or peer-led organisations having this as a key part of their role . Groups want to be fully involved in all levels of decision-making, however, they would need to be better supported and resourced to do this.

Although there is an important role to be played by cross-disability coalitions, there were concerns that the mental health voice could be marginalised or misunderstood within this. A coalition which had specialist mental health expertise and focus was supported. Such a national organisation could support the development and promotion of collective advocacy. There was also support for a body that could collect and amplify issues from collective advocacy groups across Scotland.

We think collective advocacy is key to making sure people are involved in decisions that affect them. We asked people what they thought about our proposals for strengthening collective advocacy. The proposals were:

- There should be a duty on the Scottish Government to secure and support effective collective advocacy organisations at a local and a national level.
- Collective advocacy must be available for all marginalised groups.
- There should be a duty for NHS Board/local authorities to provide and resource this.
- Collective advocacy members and workers to lead on the development of a system for supporting, monitoring and evaluating collective advocacy groups.
- The co-production of ‘Standards of Engagement’ between services and scrutiny bodies, and collective advocacy groups to ensure they have the opportunity to be involved in all aspects of service delivery that impact their members.
- Development of an opt-in programme of advocacy related learning to support the development of more advocacy workers and peer leaders.
- A national strategy for raising awareness and understanding of collective advocacy.

This is what people told us

There was widespread support for the proposals. Different responses spoke to different aspects. The need for sustainable resources and greater accountability mechanisms for groups were highlighted. A small number of responses were not supportive.

Support for the collective advocacy proposals: Responses reflected the importance of strengthening collective advocacy. They also confirmed much of what our targeted consultation last year had said.

> ‘Collective advocacy … can currently be seen as an ‘add on’ and these recommendations go a significant way to addressing this and bring parity of esteem between collective and individual independent advocacy.’ (CAPS Independent Advocacy)
>
> ‘We strongly support proposals to strengthen access to “collective advocacy”, which we see as a vital and empowering means of ensuring accountability for, and by, people with lived experience of mental health problems. We agree with the review team that the lack of specific rights to collective advocacy ensured by the current Mental Health Act is a problem.’ (See Me)
>
> ‘We like the report’s comments on the need for collective advocacy and on the importance of independent advocacy generally.’ (People First)

Collective advocacy was seen to be an important element within a human rights-based approach accountability framework (SAMH). People spoke of its ability to address systemic issues, identify trends and geographical areas where rights are being violated, and identify solutions and good practice. People valued its role in campaigning for human rights (VOX). It increases citizen participation and empowers people which was seen as a ‘good thing’.

People wanted it to be possible for anyone anywhere in Scotland. Specifically collective advocacy should not only be available to people in hospitals. It should be easy to access in the community too. The lack of provision for marginalised groups within mental health services was highlighted. People reiterated the lack of advocacy provision for more marginalised groups, including young people (SAMH) and Deaf BSL users. There were also calls for specific advocacy provision for carers (Carers Trust, Support in Mind). We were also told that specific action needs to be taken to support ethnic minority people with lived experience to be involved in the decision-making processes around policy and practice. This will need to include training and recruitment of people with this lived experience.

There was support for greater participation in all levels of decision-making (SASW). People thought collective advocacy groups did have an important part to play in redesigning and improving service provision (Thrive), policy development (AdvoCard), and in the monitoring and evaluation of services (Care Inspectorate). There was also support for experience-led development of systems of support, monitoring, evaluating and standards for collective advocacy. Protecting the independence of these groups in these activities however was stressed. SIAA members were keen to emphasise that agendas must be set by collective advocacy groups themselves. The work of collective advocacy cannot be dictated to by public bodies/commissioners looking to make improvements. This linked to responses which identified a need for greater awareness within NHS Boards and public bodies about what collective advocacy is and to engage with it.

People said the effectiveness of these proposals would rely on sustainable and long-term funding for collective advocacy groups (SAMH, SASW, Support in Mind, Social Work Services Dumfries and Galloway, CAPS). People were also looking for the provision of infrastructure (Forensic Network) and access to legal advice, guidance and support (Patients Advocacy Service). It also depended on services beginning to listen to collective advocacy and take it seriously in a way that was not happening now (Lothian Voices).

Some responses felt that these proposals needed to be supported by stronger accountability mechanisms for collective advocacy groups themselves. People were looking for ways to define groups or set expectations. Another suggestion was a framework with clear oversight, to ensure consistency and to strengthen the esteem in which they are held by services (Forensic Network, Royal College of Psychiatrists). Others suggested standardised training, professional registration, or standards to strengthen advocacy (A HSCP, and Patients Advocacy Service). In developing standards, people not only referred to the current SIAA standards, but felt that the SIAA could lead on this work with groups. One response suggested bringing three or four national advocacy groups together to work on ‘all aspects of advocacy’. On the other hand, one individual warned against advocacy being professionalised: ‘we do not want Advocacy workers to require a qualification’.

Reservations about the proposals*:* SOLAR felt we had not clearly shown any deficit in the current arrangements. They warned against change for its own sake. Without an identified need they felt it would be difficult to measure the impact of any changes these proposals made. One Health and Social Care Partnership supported the development of collective advocacy. But they could not support the proposal for a duty on authorities given the difficulties in resourcing and sustaining it. One individual felt the proposals should be piloted and evaluated before being implemented across the board.

The Scottish Independent Advocacy Alliance was keen to emphasise that, due to the current low levels of collective advocacy, ‘there would likely need to be upskilling and learning across independent advocacy organisations to support more collective advocacy as it was not currently embedded in the way individual independent advocacy is’. In addition, developing collective advocacy through the development of advocates and peer leaders is something that will take time. As one person said in response to our targeted consultation, this is not something that can be ‘bought off the shelf, pre-formed and ready to go’.

These are our recommendations

We want to ensure that there is appropriate collective advocacy so that people can come together, educate and organise themselves to effectively campaign for improvements in services. We feel that they are at the heart of starting to redress the power balance between services and the people who receive the services. They are central to the UNCRPD requirement for the meaningful and equal participation of people with disabilities in decisions that affect them.

The independence of these groups is paramount. They cannot be ‘mandated’ into existence, they must continue to emerge from the needs, wants and views of their potential members. However, there was support and recognition for a greater degree of accountability to ensure these groups are reaching out to capture the voices of everyone in their community. Collective advocacy must be available for all marginalised groups. This is because groups who face discrimination and marginalisation experience particularly poor outcomes when using mental health services. There was also support for greater training opportunities. However formal professionalisation of these groups risks making them into something they are not.

While there was widespread support for the proposals we had, people were also clear that the development of collective advocacy is something that will take time. Collective advocacy are currently working with short-term, non-guaranteed funding models. They are still experiencing, in some places, tokenistic engagement from services. In addition the very basis of collective advocacy is that it cannot be ‘manufactured’. Collective advocacy groups are run by their members. Their agendas are set by their members. They often develop organically to meet the needs of groups of people who feel marginalised and unheard.

Work therefore on our recommendations to develop and support of collective advocacy should begin now. It does not need to await legislative change. Indeed, work needs to begin now if the wider legislative reforms we are proposing are to be effective. Collective advocacy groups cannot be ‘mandated’ into existence, they must continue to emerge from the needs, wants and views of their potential members.

In Chapter 4, we have recommended

- that the Scottish Government should ensure independent individual and collective advocacy is sustainably funded. The Scottish Government must ensure culturally appropriate independent individual and collective advocacy provision.

The recommendations below aim to further strengthen the collective voice of people with mental or intellectual disability across Scotland.

We recommend:

Recommendation 11.22: People with mental or intellectual disability should have a right to collective advocacy.

Recommendation 11.23: There should be a legal duty on the Scottish Government to secure and support effective collective advocacy organisations for people with mental or intellectual disability at a local and a national level.

Recommendation 11.24: The Scottish Independent Advocacy Alliance (SIAA) and collective advocacy organisations should work with collective advocacy members and workers to lead on the development of:

- **a system for supporting, monitoring and evaluating collective advocacy groups. This system needs to respect their independence and be meaningful to the groups, commissioners and the public. It may build on the existing SIAA standards.**
- **an opt-in programme of advocacy related learning to support the development of more advocacy workers and peer leaders. This will include training on anti-racism, intersectionality and human rights.**

11.3.7: Collective complaints

This is where we started

There is currently no place for people to take collective complaints to. These are complaints about an issue that is affecting more than one person. They can be indications of a systemic issue. Without a place to take collective complaints, each person facing this same issue is required to take individual action. Even if scrutiny bodies suspect there may be systemic issues behind the individual complaints they receive, they are limited in what they can do. Within a human rights-based accountability framework, it should not be for an individual to tackle known systemic issues that breach their rights.

The National Taskforce on Human Rights Leadership recommended that organisations with ‘sufficient interest’ should be explicitly allowed to bring systemic issues of public interest to court. We feel that collective advocacy groups should be able to do this. In our targeted consultation exercise with collective advocacy groups in 2021, we asked if they wanted this right. Some groups were enthusiastic. Some felt there would be some risks to this. Groups supported an alternative escalation pathway.

We proposed:

- collective advocacy groups should have an explicit right to raise a court action for human right breaches. This right must be supported by access to legal advice, guidance and support for groups who wish to take this step.

- there should be an alternative way for collective advocacy groups to be able to escalate human rights issues that remain unresolved and unaddressed by services to another scrutiny body/Commissioner to investigate. This would need to be supported by a participatory process of referral and consideration within the identified scrutiny body.

We asked people what they thought about these proposals. We asked which scrutiny body/Commissioner people felt should be an escalation point for collective advocacy groups. We asked whether these proposals should be extended to individual advocacy.

This is what people told us

This is what people told us: the right for collective advocacy groups to take court action for human right breaches

Giving collective advocacy groups the explicit right to raise courts actions was well received. Most responses fully supported this or offered ideas to further improve the proposal. A number of responses agreed in principle but emphasised the need for additional resources to support it. Some responses disagreed with the proposal or raised concerns.

Supporting the right to raise court action*:* Individuals supporting the right of collective advocacy groups to raise a court action spoke of this as being ‘most attractive’, ‘sensible’, ‘great’ and ‘a helpful development’. Organisations in support of this included, Scottish Association of Social Work, Social Work Scotland, AdvoCard, British Deaf Association Scotland, Care Inspectorate, ENABLE ACE. Moray Council, Glasgow City Council, NHS Greater Glasgow and Clyde, and Midlothian Health and Social Care Partnership.

> ‘We would agree that this right should extend to collective advocacy as a means of supporting groups of people to access justice, with the legal rights afforded to individuals as represented in the proposals.’ (Social Work Scotland)
>
> ‘This would allow court actions to continue irrespective of one member dropping out due to the stress of a court action and/or possible deterioration in mental health. Collective advocacy could also empower and embolden group members, safeguarding their mental health in these situations. Group advocacy would also give strength to cases based on the number of members expressing shared views and/or experiences.’ (Care Inspectorate)
>
> ‘We would welcome any pathways which allow advocacy, both collective and individual, to address breaches in people's human rights.’ (AdvoCard)

Supporting the principle of raising court action*:* While supporting the principle behind this proposal, a small number of responses highlighted that additional resources would be needed to make it a reality. Thrive Edinburgh felt that ‘funding and legal aid would be crucial for supporting the recommendations to be realised in practice’.

> ‘Collective advocacy groups should have an explicit right to raise a court action for human rights breaches. This right must be supported by access to legal advice, guidance and support for groups who wish to take this step.’ (Independent Advocacy Perth and Kinross)

> ‘Advocacy organisations are well placed to notice patterns in human rights breaches, for example in particular services, and are in this regard well placed to take court action for alleged human rights breaches [. . .] however without a corresponding proposal to develop and promote legal services available to individuals we have real concerns regarding how individuals and groups will be able to access justice.’ (Law Society of Scotland)

SAMH agreed that this proposal must go ‘hand-in-hand’ with long term and sustainable funding’ otherwise ‘a change in the law will not lead to better outcomes’. One individual agreed there should be a process but questioned whether there needed to be a legal framework for it.

Concerns about the right to raise court actions: The Royal College of Psychiatrists supported the idea but felt it was out of scope of the work of this Review. They felt it applied beyond mental health. They thought it would be better placed in the developing human rights legislation for everyone. COSLA and SOLAR both questioned the evidence of any ‘difficulties facing such groups in terms of the current arrangements’. And, that we had not made a case for why change was therefore needed.

CAPS Independent Advocacy was concerned about the impact raising a court action could have on groups. They pointed to the amount of time, resources and focus it would require. One Health and Social Care Partnership who did not support the proposal pointed out that, within Adult Support and Protection large scale investigations already play a part in safeguarding individuals on a collective basis.

A small number of responses felt collective advocacy needed to be better regulated to ensure it was ‘truly representative of their individual communities (Royal College of Psychiatrists and its Scottish Faculty of Psychiatrists). An individual was generally neutral about the proposal because:

> ‘I am just mindful that many groups can have highly polarised political views that don't always represent the views of everyone in the group.’

Advocating Together (Dundee) SCIO were concerned that making a group complaint could mean a person’s individual voice was not heard.

This is what people told us: creating a way for collective advocacy groups to escalate unresolved human rights issues to an identified scrutiny body.

A smaller number of responses were received on this proposal than for the right to take legal action. Almost all the responses were supportive. A small number spoke to the need for some accountability mechanisms to support it.

> ‘We agree with this recommendation. Members of our collective advocacy groups find that some issues come up time and again and the groups have limited ways of raising their concerns. If they could escalate these concern to a body which could take action, this would be a great help.’ (CAPS Independent Advocacy)

Others welcomed this as delivering a choice of route to remedy. An individual felt this was needed because, if possible, it is ‘better to avoid court action’. AdvoCard supported this ‘second pathway ... to seek remedy without having to take legal action’.

> The group felt that both these options should be available (court action and being able to escalate an issue to an identified scrutiny body). You need to be able to choose so you can get the best outcome. (Edinburgh Lothian Voices)

Our lived experience reference group suggested that there could be a portal for groups to share and show human rights breaches.

One individual felt that there would also need to be a mechanism which held collective advocacy groups accountable. This was to make sure that they are ‘indeed representing the views of the whole group rather than the minority groups that “shout the loudest”.

People suggested a wide variety of existing bodies that could take on this role. The independence of this body was important. The Care Inspectorate thought the body should be ‘independent of health and care providers. One person felt ‘there would need to be an independent body set up’. Others suggested existing bodies. The Scottish Human Rights Commission, the MWC and the SPSO were suggested. Working in partnership with the existing advocacy groups and the wider third sector was also felt to be important.

The SPSO said it would make sense for this to be a function of its office. This would require changes to the standards they currently use to assess issues so they were more rights-focused. They also would need powers to allow them to share information with and seek views from other appropriate scrutiny bodies.

The MWC felt some of its ‘most constructive challenges’ have come from the collective advocacy movement. They were keen to consider a model being developed by Te Hiringa Mahara, the mental health and wellbeing commission in New Zealand. This would involve developing an assurance framework that would allow unresolved issues to surface and understand the significance of the issue at a national level.

The Royal College of Psychiatrists suggested that the role of the Tribunal should extend to highlighting to the MWC systemic deficiencies in the delivery of care or promotion of human rights, including through specific referrals.

This is what people told us: extending these proposals to independent individual advocacy organisations

Most of the responses wanted the additional routes to remedy extended to individual advocacy organisations. Individuals who agreed said groups with ‘sufficient expertise should be able to do whatever is necessary on behalf of their clients’, that these groups ‘have valuable insights to share regarding lived experience’, and that it would ‘all add to greater collective learning across the NHS’.

> ‘As a provider of Individual Advocacy, we often see the same issues crop up for different people. We can only support people on an individual basis and would welcome a way of escalating these issues which affect a number of people.’ (CAPS Independent Advocacy)

AdvoCard said this would allow ‘cases to be brought when needed and would bring much needed resolution’.

These are our final recommendations

There were strongly supported proposals. A right for collective advocacy groups to raise a court action for human right breaches is in line with the recommendations of the National Taskforce for Human Rights Leadership. As such, it could be incorporated within the wider civil society remedies being considered for the wider human rights framework in the Human Rights Bill. It builds on examples in other areas such as environmental justice where non-governmental organisations have standing to raise legal actions.

At the moment we do not know exactly how the wider framework will develop, so it may be necessary for our recommendations to be taken forward specifically for rights under mental health and capacity legislation.

This right must be supported by access to legal advice, guidance and support for groups who wish to take this step. We have not been able to consider in detail issues of legal aid funding and mechanisms to control costs. These will be important considerations if the right is to be meaningful and, again, there are models from other areas of the law.

We think that the provisions to increase consistency and accountability across collective advocacy groups themselves set out in the previous section will address the issues that a small number of people had about how truly representative some groups are. If necessary, any special standing to raise collective legal action could be afforded to specified groups who are recognised as meeting acceptable standards of independence, representativeness and competence.

In light of the responses we received, we think these proposals should be extended to individual advocacy groups.

The establishment of an alternative route for collective advocacy groups to escalate unresolved human rights issues was also strongly supported. We accept the point made in responses that taking legal action, even with funding support, is potentially extremely resource intensive, stressful and disruptive, and other routes of escalation are important.

We believe the SPSO could be an appropriate route where what is wanted is an independent review of a collective complaint. The SPSO does not direct services, but they can be an influential voice in highlighting improvements which need to be made by public bodies. Their individual investigations often identify systemic issues, and it seems to us a logical extension that they should be able to look in a similar way at a collective complaint on behalf of a group.

We also believe that collective advocacy groups should be able to escalate concerns to the MWC. The MWC would then consider what action to take under the expanded powers we outline above. This could include a formal MWC investigation. In some situations, the MWC should be able to use its new power to raise court action to ensure a significant human rights concern can be considered by a court.

We recommend that:

Recommendation 11.25: Individual and collective advocacy groups for people should have an explicit right to raise a court action for human right breaches.

Recommendation 11.26: This right must be supported by access to legal advice, guidance and support for groups who wish to take this step.

Recommendation 11.27: Individual and collective advocacy groups should be able to refer systemic human rights concerns to the Scottish Public Services Ombudsman. The Ombudsman's role should be extended to allow them to investigate these as a collective complaint.

Recommendation 11.28: The Mental Welfare Commission and advocacy groups should develop a participatory referral process to escalate human rights issues that remain unresolved and unaddressed by services to the Mental Welfare Commission to investigate and, if appropriate, initiate legal action.

Chapter 11: recommendations

Scrutiny and the regulatory landscape

The scrutiny landscape

Recommendation 11.1: There should be a duty on scrutiny bodies and complaint handling bodies to enhance access to justice and ensure human rights obligations are given effect by all public authorities involved in the provision of services for people with mental or intellectual disability. The Scottish Government should ensure these bodies are fully supported to build their capacity and confidence to play this part. (medium)

Recommendation 11.2: There should be a formalised network of bodies involved in the scrutiny of mental health services. This should include Healthcare Improvement Scotland, the Care Inspectorate, Audit Scotland, the Mental Welfare Commission, the Office of the Public Guardian, Public Health Scotland, the Scottish Public Services Ombudsman and collective advocacy organisations. Other members may include professional regulatory and training bodies.

Recommendation 11.3: The network should work with the Scottish Government to identify and remove any legislative barriers to this approach, such as unnecessary constraints on sharing information, or restrictions on the full involvement of people with lived experience, including their unpaid carers.

Recommendation 11.4: The Mental Welfare Commission should be the lead organisation for this network, with responsibility for co-ordination and reporting to Ministers and the Scottish Parliament.

Recommendation 11.5: This network should develop a cross-agency framework for monitoring outcomes in mental health and should ensure that:

- **the promotion, protection and realisation of people's human rights is a common aim for scrutiny bodies across the mental health landscape.**
- **there is development and support for sufficient human rights expertise within all scrutiny bodies.**
- **there are mechanisms to identify, report and address systemic issues across the work they do.**
- **people with lived experience, including unpaid carers play a leading role in determining what defines 'quality' in services as the foundation for each scrutiny body's monitoring, evaluation and inspection processes.**
- **effective monitoring of the extent to which scrutiny bodies are meaningfully fulfilling their duties under section 112 to 113 of the Public Services Reform Act 2010 in relation to user focus.**
- **there is a single entry point for the public to access the appropriate scrutiny body for any information, support or issue they want to raise.**

The Mental Welfare Commission for Scotland

Recommendation 11.6: The powers and responsibilities of the Mental Welfare Commission should be strengthened in legislation. The changes we recommend are:

- **Its core remit should be to protect and promote the human rights of people with mental or intellectual disabilities. This should include both protection of the rights of individuals and promoting systemic change.**

- **The MWC should have a statutory responsibility to monitor the operation of the adults with incapacity legislation.**
- **There should be a substantial increase in the statutory requirement to include people with lived experience as service users, or family carers on the Board of the MWC.**
- **The MWC should strengthen the involvement of people with lived experience in their management, staffing and wider engagement, and should have a responsibility to co-operate with collective advocacy organisations.**
- **The MWC should increase its work in community settings.**
- **The legislation should include a level of accountability directly to the Scottish Parliament. This would include the power to make a report to Parliament if there is a serious failure by a public body, including the Scottish Government, to follow a recommendation.**
- **The MWC should have the power to initiate legal proceedings to protect the human rights of any person or group covered by mental health and capacity law.**
- **Consideration should be given to a change of name for the MWC to reflect its focus on human rights**.

Data Collection

Recommendation 11.7: There should be a duty on Public Health Scotland to actively lead work with the Mental Welfare Commission, groups representing people with lived experience, other agencies holding data and the research community to determine what needs to be monitored across mental health services to ensure human rights obligations are being met.

Recommendation 11.8: There should a duty on organisations holding data, including Public Health Scotland, the Mental Welfare Commission, the Care Inspectorate, Health Improvement Scotland, the NHS, the Office of the Public Guardian, local authorities, Police Scotland, the Scottish Prison Service and any other relevant organisations to work together to gather and make available the structured, disaggregated, researchable data needed to monitor mental health services effectively and drive change.

The Mental Health Tribunal for Scotland

Recommendation 11.9: The Scottish Government and the Mental Health Tribunal for Scotland consider and respond to the recommendations of the research project: Mental Health Tribunal for Scotland: the views and experiences of Patients, Named Persons, Practitioners and Mental Health Tribunal for Scotland members.

Remedies and access to justice

Recommendation 11.10: Individuals who are subject to or wish to initiate legal proceedings under our proposals, or their unpaid carers or representatives, should have access to non-means tested expert legal representation. The Scottish Government, working with the Scottish Legal Aid Board and the Law Society of Scotland, should ensure that there is an adequate supply across the country of expert legal advice and representation.

Investigating Deaths

Recommendation 11.11: The Scottish Government make a timely response to the Mental Welfare Commission's proposals to allow improvements to be made to the investigation of deaths of people under compulsory care and treatment as soon as is practical.

Recommendation 11.12: The Scottish Government should ensure that the role of the Mental Welfare Commission in investigating these deaths is explicitly placed in legislation.

Recommendation 11.13: The Scottish Government should ensure there is a mechanism to monitor and review the investigations into these deaths using the experiences of the families of those who have died as a key measure.

Recommendation 11.14: The Scottish Government should ensure that the development of any independent body to investigate deaths of people in custody and the development of the proposals for investigating deaths of people under compulsory care and treatment progress together to ensure opportunities for further alignment and equity between the two processes are not missed. (short)

Recommendation 11.15: The Mental Welfare Commission's powers to request information and co-operation from other authorities should be amended explicitly to cover any organisation with which it needs to collaborate for the purpose of these investigations.

Recorded Matters

Recommendation 11.16: The existing powers of the Mental Health Tribunal for Scotland to make recorded matters under Section 64(4)(a)(ii) of the 2003 Act should be strengthened as follows:

> **The Mental Health Tribunal, in the event of non-compliance with a recorded matter should be given powers to direct the relevant provider to provide within a specified time such care and support as may be required to:**
>
> - **avoid the need for an individual's compulsion; or**
> - **ensure that compulsion respects the human rights of the patient.**
>
> **In reaching a decision as whether to issue such a direction, the Mental Health Tribunal will have due regard to:**
>
> - **the core minimum obligations and any other relevant standards in place for the provision of mental health services,**
> - **the Human Rights Enablement approach taken with the individual,**
> - **and the wishes of the individual.**
>
> **The service provider will have an appeal to the Upper Tribunal against such a direction.**
>
> **Continued non-compliance with a direction will be a breach of a statutory duty which is justiciable in the Court of Session. (medium)**

Excessive security appeals

Recommendation 11.17: All patients subject to compulsion should have a right to appeal against being subjected to unjustified restrictions.

- **This right should extend beyond a person’s right to move to a less restrictive care or treatment setting. People would also have the right to challenge the level of restrictions while staying in the same place.**

- **This right should extend to restrictions imposed by a Community-based Compulsory Treatment Order, or a Deprivation of Liberty under the AWI Act, as well as detention in hospital under the Mental Health Act or Criminal Procedure (Scotland) Act.**

- **The appeal procedures would be modelled on sections 264 to 273 of the Mental Health Act. However, there should be no need for the appeal to be supported by a medical report by an approved practitioner. Instead, there should be a sift process to ensure that groundless appeals are not pursued.**

- **Regulations should set out the nature, severity and duration of restrictions which would potentially be subject to an appeal.**

- **The use and outcome of these provisions should be monitored by the Mental Welfare Commission to identify whether there are any systemic issues giving rise to appeals which require wider investigation or action**.

Recommendation 11.18: The appeal process should ultimately replace the ‘specified person’ procedures in sections 281 - 286 of the Mental Health Act. Before then, the Scottish Government should urgently progress reforms to the specified person procedures to ensure they appropriately cover modern technology and better reflect human rights.

Complaints

Recommendation 11.19: The Scottish Public Services Ombudsman remit should be extended to allow it to:

- **Oversee and drive a more holistic and human rights based approach to considering complaints for people with a mental or intellectual disability across health, social care and other public services.**

- **Share learning and best practice on complaint resolution and handling across Scotland.**

Recommendation 11.20: The legislative restriction whereby the Scottish Public Services Ombudsman can only accept complaints in alternative formats ‘in exceptional circumstances’ should be removed.

Recommendation 11.21: The Scottish Public Services Ombudsman should work with provider organisations, the Care Inspectorate, Healthcare Improvement Scotland, the Mental Welfare Commission and the Office of the Public Guardian, to support a lived-experience led change project to design a complaints system that better meets the needs of people with mental health and capacity issues and which is based in human rights. To support this:

We recommend an improvement methodology for testing this new model.

Our work has shown that to be based within a human rights approach and to address barriers people experience in the current system, it should:

- **Have complainants as active, trusted and valued participants in a dialogue about the decisions that affect them.**
- **Be developed by complainants and their families, with complaint handling bodies as partners.**
- **Look towards more solution-focused and collaborative ways to share concerns without necessarily having to escalate them to complaints.**
- **Have meaningful processes to monitor, follow-up and report on issues raised which allow us to:**
    - **Know the outcomes in terms of what difference was made to the individual or what changes were made to the services.**
    - **Identify patterns or themes which may indicate systemic issues and be fed back into the system for learning and development.**
    - **Gather equality data to understand and monitor who the system is working for and who it is excluding.**
- **Support people to share their experiences in the way that works best for them. This could include the involvement of peer workers, having access to specialist clinicians, or providing people with additional training on communication methods, mental illness or anti-racism.**
- **Have a single point of access for the system.**

Independent collective advocacy

Recommendation 11.22: People with mental or intellectual disability should have a right to collective advocacy.

Recommendation 11.23: There should be a legal duty on the Scottish Government to secure and support effective collective advocacy organisations for people with a mental or intellectual disability at a local and a national level.

Recommendation 11.24: The Scottish Independent Advocacy Alliance (SIAA) and collective advocacy organisations should work with collective advocacy members and workers to lead in the development of:

- **a system for supporting, monitoring and evaluating collective advocacy groups. This system needs to respect their independence and be meaningful to the groups, commissioners and the public. It may build on the existing SIAA standards.**

- **an opt-in programme of advocacy related learning to support the development of more advocacy workers and peer leaders. This will include training on anti-racism, intersectionality and human rights.**

Collective complaints

Recommendation 11.25: Individual and collective advocacy groups should have an explicit right to raise a court action for human right breaches.

Recommendation 11.26: This right must be supported by access to legal advice, guidance and support for groups who wish to take this step.

Recommendation 11.27: Individual and collective advocacy groups should be able to refer systemic human rights concerns to the Scottish Public Services Ombudsman. The Ombudsman's role should be extended to allow them to investigate these as a collective complaint.

Recommendation 11.28: The Mental Welfare Commission and advocacy groups should develop a participatory referral process to escalate human rights issues that remain unresolved and unaddressed by services to the Mental Welfare Commission to investigate and, if appropriate, initiate legal action.

Chapter 12: Children and Young People

12.1: Introduction

Mental health law applies to children in essentially the same way as it does for adults. A child can be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or required to accept medical treatment. The recommendations we make throughout this document affecting mental health law are generally applicable to children. In this chapter we discuss any additional factors specific to children.

The Mental Health Act includes some additional duties and responsibilities in relation to children. We have considered whether these need to be strengthened.

Incapacity law and adult support and protection law only applies to people aged 16 or over in Scotland. However, the United Nations Convention on the Rights of the Child (UNCRC) makes clear that the rights it confers apply to people under the age of 18. There are therefore some people who have the rights that children have but who are subject to Adults With Incapacity (Scotland) Act 2000 (AWI) or Adult Support and Protection (ASP) legislation. There are also many practical issues about the transition from child to adult law and services.

The role of parents and families is of course different in relation to a child, and has implications for areas such as consent to treatment and sharing of information.

Finally, we consider how mental health law relates to other legal frameworks for decision-making in respect of children, including child protection law.

The UNCRC and UNCRPD

The UNCRC sets out the human rights of every child. The UK has formally agreed to the UNCRC, so the UN would expect the Scottish Parliament and Scottish Government to develop Scotland's law towards compliance with it. The Scottish Government intends to reintroduce a Bill to enshrine the UNCRC in domestic law, as far as it is possible to do this within devolved powers.

This would mean that public authorities must act in a way which complies with the UNCRC and courts could decide if Scottish legislation is compatible with the UNCRC.

This Review has considered the possible implications of the UNCRC for mental health law. The UNCRPD has major effects on how the UNCRC should be interpreted in this context, so the Review has also considered that Convention in relation to children. The UNCRC and UNCRPD tell us that children with disabilities, through their representative organisations, must be involved in developing all law, policy and practice which affects them.

This Review has looked at what the UNCRC and UNCRPD mean for mental health law. Children's mental health law may needs to be reconstructed within the new paradigms of the UNCRC and the UNCRPD, which require states to bring about real equality for children with mental or intellectual disability:

- Law should focus on socially constructed barriers. Those barriers can be attitudinal, physical, environmental, social and economic. They interact with impairments, and prevent children with disabilities from participating in life on an equal basis with their peers.

- Law should represent children as subjects of rights and agents of change, with evolving capacities. Children are not objects of charity or passive recipients of care, treatment or welfare.

- Law should require a human rights-based approach to designing, implementing, monitoring and evaluating all law, policy and practice. This approach respects children and enables them to affect these things to the full extent of their evolving capacities.

Overview of concerns

The Review's December 2020 interim report gave a summary of some of the evidence that we received about children and young people. Our engagement since then supported what we found in 2020.

There is a lot of evidence that the system is under great pressure, with Child and Adolescent Mental Health Services (CAMHS) spending a lot of time assessing people who then do not receive a CAMHS service. There is a huge gap between the small number of specialised interventions for people with the highest level of need, and the limited support from primary care and community services. Specialist support is important, but needs must also be addressed holistically. Also, there is evidence that people in crisis are sometimes admitted to a psychiatric bed, including under the Mental Health Act, simply because other services which might be more appropriate do not exist.

Too often, families and unpaid carers do not feel supported or empowered. There is also evidence that transitions from childhood into adolescence and then adulthood are often poorly managed.

Issues of mental distress – including distress associated with a diagnosed 'mental disorder' – are much wider than specialist children's mental health services. A huge proportion of children and young people who find themselves within the care system or child protection, or who need additional support for learning, have mental or intellectual disability.

These findings are not new or particularly controversial. They reflect findings in earlier reviews of children's mental health services. There is already a great deal of work underway to address these issues. We are focusing particularly on where the law might make a positive difference.

Several reviews have found a need for human rights-based approaches to mental health services for children. For example, the Independent Care Review proposed law reform which moves away from law that reflects the needs of services, and which moves towards a system that reflects the needs of Scotland's children and their journeys into adulthood.

12.2: Principles

12.2.1: This is where we started

We discuss in Chapter 3 the principles which guide current mental health law, and our proposals for reforming them. One of the principles of the Mental Health Act is a 'child welfare' principle – that anyone 'discharging functions under the Act' in relation to someone under 18 shall do so in 'the manner that best secures the welfare of the patient' (section 2).

This appeared to us to be broadly consistent with Article 3 of the UNCRC:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

We felt that there should continue to be a specific principle reflecting the needs and rights of children in the principles of future mental health law. We asked for views on whether the current Mental Health Act principle for children is sufficient, or whether it should be replaced by a wider principle: that all the rights of the child under the UNCRC should be respected in any intervention.

12.2.2: This is what we heard

There was widespread, though not universal, support for the retention of a ‘children principle’. There was also significant support for replacing the current principle with a general reference to the UNCRC, although some respondents said that the implications of the Convention for mental health care were significant and would need detailed consideration in guidance, and widespread consultation, including with children and young people.

Responses in favour of a UNCRC principle included the Children and Young People’s Centre for Justice, Scottish Association of Social Work, the Mental Welfare Commission, Support in Mind Scotland and Children in Scotland.

Children in Scotland said:

> ‘We agree…that a specific principle relating to children and young people should be widened to make reference to the fact that all rights under the UNCRC should be respected when considering and undertaking interventions and indeed when considering mental health policy more broadly. We would be particularly supportive of this approach as it would give greater respect to the voice of children and young people when decisions are being taken (Article 12). It would also be more explicit in determining what constitutes the best interests of the child (Article 3) than the principle contained within the 2003 Act.’

The Scottish Human Rights Commission said:

> ‘We agree that the current child welfare principle is broadly consistent with Article 3 UNCRC and also reflects Article 7(2) CRPD. The principle may need to be expanded to reflect respect for the evolving capacities of children in line with Article 12 UNCRC and Article 7(3) CRPD. Article 7(3) states: “States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children,

> and to be provided with disability and age-appropriate assistance to realize that right." Incorporating this aspect highlights the respect for a child's will and preferences as a balance against over-reliance on a best interests approach. Article 7(3) recognises that the evolving capacities of a disabled children must be given as much weight as for a non-disabled child, and highlights the need for support to evolve and express them where needed.'

The First-tier Tribunal for Scotland Health and Education Chamber said:

> 'With the planned incorporation of the UNCRC, which makes reference to the "best interests of the child" (Art 3), the current wording of the 2003 Act will become outdated…A general reference to functions under the 2003 Act having to be 'discharged in a way which respects the rights of the child under the UNCRC' or some such formula would be a way to ensure alignment between the 2003 Act and the UNCRC. The language of 'best secures' in section 2 of the 2003 Act is weaker, and could lead to a dilution of respect for the rights of the child.'

The Royal College of Psychiatrists stressed that 'The implications of the UNCRC and how this would be delivered in mental health settings needs consideration. Clinical guidance, in particular for children with communication / intellectual difficulties, would be essential to the delivery of ambitious extensions of the consideration of rights in clinical practice, if full incorporation of the UNCRC is to be achieved. With this in mind, the current principle is more applicable to mental health care and treatment than wider UNCRC principles.'

The MWC and a detailed individual response highlighted that there were tensions between the approach for children and the general principle of Autonomy. The UNCRC requirement of respect for the evolving capacities of children as they age and mature was felt to be in tension with a general principle based on respecting the will and preferences of the individual.

Social Work Scotland and the Care Inspectorate highlighted that the principles of Getting It Right For Every Child (GIRFEC) were embedded across children's services in Scotland and should also underpin mental health support. Social Work Scotland also said that a link to the UNCRC 'would provide additional weight and emphasis to considering rights currently less prevalent in assessing children's mental health such as the right to family life.'

COSLA suggested that, if the proposed new legislation to incorporate the UNCRC was successful, a specific principle in mental health law would not be necessary, as relevant bodies making legal interventions would automatically be legally obliged to comply with UNCRC. They also pointed to the need to make clear links to the current refresh of GIRFEC in taking forward this work.

The Health and Social Care Alliance recommended that any changes to legislation should undergo a Children's Rights and Wellbeing Impact Assessment.

12.2.3: These are our final recommendations

We are persuaded that a direct reference to the UNCRC is the most straightforward and comprehensive way to ensure that all the rights in the Convention are considered in future mental health interventions. This will avoid any suggestion that the focus is narrower in clinical settings or that there is an additional balancing exercise to be carried out.

We note the concerns regarding the autonomy principle but, as we say in Chapter 3, tensions will exist between different principles, and the UNCRC alongside the UNCRPD provide the framework for reconciling those tensions in relation to children. So an autonomy principle as it applies to a child should be read in the context of Article 3 (best interests of the child to be a primary consideration) and Article 12 (views of the child to be given due weight according to their age and maturity), alongside Article 7 of the CRPD (disabled children to be provided with disability and age-appropriate assistance to realise the right to express their views freely).

We note COSLA's point that this principle may be unnecessary if wider legislation requires that the UNCRC be applied in any event. That may be an issue for consideration in drafting future legislation but our current view is that it is helpful to ensure that the duties in relation to the UNCRC are clearly highlighted alongside other key principles of the legislation.

We also note the importance of GIRFEC in Scotland. We do not believe this needs to be specifically mentioned in our primary legislation, but making the connections to GIRFEC will be important for subsequent guidance.

We recommend

Recommendation 12.1: That the principles of future mental health and incapacity legislation include one of Respect for the rights of the child: Any interventions concerning a person aged under 18 shall respect the rights of that person under the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities (see also chapter 3) .

Recommendation 12.2: Before finalising the wording of the principle of respect for the rights of the child, and developing related guidance, there should be a process of consultation and engagement with children and young people.

12.3: Rights to support

12.3.1: This is where we started

As we set out in Chapter 2, we believe mental health law should ensure that all human rights of people with mental disabilities, including children, are respected.

The National Taskforce on Human Rights Leadership has identified that there should be minimum standards which can be guaranteed. It recommends:

> ‘That there be a participatory process to define the core minimum obligations of incorporated economic, social and cultural rights, and an explicit duty of progressive realisation to support the effective implementation of the framework.’

As far as we can tell, although the existing duties in the Mental Health Act for local authorities to provide services (sections 25 to 27) apply to children as well as adults, they are not used in that way, at least in any sense that can be measured.

We propose at Chapter 6 a legal requirement for the Scottish Government to establish minimum core obligations to people with mental or intellectual disabilities to secure their human rights, and that the duties at sections 25-27 be reframed and extended – for children as well as adults.

The Mental Health Act also contains, at section 23, a general responsibility for health boards to provide ‘such services and accommodation as are sufficient for the particular needs of [a] child or young person’, but this is confined to children who are detained or admitted to hospital.

Section 23 is generally understood to mean that children should be in specialist services rather than adult wards, although it is not an absolute requirement. The MWC monitors and reports on the extent to which children are admitted to adult or non-specialist wards.

There is some evidence that this has contributed to the development of specialist in-patient services for children, but we wanted (a) to strengthen the accountability for it and the ability of young people, their families, or bodies like the MWC to challenge a failure to deliver, and (b) to extend the duty beyond in-patient services.

Section 277 of the Mental Health Act seeks to ensure that children who are detained continue to have access to education. There are some good examples of this for long term detention, but children with more intermittent admissions or who are ill at home may often lose out on their education.

Section 260 of the same Act requires ‘hospital managers’ to ensure that ‘reasonable steps’ are taken, including providing information, so that people who are subject to orders understand the effects of those orders and rights which they have. This duty could be developed further for children.

We sought views on a statutory duty on Scottish Ministers and health and care agencies to provide for children the minimum standards needed to secure the human rights set out in international treaties.

12.3.2: This is what we heard

There was support for broader and stronger statutory duties from a number of responses, including See Me, the Children and Young People Centre for Justice (CYCJ), SCLD and Includem. CYCJ said:

> ‘CYCJ believe that having a statutory duty on Scottish Ministers and health and care agencies to provide the minimum standards required would help to ensure delivery of these rights for children. We are also in agreement that this should be extended to all children whether they are being supported in hospital or at home in the community. In addition, the statutory duty should be extended to ensure those children deprived of their liberty in custody or secure care centres also have the minimum standards met.’

SCLD agreed, but added that ‘meeting a minimum core should not be where aspirations end’. They sought an additional commitment to continue progressive realisation of the rights of children and young people accessing mental health services in line with Article 24 of the UNCRC.

SASW commented:

> ‘An enforceable statutory duty on Scottish Ministers should serve to strengthen mental health support, but only if accompanied by the necessary resources. Such a duty, to be fully effective, would need to ensure adequate, consistent provision of a range of supportive services, from preventative through to acute, with smooth transitions all the way from infancy to adulthood, across all of Scotland. We hear from our members that provision is currently patchy and not always straightforward for children and their families to navigate. Clear pathways for assessment and provision of services should be in place for all children.’

The scope of the duties

Several respondents pointed out that work to develop service standards already existed, for example through the Child and Mental Health Services (CAMHS) service specification, the Neurodevelopmental Service Specification and the work of the Mental Health Task Force. It would be important to consider how any additional standards related to this work.

Social Work Scotland agreed that ‘There are consistent issues related to the lack of Child and Mental Health Services (CAMHS), particularly for those who are most vulnerable i.e. those struggling with other underlying challenges such as poverty, disability, abuse or trauma, or with care experience.’

They went on to point out that:

> ‘Children’s mental health is a complex area, and not all mental health support is, or should be, health focussed…Education provision and community supports, which may not neatly fit with a ‘mental health support’ label, are important parts of the mental health framework for children…For some children, there are specific issues, and provision of treatment centres and in-patient services for children are particularly poor and not accessible to many children and young people.’

Includem highlighted that almost half of care-experienced children and young people meet the criteria for a psychiatric disorder, rising to 75% for those in residential homes.

Whose responsibility?

The Forensic Network pointed out that if duties extend beyond existing service specifications into the wider social determinants of mental ill health, it ‘should be clear which level of governance has responsibility for initiating change’.

The Royal College of Psychiatrists said that: ‘Co-ordinated Support Plans and other mechanisms already impose duties on services to meet children’s mental health needs, but that these duties do not have sufficient teeth to be enforced.’ In relation to systemic issues, they felt it was important not to raise expectations on clinicians without the subsequent power to enact change. From their perspective:

> ‘It is uncertain whether these duties would address the core issue preventing the fulfilment of rights in CAMHS, of in-patient units getting ‘blocked up’ by young people waiting on social care supports. A statutory duty on IJBs and other authorities to address such specific gaps would be much more meaningful than overarching responsibilities not directly linked to clearly present issues.’

The MWC agreed that ‘it would be unrealistic to expect mental health services as currently constituted to be able to deliver on meeting all the rights set out in international treaties.’ They suggested that the HRE framework (see Chapter 8) might be helpful in setting out how these wider rights have been considered in an individual case.

Right to education (section 277)

The Health and Education Chamber gave a detailed response on the duty in section 277 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and section 14 of the Education (Scotland) Act 1980 to secure education for children subject to compulsory measures. They identified a number of limitations meaning this did not fully live up to the right of children affected by a mental health condition to a decent education, including:

- It only applies to children subject to compulsory measures
- It only applies to children unable to attend school, not those who could attend part-time or who need other supports
- For those not subject to compulsion, section 14(1)(b) of the 1980 Act referred to ‘prolonged’ ill-health, which they argued was not a necessary condition if the child is unable to attend school.

They proposed replacing this with a duty on all education authorities to comply with the duties in section 2 of the Standards in Scotland’s Schools Act 2000 and section 1 of the Education (Scotland) Act 1980, in light of the provisions of the UNCRC, in relation to all pupils, whether they have mental or intellectual disability or not. This would require education authorities to secure education ‘directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential’ (section 2, 2000 Act). This new duty would need a direct and effective enforcement mechanism, which is lacking in the current law.

A further suggestion from the Salvesen Mindroom Centre was that people subject to compulsion under mental health law could be automatically deemed to have Additional Support Needs, as already applies to care experienced children. This would bring into play the duty in the Education (Additional Support for Learning) (Scotland) Act 2004 to make ‘adequate and efficient’ provision for additional support needs.

Information (section 260)

Includem commented that:

> ‘It is recognised that children experience mental health challenges differently to adults, resulting in needing different things from services. This includes how their experience of poor mental health is understood.
>
> This often results in barriers to them accessing the right care at the right time. Includem support the view that Article 12 of the UNCRC, the right to be heard and for due weight to be given to these views, is fundamental to accessing all other rights. As stated in the United Nations Committee on the Rights of the Child’s General Comment No. 12 (2009) The right of the child to be heard, “Article 12 is connected to all other articles of the Convention, which cannot be fully implemented if the child is not respected as a subject with her or his own views on the rights enshrined in the respective articles and their implementation”.
>
> Includem would therefore like this to be strengthened throughout the legislation and any subsequent practice guidance to ensure that children and young people experiencing poor mental health are afforded the space and mechanisms to be able to express a view in relation to their care and for this view to be given due weight, particularly in relation to any administrative proceedings under the Act.’

Developing new duties

Includem highlighted the importance of working directly with children and young people with expertise by experience to develop the minimum core obligations. The Care Inspectorate agreed that additional minimum standards should be ‘developed in partnership with children and young people who have first-hand experience of services’. They added:

> ‘Considerable time for service implementation and culture change would be needed and it would be important to consider monitoring, reporting, quality assurance, inspection and crucially understanding impact and outcomes for children.’

12.3.3: These are our final recommendations

We remain of the view that there should be clear statutory duties reflecting the human rights of children and young people who need support for mental health needs, or learning disability or other neurodevelopmental differences.

We have considered carefully the question raised by several respondents that, with work already underway to develop mental health service standards, what is the added value of new statutory duties?

Our view is not that the duties we propose are a substitute for the development of robust service standards – but that the way those standards are developed should reflect a human rights-based approach. That includes well-developed concepts set out in the National Taskforce for Human Rights Leadership report such as the requirements to establish minimum core obligations, the duty of progressive realisation, and a robust accountability framework including remedies for non-compliance.

We think it will be important, at least for the foreseeable future, that the general obligations in the human rights bill are reinforced by specific duties in mental health and capacity law. This applies equally to the duties relative to children.

Framing these duties in the context of the current complex framework of education, children's and mental health law is not straightforward. Assuming these frameworks remain distinct, the duties need to complement and support each other, and not leave gaps where a child's particular needs can be lost. As The Promise Scotland has highlighted in its work, it should be for services to join up around the child, not for the child to navigate these complex systems. Our recommendations are developed from the existing duties in the Mental Health Act, but they will need to be seen in this wider context.

We strongly endorse the view that the way in which minimum core obligations and duties of progressive realisation are designed must also reflect a human rights-based approach, with the full and meaningful involvement of children and their families.

We recommend:

Recommendation 12.3: There should clear and attributable statutory duties on Scottish Ministers and on NHS Boards, local authorities and integration authorities, to provide or secure such care, support and services as are needed to secure the human rights of children with mental or intellectual disability, including but not restricted to the right to the highest attainable standards of mental and physical health. This should include specific care and support for children who have, or have had, a mental or intellectual disability, alongside measures to prevent mental ill-health and promote the wellbeing of all children.

Recommendation 12.4: These duties should reflect agreed minimum core obligations developed through engagement with experts including experts by experience, alongside duties and a framework for progressive realisation of those rights. The development of these duties and associated standards should draw on human rights approaches including applying the PANEL principles and use of the AAAQ framework. Services should be age-appropriate.

Recommendation 12.5: In line with the recommendations of the National Taskforce for Human Rights, there should be accessible, affordable, timely and effective remedies and routes to remedy where any of the above duties are not upheld. This should include the ability of individuals to raise a legal action in the civil courts.

Recommendation 12.6: Education authorities should have a duty to secure appropriate education for all children with mental or intellectual disabilities, including but not restricted to children in hospital or subject to compulsory care. This should be enforceable at the Additional Support Needs Tribunal.

12.4: Crisis services

Our work included a joint event with the Royal College of Psychiatrists which also involved lawyers, social workers, nurses, psychologists and other stakeholders. That event highlighted a particular concern around crisis interventions when children are felt to be at serious risk of self-harm.

It was suggested that mental health services were being asked to fill in for gaps elsewhere in the system. This meant some children received sub-optimal care, but it also risked professionals feeling they had to stretch legal tests simply to keep people safe. It also risked escalating rather than resolving crises.

There was widespread support for the development of alternative places of refuge for children and young people experiencing acute distress.

We invited further views on the need for reform of crisis services for children and young people.

We found strong and widespread support for the view that current crisis services were inconsistent, and often inadequate, leading to children being left unsupported or required to be cared for in inappropriate settings. The case for reform was supported by, amongst others, the MWC, Includem, Children in Scotland, Support in Mind and Glasgow City Council.

Moray Council commented that ‘The current care provision for children and young people’s mental health is not fit for purpose’.

The Royal College of General Practitioners said: ‘Our…RCGP Scotland members tell us that there has been a significant rise in the number of crisis mental health presentations across all ages to General Practice, and resources available are insufficient to meet this demand’.

The Care Inspectorate highlighted that this problem has already been identified:

> ‘In our publication, on the deaths of looked after children in Scotland during 2012-18, we reported on the deaths of 42 looked after children and young people…We noted, “From an early age, these young people were self-harming and frequently identified as experiencing suicidal thoughts or making actual suicide attempts. They were referred to child and adolescent mental health services but rarely diagnosed with a recognisable mental illness...A common theme was the significant gap in accessible community-based services to improve the mental wellbeing of looked after young people.”

> There is a need to reform the crisis supports available to children and young people experiencing acute mental distress. However, any developments in this area should consider the holistic needs of children experiencing distress and displaying behaviours that place themselves or others at serious risk. This would be regardless of the cause, whether mental distress, substance use or for other reasons. Children need the right response at the right time.
>
> We have concerns about the pathways young people follow to access mental health services; often this is crisis-led, with poor planning, and dependent on the local authority for provision of supports.
>
> These concerns were reinforced by the Care Inspectorate's triennial review of initial and significant case reviews which found that 'Young people repeatedly present at emergency departments with self-harming or possible suicidal behaviour…with no follow-up referral to the Child and Adolescent Mental Health Service (CAMHS), or to social work prior to discharge.'

Our earlier engagement highlighted concern about children being placed in mental health services because of a lack of alternatives. There was confirmation that this can sometimes be the case, particularly in the context of a breakdown in a placement of a child who is looked after by the local authority.

However, several responses highlighted that the problem can also work the other way – with people in secure care because they cannot access mental health support.

> 'In the above report we commented that, "young people at high risk of self - harming and suicide" were "inappropriately placed in secure accommodation because there was no available inpatient mental health facility"…There were limited options available to rehabilitate these young people from secure accommodation back into the community when they were discharged between 16 and 18 years of age.' (Care Inspectorate)

> ‘We also agree that there should be provision of safe and child-centred alternatives to admission to psychiatric care. However, these are also required for many children who are deprived of their liberty within secure care centres due to experiencing acute distress and mental health issues (including trauma, attachment difficulties and self-harming behaviours) and a lack of appropriate community alternatives (Moodie & Gough, 2017)’.

Several local authority responses highlighted concern about CAMHS being a 9-5 and weekday service, suggesting that this contributed to the need for Emergency Detentions out of hours.

A number of respondents stressed the need for preventive measures:

> ‘…it would also be prudent to think about preventative measures which stop children becoming distressed. Early intervention and more community-based services are going to be key to intervening before a child gets to crisis point.’ (SAMH)

SASW pointed out that a good initial response to a child in crisis is, in itself, preventive:

> ‘If we can get it right at the point of initial contact, with responsive, need-led, rights-based crisis provision the benefits will not just be to children and their families at the point of crisis, but will serve to reduce repeated escalations and long-term intervention.’

Some responses highlighted work already underway, with Children in Scotland mentioning the new National Suicide Prevention Leadership Group’s Youth Advisory Group and COSLA pointing to the work of the Children and Young People’s Mental Health and Wellbeing Joint Delivery Board, and emerging evidence from the DBI (Distress Brief Intervention) pilots. The national CAMHS specification 2020 sets out expectations, including that CAMHS should contribute to a 24/7 liaison model for under 18s.

However, we did not get the sense from respondents that the known concerns about the system were on the cusp of being resolved.

12.4.1: These are our final recommendations

From a legal perspective, one of our initial concerns was that the Mental Health Act may, with the best of motives, sometimes be stretched to breaking point to detain children in hospital whose needs would be better met by other services. We are still concerned that this may be happening.

However, the consultation response suggests that the issue is wider. People in the NHS are concerned at the lack of community services; people working in local authorities complain of difficulties in accessing CAMHS support; and nearly everyone agrees that there are major gaps across the system.

We recommend

Recommendation 12.7: The Scottish Government should lead systemic reform of services available to children and young people experiencing acute mental distress, including the provision of safe and child-centred alternatives to admission to psychiatric care.

12.5: Emergency detention safeguards

12.5.1: This is where we started

Children, like adults, can be subject to emergency detention for up to 72 hours in hospital (sections 36-43 of the Mental Health Act). This can be authorised by a medical practitioner, including a GP. The doctor should obtain the consent of a Mental Health Officer, but need not do so ‘if it is impracticable’ (section 36(6)).

The MWC is concerned that Mental Health Officers (MHOs) may often not be involved in emergency detentions. The MWC has reported a rising number of detentions of young people aged 16 and 17 for mental health care and treatment in Scotland with self-harm as a key characteristic, particularly for young women.

The involvement of a social work professional who can consider and potentially provide access to alternatives to admission is particularly important for children, in our view.

Being forced to go to hospital and remain there can be traumatic for anyone, but particularly so for a child. Experts have argued that a child has a right to be brought before a ‘competent authority’ within 24 hours of detention. Article 37(d) of the UNCRC requires that:

> ‘Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action’.

In the Oxford commentary on the UNCRC, Tobin and Hobbs (2019) state that protection against arbitrary and unlawful deprivation of liberty is applicable to all deprivations of liberty, including for mental illness.

We consulted on whether the safeguards for children should be strengthened by

- A requirement that a Mental Health Officer should always consent to emergency detention
- A provision requiring a formal review within 24 hours.

12.5.2: This is what we heard

A number of respondents were in support of the suggested additional safeguards, including Advocard, Support in Mind, and a local authority. Salvesen Mindroom Centre felt that the right to legal representation within 24 hours was essential, alongside access to suitably skilled advocacy practitioners.

The MWC agreed in principle with the requirement for MHO consent, but were unsure why this should only be for young people:

> ‘The expectation is that the safeguard is available for everyone and yet we are seeing a fall in the use across age ranges and particular gaps when we consider marginalised groups who are less likely to receive this safeguard…if the system is serious regarding multi-disciplinary involvement to ensure a wider perspective on restrictions, provisions in the law that allow detention to proceed from a community setting, on the basis of a single medical professional view-point, need to be ended.’

SHRC said that early review of emergency detention was required in order to comply with Article 5.4 of ECHR.

However, several respondents highlighted concerns about practicality, particularly in the current context.

> ‘The demand for MHO scrutiny in an emergency situation could lead to delay in detention processes which may escalate risk for the child. Data would suggest that [emergency detention] without MHO consent is heavily utilised across the country and while this may be a practice issue that can be improved upon, the demand on human resource, especially in rural areas should not be overlooked.’ (Dumfries and Galloway Council)

The Royal College of Psychiatrists said: ‘The notion mental health officers could be able to confirm an EDC 24 hours a day is unrealistic based on current staffing provision. MHO authorisation will lead to young people waiting on interventions they need.' However they also argued that 'an expectation that an MHO be made available 24/7 to all children being considered for detention in Scotland would be an appropriate application of [the reciprocity] principle. This should be a minimum standard under any new legislation and drive appropriate training and recruitment'.

Another concern was that the involvement of an MHO was of little value unless they were able, at least in some cases, to identify and access alternatives to hospital detention, and that not all MHOs had strong links to or experience in child and family support teams.

Dumfries and Galloway Council suggested:

> 'Extending duties to children specialist social work teams as a key stakeholder when a child is being assessed or has been detained will offer access to appropriate alternatives to hospital admissions and a key gatekeeper to ensuring that children in crisis, that can be managed out with a clinical environment, are appropriately placed. There would however need to be significant resource investment into alternative "places of refuge".'

There was significant doubt about the practicality and value of a review within 24 hours of an emergency detention. The [Royal College of Psychiatrists argued that it wasn't clear how any independent review would not disrupt the child's care and treatment and that if the review were by a Tribunal this 'could be an additionally traumatic and intimidating experience if not appropriately handled'. However the College saw more value in a review on behalf of the Chief Social Work Officer, with the key role being 'to consider and provide where appropriate, a meaningful alternative to hospital detention (such as enhanced family support or an alternative social care placement)'.

12.5.3: These are our final recommendations

We are persuaded that it is not possible as services currently stand to require a MHO attend an emergency detention in every case, or that there be a formal review of emergency detention within 24 hours. We still believe, however, that the safeguards for children subject to emergency detention must be strengthened.

We recognise that, even with a more realistic complement of Mental Health Officers, there may be exceptional cases where it is essential to initiate an emergency detention before an MHO can consider and agree to it. But this should be exceptional – not the norm, as it has increasingly become.

We are also persuaded that a review by the Mental Health Review Tribunal within 24 hours is not the best way to safeguard the rights of children facing emergency detention. We have sought to recommend some practical alternatives, building on our wider reforms.

We recommend

Recommendation 12.8: Section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be amended to make clear that emergency detention without MHO consent should only take place in exceptional circumstances. These circumstances should be recorded and monitored by the Mental Welfare Commission

- **Scottish Ministers should, as part of the duty of progressive realisation, ensure that there are sufficient MHOs with expertise in child and family services to realise this expectation**

- **In any case where an MHO has not given consent, there should be a review by an MHO within 24 hours**

- **Within 12 hours of emergency or short term detention, a child should be given access to an experienced independent advocate**

12.6: 16 and 17 year olds in CAMHS

12.6.1: This is where we started

The child welfare duty in section 2 of the Mental Health Act applies up to the age of 18, as does the UNCRC.

However, we were told of inconsistencies in access to CAMHS by 16 and 17 year olds, particularly if they have left formal education. Sometimes this reflected different local policies about when transitions to adult services should take place. We also heard that resource pressures on CAMHS can sometimes mean that a 16 or 17 year old might be moved to adult services in order to free up capacity for younger children in urgent need.

We asked if there should be an entitlement for children to access CAMHS where needed, at least up to their 18th birthday.

We also noted that the brain continues to grow, and cognitive abilities continue to mature, until as late as 25 to 30 years of age. This has been reflected in other areas, including sentencing policy. Some duties to care experienced young people have also recently been extended to 26.

We were interested in whether there may be a need for a developmental approach to transition for young adults.

12.6.2: This is what we heard

There was support for a legal entitlement to access CAMHS up to age 18 from a number of respondents, including See Me, SAMH, the Royal College of General Practitioners and Salvesen Mindroom, with a recognition that this would require additional resources:

> ‘CAMH services are currently chronically over-stretched so this aspiration needs to be backed up by more resources: not just trained mental health professionals, but also allied health professionals and third sector providers.’ (Salvesen Mindroom)

Other respondents agreed with the principle that CAMHS should be available to at least age 18, but pointed out that the 2020 CAMHS Service Specification already provides that ‘CAMHS will be available for all children and young people who are aged 0 – 18, and who meet the agreed CAMHS referral criteria’. They suggested that this meant that a legal requirement was unnecessary. The Royal College of Psychiatrists went further and said ‘the CAMHS service specification is being implemented, and making these legally binding would have potentially unintended consequences’.

This reflected a wider concern for children and for young adults – that:

> ‘The transition of a young person with mental health difficulties should not be based on legislation or an arbitrary age range. Transition should be based on which service is best able to meet the young person’s needs. This would be a rights based approach and would avoid any potential discrimination on the basis of age.’ (Forensic Network)

Support in Mind took a similar view, at least in relation to people aged 18 or over:

> ‘Many of our participants voiced that “18 years is an arbitrary cut-off” and believe that the transition age should be more flexible and based on the needs

> of the individual. They felt that the transition age should be in the early 20s when their lives are ‘more stable’ and they are ‘fully adult’. This suggests that for young people accessing CAMHS transition into adult services should be based on developmental and clinical readiness instead of their age.’

SAMH highlighted that their ‘Going to Be’ campaign has called for CAMH Services to be available up to the age of 25 if that is what the young person wants. They welcomed a commitment to this in the Scottish Government’s NHS Recovery Plan and would also welcome this change being reflected in mental health law.

Respondents also stressed that the transition date was far from the only concern. Transition is a process that can take place over years, and there was significant concern that it was not always well handled.

> ‘We know from previous reports that children and young people feel that there is a big change in how adult services are delivered and that often their needs are not met as they undertake this transition. Increasing the age in which people can access CAMHS would enable young people to continue to work with practitioners who they know and trust. Indeed, we would support a more holistic approach to this whereby young people could continue to access CAMHS beyond the age of 18 in a similar approach to that taken with rights to continuing care, which covers care experienced young adults up to the age of 26.’ (Children in Scotland)

The Care Inspectorate highlighted particularly poor experiences for care leavers:

> ‘In our review of findings from children and young people inspection programmes over 2018-20, “we saw the poorest outcomes for young people in continuing care and care leavers. Many young people were constrained in their ability to successfully move on to adulthood by difficulties in accessing services such as mental health and wellbeing services”. We asserted that the transition period when a young person moves from children’s services to adults’ services

> was particularly challenging. “Processes to support the positive transition of young people between children’s and adults’ services were often disconnected and complex”.
>
> Children and young people involved in child protection or similar processes and looked after or care experienced children require specific consideration when ensuring age and developmental stage appropriate services…We would urge that when consideration is given to accessing CAMHS that flexibility is given at transition periods to ensure children receive support from staff with whom they have built relationships and understand their journey.’

The Royal College of Psychiatrists also highlighted the importance of a more consistent and a better managed transition process:

> ‘The dialogue between CAMHS and generalist adult services around transitions vary widely, between 6-month forward planning and a ‘trapdoor’ between the two settings from one day to the next. A wider cultural change is needed to fulfil a young person’s rights, recognising that person’s needs and preferences which can include preferring engagement from adult services. Adopting the principle of the service that best meets their needs is where they are engaged would be a better option.’

12.6.3: These are our final recommendations

We agree that young people should have a right to expect that they will have access to CAMHS up to age 18 at least, if that is what is right for them. We also agree that there should not be arbitrary cut-off dates, that it should be possible to retain links to CAMHS well beyond this, if that meets the person’s needs, and that for some young people, it may be right to move to adult services before then.

We have concluded that specifying a particular age limit for CAMHS in mental health law is not the right way to achieve these aims. There is a risk that it inhibits flexibility and care centred around the particular needs of the young person.

We believe that the best way for legislation to support our expectations is through the wider duties we set out, the HRE framework, the principle of respect for the rights of the child, and appropriate monitoring and accountability.

We are supportive of developing the approach already introduced for care experienced young people, that young people who have accessed CAMHS services should continue to be able to access support up to age 26 at least. We recognise that this will take time and would be part of the expectation of progressive realisation.

We recommend:

Recommendation 12.9: The existing service standard that CAMH Services should be available to children who require them up to age 18 should be considered for inclusion in the minimum core obligations for those services.

Recommendation 12.10: As already happens for the placement of children in adult wards, any decision to transfer someone to adult services before age 18 should be recorded and subject to oversight by the Mental Welfare Commission.

Recommendation 12.11: In defining those duties subject to progressive realisation, consideration should be given to ensuring that young people who have accessed CAMH Services continue to have access to support if they require it up to age 26.

Recommendation 12.12: There should be a programme of improvement to transitions between CAMHS and adult services, to ensure that transitions are well planned, maintain relationships which are important to the young person, and reflect the developing capacities and needs of the young person.

12.6.4: Interaction between child and adult legal provision

There is a complex set of provisions governing when someone moves from being a child to an adult in mental health, capacity, adult protection and children's legislation. This particularly affects 16 and 17 year olds.

The provisions of the UNCRC generally apply to anyone under 18 and this has been reflected in the UNCRC (Incorporation) (Scotland) Bill. As we discuss above, CAMHS generally operates up to age 18, as do a number of the duties applicable to children in the Mental Health Act. Child protection and welfare law is increasingly seeking to extend its remit to 18 and even beyond. But people become 'adults' in terms of legal capacity at 16. The AWI Act and ASP Act both apply to people aged 16 and over.

We met with professionals and officials working on the interface between child and adult law to discuss whether this causes particular problems in practice, and whether there was a case for changing any of the age limits.

Our provisional conclusion was that there was not a strong case for changing the age thresholds of the AWI, ASP and Mental Health Acts. However, attention does need to be paid to the position of 16 and 17 year olds, particularly in ASP, because of these developments in support and protection for children (as highlighted particularly in the National guidance for child protection in Scotland 2021).

The Scottish Government is committed to introducing a Children's Care and Justice Bill. The consultation on the Bill set out an intention to raise the maximum age of referral to the Principal Reporter to 18, for all children where there are concerns that may require compulsory measures of supervision through the Children's Hearings System.

In the consultation, views were sought on whether children should be able to be subject to measures via the Children's Hearings System beyond their 18th birthday.

In addition, within the consultation views were sought on broadening routes to secure care to ensure any child under the age of 18, where it is deemed necessary and in their best interests, has a legislative route. This would include 16 / 17 year olds who meet the secure care criteria under the Children's Hearings (Scotland) Act 2011.

All of these measures are premised on ensuring children aged under 18 are recognised, treated and supported as children, within age and stage appropriate systems and services.

It is unclear how this change might interface with young people currently being supported through Adult Support and Protection.

The interface is complicated, with different criteria for statutory intervention and different legal measures that can be authorised.

In some cases, it is conceivable that a 17 year old could be subject to measures under the Mental Health Act, the Adults with Incapacity Act, the Adult Support and Protection Act, Children's Hearings system and child protection legislation at the same time.

Also, young people aged 18-25 are increasingly recognised as an age group requiring distinct attention. This is evident in provisions in respect of care leavers and young people in conflict with the law through the Scottish Sentencing Council: Sentencing Young People Guideline.

Care leavers may of course have mental or intellectual disabilities, and there could be a complex interface between stronger duties of support under mental health and capacity law and any enhanced duties flowing from their status as care leavers.

These matters require further detailed consideration, including the engagement of young people. As an initial step, we believe it will be important for the Scottish Government to map out the interfaces between legislation to protect adults and children, identify groups where this interface is particularly salient, and explore how best to ensure support and protection is seamless and reflects the expectations of the UNCRC and the UNCRPD.

We recommend

Recommendation 12.13: The Scottish Government should take forward detailed analysis of the implications of changes in age limits in the child welfare system for the interface with adult support and protection.

12.7: Children, young people and parent carers

The aim of this Review's Children and Young Person's Advisory Group was to review developments in mental health law and practice to meet the mental health needs of children and young people since the current Mental Health Act came into force, and make recommendations to the Executive Team, with specific consideration of:

- The duties in the Mental Health Act relating to children and young people
- The interaction between mental health and child law and practice
- The implications of incorporation of the UN Convention on the Rights of the Child for mental health law
- The findings of the Children and Young People's Mental Health Task Force, the Youth Commission on Mental Health Services and the Care Review.

Early in the Advisory Group process, it was decided that we needed to hear from parent carers, children and young people and practitioners. The group agreed a way forward for taking evidence from relevant parties. It was proposed that evidence-taking be divided into formal evidence-taking from professional interest groups and a more informal way of evidence-taking for consulting with young persons, parents and carers.

Timing of evidence sessions was flexible to accommodate the working hours of professionals and availability of support groups, carers, young people and families.

Due to COVID 19 restrictions, evidence sessions had to be held online. The exception to this were the sessions involving parent carers and young people. These were, by request, mainly conducted via telephone.

12.7.1: This is what we heard (1)

From the interviews with parent carers some common themes began to emerge, especially around the issue of meeting the needs of young people with neurodevelopmental differences. Generally, it was felt that current CAMHS was not the most suitable service to meet such needs.

Communication was, on the whole, felt to be poor by majority of carers, especially during the time spent on waiting list and over three quarters of carers did not feel they were seen as equal partners in care and found it hard sometimes to have their views listened to. However, when they were listened to the carers felt valued and part of the team.

Carers did comment that they felt in some cases GPs were reluctant to refer knowing that a long wait ensued and often did not fully grasp the difficulties the child and family were facing.

Others felt that no matter what the GP did they could not access CAMHS services and even repeated referrals were rejected.

> ‘Problem is getting an appointment in the first place. GP was brilliant but they just said our daughter did not meet the criteria.’

Several carers pointed out the differences in different areas of Scotland. One family who moved during treatment noted:

> ‘…really cannot fault them, [CAMHS] right from the start they worked with us and communicated with us as partners. However, when we moved to another area, it was complete opposite.’

This lack of continuity was experienced even within a CAMHS team and this was seen to be down to high staff turnover and sickness rates.

> ‘…you very often don’t see the same person twice and this means having to repeat history etc.’

The role of named person was one which a few of the parent carers had experience of and it was generally felt that they were given sufficient information about it, although one parent did feel that she could have had more information about her own right to a solicitor.

The rights of parents and carers seemed to vary across services, with in-patient settings being more aware of the need to involve parent carers. However, this was not the case when it came to involving other members of the family, in particular siblings.

> ‘…they never ask you about your other children and how they are coping unless they think they are at risk.’

Some feedback from young carers - that is, young people under the age of 18 who provide unpaid care - was summed up in the following statement:

> ‘…it’s like they don’t see you. You are just the big brother, but they don’t see the nights when I am keeping him safe, preventing him from walking outside onto a road, helping him get dressed for school, all so I can give my mum a break. We are the invisible army who just get on with it but are never asked how do you feel, or what can you tell us.’

Within in-patient settings staff did not seem to understand the trauma of leaving a child in a psychiatric unit for a parent and little support if any was given at this time.

It was often difficult on the ward to have any time to speak to staff.

Families found it difficult to consult with medical staff and found months could pass without review meetings happening.

Weekly telephone updates were often made by junior staff who had not attended meetings and therefore could not answer any queries.

Reviews took place in large conference rooms with lots of staff which were intimidating to the young person and the family.

Areas of concern

The evidence collected from parent carers and young people had several concerning issues. In no particular order these concerns are outlined below.

- Age appropriate support where possible

The young people who provided evidence all felt that a peer worker would have been welcomed within CAMHS (both in-patient and out-patient). Having someone of a similar age was felt to be important by the young people.

> ‘One of my friends was being treated for cancer when she was 15 and in the ward there were youth workers who could work with and support the young person in what they were going through. Why can’t that be done in mental health? It is great to have people around your own age to talk with.’

- Accessing information

To enable young people to express their views and opinions it is crucial that accurate information is provided. The UNCRC makes this clear and there needs to be more effort made to ensure such information is provided to allow young people to make decisions.

- Dignity and respect

The young people interviewed shared the same concerns as parent carers around inconsistency of staff and changing of staff. Another shared concern was staff being late for appointments.

Also of concern was time-keeping of staff. Barriers to accessing services can be found in things we don’t always consider as barriers such as waiting areas. However, for children and young people with neurodevelopmental differences who experience sensory issues, a barrier may very well be the waiting area of the clinic. This may impact onto the child or young person’s right to accessible health services in its broadest interpretation. Although a service is available, the person requiring it may be hampered from using it by barriers such as noise, lighting levels and space.

The use of restraint techniques was raised by some parent carers and the young people. Some had witnessed the use of restraint and one young person had been the subject of restraint. On being restrained on a soft chair as opposed to the floor the young person reflected,

> ‘…how awful is that? I am, at the age of 15, thinking to myself well it’s better on a soft chair than a floor, rather than thinking is there nothing else they could do to help me understand my behaviour so I might not need to be restrained?’

Lack of understanding of LGBT+ issues was mentioned by one young person and a parent carers, and lack of any kind of peer support for young people in general:

> ‘…they refused to use my chosen name and insisted on my birth name. I am transgendered and it made things really traumatic for me.’

- Involvement in care and treatment

For many parent carers this was patchy and depended on how vocal the parent carers was. Involvement in discharge, a right extended to carers under the Carers (Scotland) Act 2016 (the Carers Act) was again a mixed story with many carers feeling that staff were not aware of their duty under this Act:

> ‘My husband works off-shore and we were assured our child would not be discharged when my husband was away. That is exactly what they did. I have two other children and I work part time. Do they not listen when you tell them things? I felt I was forced into taking them home. Lasted 4 days and was readmitted all before my husband could get home.’

- Neurodevelopmental differences

The majority of parents / carers who contacted us cared for a child or young person with neurodevelopmental differences such as autism, ADHD or Tourette syndrome. This perhaps highlights a growing concern about a gap in provision of services.

When asked if CAMHS was the right service for a child or young person with neurodevelopmental differences, the vast majority of responses were negative, including from two young autistic people.

> ‘You get a leaflet, a parent course and sent on your way’.

Many families felt blamed by services and some were actually accused of being part of the problem.

The standard treatment offered to these families seemed to be parenting courses, the majority of which were designed for behavioural issues in ‘neurotypical’ children and were of no use to these parents. They felt they couldn’t share their child’s behavioural issues and became more upset and isolated as a result.

> ‘The classes are well intentioned, but they are geared for parents of neurotypical children. We kept going because we thought we might learn something but as soon as we started to talk about our son and what we deal with we then felt we did not belong in the group. No other parent was going through this.’

> ‘Parenting classes are an insult to families dealing with complex and dangerous situations alone.’

One parent had been referred to parenting classes eight times.

12.7.2: This is what we did next

Following on from this initial piece of consultation the Advisory Group were able to discuss proposals for the final consultation. These proposals were discussed and decided upon by the Review’s Executive Team.

We had a lot of evidence from our initial consultation of families feeling shut out of decision-making – but also some evidence from young people of services talking to families rather than them.

Under Article 5 of the UNCRC, families have a right to support their children, and this may need more formal recognition.

We acknowledged that there were tricky issues about how to frame this for children aged 16 or 17, who are adults in terms of parental rights and the AWI Act, but children under the UNCRC. We address this at section 12.6 above.

We also recognised there will be situations where a child aged under 16 may choose not to have their parents involved and may have the capacity to do so. This may constrain what can be shared with parents, but they may still be entitled to support to meet their own needs, including caring needs.

Many of the problems we found required investment in training and culture, but we believe a legal responsibility to recognise the needs of parents could be an important starting point.

Unlike adults, children cannot choose their Named Person under the Mental Health Act. We think this should change where a child is able to choose – but we want to avoid the problems of the ‘listed initiator’ for adults (as discussed in chapter 3 under ’named persons’).

12.7.3: This is what we heard (2)

We then moved on to our final consultation.

Partners in Advocacy carried out a small number of activities with children and young people who were within an in-patient CAMHS service. Young people were asked if they were able to nominate a named person, and those over 16 years stated they had been informed. One young person however stated:

> ‘I didn’t want a named person but because I was under 16 I was told there would be a default named person put in place. My advocacy worker told me this would change when I became 16.’

The young people were asked their views on what coming into hospital was like and their replies ranged from being scared to feeling that they had no rights whatsoever. The Review similarly heard this from parents and carers of young people who had been admitted in both phases of the consultation.

The lack of information provided to parent carers and young people on admission appeared to increase the anxiety felt and meant that establishing a trusting relationship with staff proved more difficult. Young people could also view the admission as a way of punishing them for being unwell, as one young person stated:

> ‘They need to explain what is happening and help us when we are scared and angry. They need to talk to us and explain every step. I felt as though I was thrown into hospital as a punishment.’

The planning and process of discharge was discussed by the young people and the overwhelming responses were that young people did not feel included in any decision made about them especially around discharge, with one commenting:

> ‘Nurses just kept saying ‘you’re not going home anytime soon’ and I didn’t know what the plan was right up until the end.’

Issues of safety were also discussed with only one young person feeling safer in the hospital than at home as they could not self-harm. Others noted the impact of the behaviour of other patients and of staff watching them all the time and feeling stressed and unsafe due to this.

We feel that the experiences of this small sample of young people may highlight a need for raising of awareness around UNCRC, and in particular Article 12 on respect for the views of the child.

Feedback from children and young people throughout the Review consistently highlighted the need for more age-appropriate, culturally-sensitive independent advocacy to ensure bodies such as tribunals, NHS and local authorities place children’s rights at the heart of their services and when carrying out duties required by law.

- Parent carers and involvement

We consulted on a range of proposals on the involvement of parent carers:

Proposal: There should be a requirement for health and care authorities to take account of the needs of parents and families to information and support where this will help to support the child.

Many respondents felt that children's rights should be at the centre but there needs to be a recognition that parents have rights as well.

Children and Young People's Centre for Justice commented:

> 'The needs of parents and families should be provided for so that they in turn can provide the best support possible for children.'

They noted that this was relevant to ensuring that Articles 5 and 18 UNCRC were met.

Social Work Scotland stated:

> 'Children have rights and this must be at the centre of any decision made about them, and it is incumbent on professionals, alongside the child or young person and the person with parental responsibilities to ensure that those rights are upheld.'

This view was shared by many individuals as well as organisations. In discussions with some young people, they also agreed that their rights must be given regard to and placed at the centre.

British Deaf Association noted particular concerns for deaf children and young people and stated that parent carers should be given appropriate information and support that is tailored to the child/ren's needs to aid effective decision-making. For many deaf children and young people, not having the right information in a format they understand can mean procedures or treatments are not explained adequately. This reduces the involvement of the child or young person in decision-making.

The Royal College of Psychiatrists noted that care needed to be taken not to disenfranchise family members: '…the tension of a child being able to potentially 'disenfranchise' a parent places clinicians in difficult situation of potentially disenfranchising family members'. This was felt to be especially important around areas of obtaining health history and medications which have been tried in the past, information which is usually held by parents.

Children in Scotland brought attention to the fact that not all children and young people have positive relationships with parents and sometimes their views may be in opposition. They suggested a role for independent advocacy to help address this .

This view was also shared by a group of LGBT+ young people whom we spoke with. We heard concern about professionals not fully understanding the dynamics of a young person's family, and so placing the young person in a situation of potential conflict with a parent or family member over how the young person wanted to be known . One parent of a young person identifying as female but born male found it very disrespectful and that the CAMHS in-patient service referred to the patient by birth name and not chosen one. The parent stated that this had an adverse impact on the person's recovery and broke any trust between family and staff.

Includem commented that children's rights should take precedence over any other provisions of the Mental Health Act and should inform the development of new provisions. They felt that Human rights enablement should be led by UNCRC and should not just take account of UNCRC.

Dumfries & Galloway Social Work commented that information sharing with parent carers should be done in a manner that is inclusive of the child. The MWC noted that more robust safeguards may be needed to allow easier sharing of information.

Proposal: Children who are able to do so should have the right to choose their named person in the same way as adults can.

Responses here were mainly positive with majority of organisation and individuals agreeing with children having the same right as adults. However, the Scottish Association of Social Work asked for more clarity around what the Review meant by ‘a child not being sufficiently mature’ and raised a concerns on this about risk to the Review’s intention on children’s rights.

The Royal College of Psychiatrists noted that robust alternatives were needed to ensure that a young person is not disadvantaged by not having a named person, and to make the switching of a named person work.

Proposal: Where a child is not sufficiently mature or is too unwell to choose a named person, the person with parental rights and responsibilities should remain as named person. Where this is not in the best interests of the child, the Tribunal at its own hand or at the request of a Mental Health Officer may remove that person and may also appoint another named person.

Responses on the whole supported this proposal, with Social Work Scotland stating:

> ‘As some children’s trauma and related mental health issues may be related to experiences in childhood involving immediate family, particular care is required in how information is shared. However, the person with parental rights choosing that individual where the young person is unable to do so due to capacity or age, would be in line with the legislative basis of parental rights, with this transferring to the MHO if this is not in the best interests of the child. However, we would suggest that this only happens where the Team Around the Child meeting has taken place to consider all the circumstance.’

This seems an acceptable approach and ensures that the best interests of the child can be safeguarded where the child is not able to consent.

Moray Council also agreed that a child who is able to do so should be able to choose their named person: the default named person, who is usually a family member, may not be the best candidate where the family is the source of trauma or distress. They felt that where a child or young person is unable to choose then the MHO should have that responsibility

Dumfries & Galloway Social Work felt that where a child is unable to nominate a named person then the default route to named person could be problematic where professionals may consider this is not in the best interests of the child. They suggested that a more transparent route of removal of named person should be developed to ensure that the best interests of the child are not overlooked. They suggested that there could be a professional ‘nomination’ if the default named person was removed, and proposed that any opposition to a no nomination could be raised through the Tribunal.

12.8: Supported decision making, Human rights enablement and Autonomous decision making

12.8.1: This is where we started

We set out in Chapter 8 a suite of measures which we hope will provide a basis for a reformed legal framework based on human rights. These have primarily been developed with reference to adults. Since mental health law also can apply to children, we need to consider how well our proposed approach may work for children.

The UN Committee on the Rights of Persons with Disabilities has issued General comment No. 7 (2018) on ‘the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention’. Paragraph 25 states:

> ‘States parties should adopt legislation, regulations and develop programmes to ensure that everyone understands and respects the will and preferences of children and considers their personal evolving capacities at all times. The

> recognition and promotion of the right to individual autonomy is of paramount importance for all persons with disabilities, including children, to be respected as rights holders. Children with disabilities are themselves best placed to express their own requirements and experiences, which are necessary in developing appropriate legislation and programmes in accordance with the Convention.'

The reference to considering the child's evolving capacities makes clear that 'respect for will and preferences' needs to be considered differently in relation to children. The UNCRC and Scots law provide that the best interests of the child should always be a primary consideration, and parents have a right to give a degree of direction, consistent with the evolving capacities of the child. However, there is a human rights imperative to strengthen the voice of children.

Under the Age of Legal Capacity (Scotland) Act 1991, if a child has the maturity to make a decision about medical treatment then their choice is respected. The test is the child's ability, in the view of the medical practitioner, to understand the treatment or medical procedure proposed and the possible consequences of treatment.

As with adults, this right to refuse treatment can be overridden under the Mental Health Act where there is evidence that the individual has significantly impaired decision making ability (SIDMA) which is related to the presence of a mental disorder. Initial evidence from the Royal College of Psychiatrists to this Review was that the SIDMA test worked reasonably well with children and young people.

However, this may not be the only route by which a child might be required to accept treatment that they do not want.

Where a child or young person under the age of 16 is too young or immature to take decisions about medical treatment, their parent (or someone with parental responsibilities) may consent to or refuse such treatment on their behalf (section 1 of the Age of Legal Capacity (Scotland) Act 1991). This potentially includes treatment for a mental or intellectual disability, and could mean the child being given such treatment without the safeguards of the Mental Health Act.

This can give rise to complex questions about which route should be used to authorise non-consensual treatment in children.

The existing Mental Health Act Code of Practice states that if a child or young person objects to, or resists, treatment for mental disorder then the appropriateness of using the Act should be considered (Vol 1, Chapter 1, para 33).

We felt that in principle, the Supported decision making / Human rights enablement / Autonomous decision making framework should be able to apply to children, but we sought views on any issues that this may create.

12.8.2: This is what we heard

Supported decision making (SDM)

There was very wide support for developing SDM for children:

> ‘Social Work Scotland members strongly held the view that there is no question that supported decision-making should apply to children – otherwise their rights are being considered as less than adults and the legislation would not be UNCRC compliant.’
>
> ‘Universal access to supported decision-making for children and young people is crucial to ensuring they are involved, respected and heard at all times.’ (Scottish Association of Social Work)

The Scottish Commission for Learning Disability said they ‘would welcome an exploration of a supported decision-making approach which is specific to working with children and young people’, and that ‘there will be significant learnings to be gained from the children's sector in Scotland given their considerable experience in ensuring the voices of children and young people are heard and taken into account'.

Specific approaches were cited in responses, including the Lundy Model of Child Participation, the My Rights My Say service, Children in Scotland's Principles and Guidelines for the Meaningful Participation of Children and Young People and Guidance from the Health and Education Chamber on how a child's evidence should be taken in a tribunal.

The Care Inspectorate supported the idea of SDM for children, but cautioned against adding to the number of people involved with supporting a child, given that they may already have a named person, an advocacy worker, a solicitor, a key worker and a social worker or lead professional all trying to ascertain and understand the child's views.

Human rights enablement (HRE)

There was more tentative support for the application of HRE principles to children, with some respondents supportive in principle but looking for more detail of how in practice this would work.

Autonomous decision making (ADM)

This was the most contentious area. Several respondents, including the Royal College of Psychiatrists, said that it was hard to engage with the proposals as they stood without a clearer understanding of how it was intended to apply to children. The Forensic Network wrote that:

> 'The impact on children and young people with capacity (as currently defined) is not clear. It was not clear how this new test would be affected by developmental maturity.'

Glasgow City Council wrote that:

> ‘Respondents warned of concerns at making significant changes to SIDMA/capacity in urgent situations.’

Respondents to our consultation also raised questions about how to guide practitioners in distinguishing between the supportive involvement of parents and family members and ‘controlling influence’, and the safeguarding implications of children being treated informally (with parental consent) for mental health conditions.

Advocard commented that:

> ‘In terms of how the ADM test might apply, the focus on will and preferences could be clouded from a maturity perspective, but we would expect considerable safeguarding in this situation, which would fall back on the HRE assessment. More detail of how this might work in practice would be helpful.
>
> It is our experience that it is very rare for our younger advocacy partners, not to be able to give any view. We would imagine that a best interpretation of that view, notwithstanding issues of maturity, and the ability to weigh complex risks, is still possible. This would require to be done by people who specialise in this area.’

Includem said:

> ‘We would strongly urge that the development of any test on decision-making capacity be developed with children and young people with expertise from experience of inpatient care or involuntary detention. This should be developed for and by children to ensure that it meets their unique needs and is not an adaption of something developed for adults.’

The MWC proposed that an ‘expanded Capacity/Incapacity test within the ADM framework that considers aspects around illness and maturity within the ‘appreciate’ construct of the current test of incapacity might enable a clearer test that works across all age-ranges.’ However, they stressed that the ‘details of these constructs will need to be clarified and then tested out against scenarios to demonstrate any issues in the application to children and young people'.

12.8.3: These are our final recommendations

We are still of the view that, in principle, our new approach is relevant to children, just as it is for adults, and has the potential to safeguard and advance their rights.

As we set out in Chapter 8, there will need to be much work to refine and operationalise the HRE framework and ADM test before they are brought into law.

We recognise that there are additional complexities for children, particularly in the application of the ADM test. For adults, the ultimate intention is that the ADM test would operate across capacity and mental health law. This is different for children, in that we do not propose amending the Age of Legal Capacity Act, which governs most decisions about medical treatment for children.

This does create complexities. However, the current split between the two Acts is also complex, yet appears to create relatively few problems in practice. We believe that these issues can be resolved, although we recognise that it will take a considerable amount of further work.

We recommend

Recommendation 12.14: Our proposals regarding Supported decision making, Human rights enablement and Autonomous decision making should apply to children who are subject to mental health law.

Recommendation 12.15: Before legislation on SDM / HRE / ADM is introduced, there should be a detailed process of further policy development, involving children with lived experience, their families and professionals, to address

particular issues affecting children, including the interaction between the ADM test and the Age of Legal Capacity (Scotland) Act 1991.

12.9: Independent Advocacy

12.9.1: This is where we started

In our March 2022 consultation, we noted evidence from the MWC and others that there is inadequate provision for mental health advocacy for children and families, despite the existing duties on NHS and local authorities in sections 259 and 259A of the Mental Health Act. Advocacy is being introduced to Children’s Hearings, and for people with disabilities claiming devolved benefits, and we felt that there may be an opportunity to join up these various provisions.

We also noted that collective advocacy for children with mental or intellectual disability is even less prominent than for adults. Children and young people with mental or intellectual disability have a right to be engaged in the planning and development of services to support them, not to be represented only by adults. We referred to our initial proposals for strengthening collective advocacy for everyone, reflecting the requirement of Article 4.3 of the UNCRPD that:

> In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations.

The Review’s consultation on additional proposals in May 2022 included a section on independent advocacy, which noted that there is a lot of confusion amongst professionals about the right to independent advocacy, that the Scottish Government has recognised that there are many situations in which people require advocacy, and that in addition to the Mental Health Act there is other legislation which grants a right to independent advocacy. Some of this legislation is particularly relevant to children, including the Children‘s Hearing (Scotland) Act (2011), the Education (Additional Support for Learning) (Scotland) Act (2004), Guidance on Looked after Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007.

12.9.2: This is what we heard

As discussed above (12.7), feedback from children and young people throughout the Review consistently highlighted the need for more age-appropriate, culturally-sensitive independent advocacy to ensure that bodies such as tribunals, the NHS and local authorities place children’s rights at the heart of their services and when carrying out duties required by law.

There was strong support for the all of the Review’s proposals on independent advocacy from a range of organisations. The MWC wrote: ‘On advocacy, we agree’.

Collective advocacy

On the proposed new duty on Scottish Ministers to support collective advocacy for children with mental or intellectual disability, all respondents who addressed this supported the proposal. In **addition** to strongly supporting a duty on collective advocacy, Includem supported the establishment of a children and young person’s oversight group to ensure their voice is at the centre in the planning and development of services to support them: ‘The work of the Youth Commission on Mental Health Services has already demonstrated the benefit of this approach’.

Strengthening duties to provide access to independent advocacy

In the March 2022 consultation, we proposed that the duties in the Mental Health Act to secure advocacy should be strengthened to ensure that any child with a mental or intellectual disability is made aware of their right to independent advocacy and is able to obtain this when needed.

The Equality and Human Rights Commission referred the Review to their ‘previous agreement with independent advocacy on an opt-out basis. This must include access to specialist advocacy for groups sharing protected characteristics, including young people'. Children in Scotland believed that 'advocacy can play a key role in ensuring that the views of children and young people are heard and considered' and wrote that 'under the Children's Rights Scheme included with the UNCRC (Incorporation) (Scotland) Act, Scottish Ministers must: "ensure that children are able to participate in the making of decisions that affect them with access to such support and representation (for example from children's advocacy services) as they require to do so".'

SAMH strongly supported a 'duty on Scottish Ministers to support collective and individual advocacy for children. While collective advocacy will help bring the voice of children and young people to the table, individuals may still need more one-to-one support. While all Local Authorities have a duty to provide advocacy, very few local authorities have advocacy in place for children and young people. We would also welcome a duty on Scottish Ministers to work with Local Authorities to remove barriers to individual advocacy for children and young people'.

Support in Mind Scotland also agreed with the Review's proposals:

> 'According to The Scottish Independence Advocacy Alliance (2020) their research for The Advocacy Map has highlighted significant gaps in the provision of independent advocacy for children and young people. This is concerning when children and young people are meant to have the right to access an independent advocate in the current Mental Health Act. Research has established that children and young people in secure mental health settings believed that independent advocacy was important because it got 'their voices heard' and helped them to articulate their needs and feelings. It was also reported that have an independent advocate made children and young people feel validated; that their voice and opinions mattered, and they were taken seriously (Thomas et al, 2017).'

The Care Inspectorate wrote that:

> 'Our joint inspections of children's services highlighted that independent advocacy was not used as widely as it could have been to support children and

> young people to be heard. At times children and young people did not know what independent advocacy was. Independent advocacy was more readily available to care experienced and looked after children and young people. Children and young people undergoing particularly traumatic processes, including child protection, were less likely to have the same access.
>
> There has been considerable work done to develop a national practice model for advocacy in the children's hearing system. Any developments in relation to independent advocacy for children with mental ill-health should take account of national learning and developments in this area. We agree that joining up independent advocacy provisions may be helpful.
>
> Providing independent advocacy for children and young people requires specialist understanding of children's needs, communication and a core understanding of child development, ensuring practice is trauma informed. We agree that all young people should be provided with the opportunity to access an appropriate independent advocacy service.'

CAPS Independent Advocacy believed that 'all children and young people should have the right to independent advocacy - individual and collective - and that this right to access should be able to support them in all areas of their life - education, health, children's hearings etc. and not just mental health.' This would 'require more resources - more staff, more training, more awareness'.

A Health and Social Care Partnership saw advocacy for children and young people as essential but wrote that this 'needed to be considered on a case by case basis. Availability of children's advocacy services particularly when considering current MH legislation would require to be additionally resourced'.

Advocard felt that adequately-resourced collective advocacy for CAMHS, if provided on a networked national level, could support more cohesive oversight and accountability would benefit young people in relation to their mental health.

'Streamlining' duties on independent advocacy

We proposed that the various duties in respect of advocacy - in mental health, in Children's Hearings, and in additional support for learning - should be streamlined to ensure comprehensive, holistic and child-centred individual advocacy services.

Includem supported 'the call for the streamlining of advocacy services for children to include all systems children interface with including Children's Hearings, Additional Support for Learning and Secure Care. Children do not experience these systems in isolation, so it is imperative that they are supported in a way that provides consistency of relationship across all the challenges they are experiencing' .

Children in Scotland and My Rights, My Say also agreed, but cautioned that the streamlining of services should not mean a reduction in specialist advocacy for different areas. My Rights, My Say wrote that:

> '…the availability of advocacy services for children is patchwork across different geographical and subject areas. However, it would also be important that advocacy within specialist areas (additional support needs, mental health etc) where specialist knowledge and experience is of importance, is not lost by creating a single, generic service.'

Dumfries and Galloway Council Social Work Services wrote:

> 'The development of one advocacy service for children coming into all legal processes would have the advantage of developing a highly skilled and visible service for all young people. The added advantage for the most vulnerable children, who care and support needs, span across several systems ie mental health and children's hearing, would be a continuity and familiarity of services. The service provision for young carers being incorporated into this system would also offer these young people visibility and access to a universal service that is not niched but inclusive.'

The Children and Young People's Centre for Justice said that:

> 'In relation to advocacy, we agree that every child should be made aware of their right to independent advocacy and that they are able to access this as

> required. There are some issues in the Children’s Hearing System (CHS) where children are not provided with this service as they are unable to opt in due to being incapable, distressed or non-verbal. CHS have established a working group to consider this nationally. A more consistent and joined up approach across the country is required to ensure all children are provided with advocacy and with workers who can support their needs.’

AdvoCard wrote that ‘If there was to be unification of children's advocacy to provide holistic services, then this may need to be addressed across different policy areas, and commissioning strategies. In principle a unified system would benefit children.’

Salvesen Mindroom Centre did support the view that there should be advocacy available to children affected by mental health legislation:

> ‘However, to combine this with advocacy under education law, the benefits system and the Children’s Hearings system is likely to result in one or two preferred providers being appointed to provide all advocacy to all children, restricting choice and the independent nature of advocacy services. For example, our organisation provides support and advocacy to any child who is neurodivergent, irrespective of diagnosis. Over many years, we have developed enormous expertise in working with these children. However, we are likely to be priced out of competitive tendering against larger organisations that have less specialist knowledge of neurodiversity. Therefore, while we support the principle that advocacy should be available, we urge that this is not provided in a way that restricts choice or special expertise.
>
> It is important that children affected by mental health law are able to access non-instructed advocacy, where appropriate. This is especially important for children with neurodevelopmental conditions, who may be non-verbal.’

The Health and Education Chamber of the First-tier Tribunal for Scotland wrote:

> ‘In the HEC, we use advocacy services regularly to collect the views of children and young persons. Often, children and young people have a lot to say. Trained, professional advocacy workers can usually build a rapport over more

> than one visit, enabling detailed, authentic and unguarded views to be collected in a way that might not be possible even in an accessible tribunal hearing setting. Some children and young people like to be supported in hearings by independent advocates, especially where a previous rapport has been built. Others still prefer to speak for themselves, and do a very good job of this.
>
> The importance of the option of advocacy is crucial for all vulnerable children and young people, especially where major decisions are being taken that could affect their future liberty, education, life prospects and (above all) happiness.
>
> We support Review Report's proposal (at page 141) to streamline advocacy. Where a child or young person has to face more than one decision-making body (sometimes several), advocacy from the same person should be available across all contexts and forums. This would enhance consistency and comfort for the child and young person, and would lead to a better chance of high quality views being shared.
>
> The statutory duty to provide advocacy services in the 2003 Act (ss.259 and 259A) lies on health boards. This is in contrast to the statutory duty to provide advocacy services to children and young people with additional support needs in the education context, where the duty lies with the education authority and with the Scottish Ministers (the latter in connection with HEC proceedings): ss.14 and 14A of the 2004 Act. This makes the provision for advocacy in judicial proceedings stronger.'

Advocacy and Supported decision making

We also proposed that the various duties in respect of advocacy should be integrated with broader duties to ensure support for decision making. Some respondents made points which related to support for decision making more broadly. Some respondents also addressed the need for consistency in independent advocacy provision and practice.

Social Work Scotland wrote that:

> ‘Advocacy for children and young people is critical, and even more so in situations where they are experiencing difficulties with their mental wellbeing is. However, care must be taken in considering the nature of that advocacy and who is best placed to undertaken the role. Independent advocacy groups for children are not currently regulated. The important issue for children and young people is that there is someone they trust to support and advocate for them. This could be a parent, or trusted adult or an independently appointed person. Flexibility and sensitivity to individual circumstances is therefore required, rather than a blanket provision.’

An individual agreed that it is important that children have access to specialist children’s advocacy as standard which is available when needed, but felt that it is ‘important that there is sufficient scrutiny of advocacy services and practise to ensure all measures are taken to guard against any unintended undue influence and controlling influence’.

COSLA wrote:

> ‘For a child or young person, the critical issue is that an advocate is someone whom they trust to voice their views. This could be several people such as a care giver, trusted adult, or an appointed person. Flexibility and sensitivity to individual circumstances is therefore required, rather than a blanket provision. Flexibility must be embedded in the approach…
>
> The provision of advocacy for children and young people must be delivered by appropriately skilled and supported staff.’

A local authority wrote that it is important that advocacy workers have adequate training and that services are properly regulated.

The Scottish Association of Social Work said that:

> ‘It is crucial that children and young people have access to advocacy. However, it should be noted that independent advocacy is not regulated. Consideration should always be given to what sort of advocacy is best for the young person

> based on their individual circumstances and needs. For example, a parent or trusted adult might be better placed to provide advocacy. The fundamental consideration is that the young person has someone who they trust to support and advocate for them.
>
> Training and education around advocacy should be widely available so that Children's Rights Officers and other groups have all information to support the young person.'

We understand that Children's Rights Officers are generally employed by local authorities and therefore cannot provide independent advocacy.

Chapter 11 on Accountability includes recommendations on how the independent advocacy sector and independent advocacy practice should develop in future.

12.9.3: These are our final recommendations

We recommend

Recommendation 12.16: The duties in the Mental Health Act to secure advocacy should be strengthened to ensure that any child with a mental or intellectual disability is made aware of their right to independent advocacy and is able to obtain this when needed.

Recommendation 12.17: The various duties in respect of advocacy (in mental health, in Children's Hearings, and in additional support for learning) should be streamlined to ensure comprehensive, holistic and child-centred individual advocacy services. These duties should be integrated with broader duties to ensure support for decision-making

Recommendation 12.18: There should be a new duty on Scottish Ministers to support collective advocacy for children with mental or intellectual disability.

12.10: Accountability

12.10.1: This is where we started

We were concerned that the accountability framework for children with mental health needs may be fragmented, leading to gaps in accountability.

The MWC has a role in respect of children, but has generally focused on the small number of children who are in-patients. Many children with significant mental health issues, intellectual disability or autism will be in other settings, including residential schools, secure care or young offenders institutions, and of course, the majority will be living with families at home.

There are examples of collaboration between, for example, the MWC and Care Inspectorate in relation to oversight of the secure estate. However, these examples appear to be limited and sporadic.

The strong criticism by the Children and Young People’s Commissioner Scotland (CYPCS) of the oversight by Education Scotland of the use of restraint in educational settings suggested that there may be a gap in safeguards.

An even bigger gap may exist in relation to children living with families who are not receiving the help and support they need. It is unclear at the moment how this might be affected by the development of the National Care Service.

We felt that there needed to be a more consistent and coherent system of oversight and accountability involving all the bodies with a role in relation to children’s mental health, including the MWC, the Care Inspectorate, Education Scotland, Healthcare Improvement Scotland (HIS) and the CYPCS. The overall focus would be to ensure proper scrutiny and accountability on the right of all children to the highest attainable standard of mental health.

12.10.2: This is what we heard

There was support from respondents, including SASW, Children in Scotland and the Children and Young People's Centre for Justice (CYPCJ) for this proposal. The CYPCJ said that: 'This should fundamentally be based on monitoring whether the minimum standards are being delivered to ensure children's rights are being upheld'.

Children in Scotland added:

> 'In our experience of working on the Children and Young People's Mental Health Joint Delivery Board as well as through our wider policy work and engagement through the Children's Sector Strategic and Policy Forum, the national policy landscape is tangled and this contributes to a lack of progress in improving outcomes for children and young people.'

They argued that the list of organisations we suggested was not wide enough, and that it omitted 'much of the children and young people's sector who have key insights to offer from their role working directly with children and young people and delivering valued community based mental health services'. They suggested one option would be a formal role for the Children's Sector Strategic and Policy Forum to be directly involved in oversight and accountability.

Dumfries and Galloway Council highlighted a number of areas where mental health provision for children was an issue, including in education settings which are not exclusively for young people with a mental disorder diagnosis but which included children with complex mental health needs. They also mentioned secure units, saying: 'There is anecdotal practice experience that young people with significant mental health/behavioural issues are being placed in these services and limited therapeutic intervention and containment and risk management is the only achieved outcome'.

The MWC cautioned against a separate accountability structure for children and young people's mental health, partly because one of the most significant areas of concern was transition from child to adult mental health services. They argued that ‘the assurance framework should be unitary across the age range’.

12.10.3: These are our final recommendations

We discuss the general scrutiny and accountability framework in Chapter 11. We recommend a formalised network of bodies involved in the scrutiny of mental health services, including collective advocacy organisations.

As part of its work, this network could also take an overview of issues relating to children with mental or intellectual disabilities across a range of settings. In doing so, this network would need to involve organisations with a particular focus on representing children and organisations which regulate children’s services.

We have considered Children in Scotland’s suggestion that the network be widened to include other organisations including service providers. That is wider than we intended, since we saw the purpose of the network as strengthening independent scrutiny of mental and intellectual disability services, not as a wider policy forum. However, we recognise that there will be other potential candidates for involvement, and this can be considered further if the recommendation is taken forward.

We recommend

Recommendation 12.19: The scrutiny network which we propose in Chapter 11 should also oversee the scrutiny of outcomes for children with mental and intellectual disabilities across health, care and education settings. In doing so it should add agencies including Education Scotland, the Children and Young People’s Commissioner Scotland, and collective advocacy organisations representing children and young people.

12.11: Autism, intellectual disability and other neurodevelopmental differences

12.11.1: This is where we started

Autism is generally understood to be covered by the definition of mental disorder in the Mental Health Act, although it does not readily fall within any of the three sub-categories of mental illness, learning disability and personality disorder. This topic is discussed in Chapter 2. In this final report, we use a preferred term from the National Autism Implementation Team of ‘neurodevelopmental differences’.

We received a lot of evidence that autistic children and children with other neurodevelopmental differences (such as ADHD) were particularly poorly served by the care and support on offer in mental health services, and that CAMHS were not designed with their needs in mind. These children are affected by a huge share of the disputes referred to the Health and Education Chamber’s Additional Support Needs jurisdiction (the ASN Tribunal).

Ensuring access to economic, social and cultural rights will be particularly important for children with neurodevelopmental differences, alongside a stronger right to services that are appropriate for their needs, rather than being slotted into services designed for other people.

In our consultation we had not yet reached a concluded view on the use of diagnostic criteria within mental health law, and whether these should include learning disability or autism.

We generally endorsed the recommendations of the Independent Review of Learning Disability and Autism in the Mental Health Act (the Rome Review) in relation to autistic children and children with learning disabilities, particularly:

- All autistic children and children with intellectual disability who need services for their mental health should have a right to be offered a Co-ordinated Support Plan

- Parents of autistic children and children with intellectual disability should have a right to support that is specific to their needs and their child's needs, to enable them to promote, protect and fulfil the rights of their children.

- Statutory duties towards children who have a Co-ordinated Support Plan and to their parents should extend to all public agencies, including NHS Boards, local authorities and local or national integration bodies.

The Co-ordinated Support Plan is provided for in the Education (Additional Support for Learning) (Scotland) Act 2004. It is intended for children and young people who have additional support needs arising from complex or multiple factors which require a high degree of co-ordination of support from education authorities and other agencies. The plan is designed to enable children or young people to work towards achieving their educational objectives. It is separate from a Child's Plan, which is part of the GIRFEC framework and was established by Part 5 of the Children and Young People (Scotland) Act 2014. It is intended to offer tailored, coordinated support that meets the wellbeing needs of an individual child.

We invited views on autism, learning disability and these potential reforms.

12.11.2: This is what we heard

Responses mainly focused on the place of learning disability and 'neurodiversity' in mental health law, and the possible reforms to Co-ordinated Support Plans.

Responses were divided on whether learning disability, autism and other neurodevelopmental differences should be part of mental health law at all. We discuss this at Chapter 2 and also later in this chapter on children and young people.

Salvesen Mindroom Centre were strongly of the view that autism and neurodiversity should not be classed as 'mental disorders', but felt that a new legal framework which did not focus on a diagnosis but on impaired autonomous decision-making was a better approach.

SCLD however argued that mental health law was the wrong framework to ‘support realising Article 23 of the UNCRC. Instead, alternative provisions such as the Learning Disability, Autism and Neurodiversity Bill may provide a more suitable asset-based approach to support the realisation of such positive rights’.

Other respondents such as the Forensic Network, who felt that autism and learning disability had a place in mental health law, nonetheless felt that any reforms to Co-ordinated Support Plans were a matter for education law, not mental health law.

There was significant opposition to the suggestion of an automatic right of an autistic child or child with intellectual disability to a Co-ordinated Support Plan (although that is not quite what the Rome Review proposed, as we understand it).

> ‘Differences in approach to support in education across the country, including provision for certain groups to automatically have a coordinated support plan is not considered helpful, and could lead to confusion. We suggest as an alternative work with local authorities on a more standard approach to additional support for learning, within the education rather than the mental health umbrella.’ (Social Work Scotland)

> ‘We have significant concerns about the proposal that all autistic children and children with an intellectual disability who need services for their mental health should have the right to be offered a Co-ordinated Support Plan (CSP)…We are aware and understand the reasons why some families and practitioners may feel this duty to assess would be helpful. All My Rights, My Say partners hear directly within their work from families about the challenges and frustrations faced in accessing CSPs. However, our main concern is that to make specific diagnosis a reason to be considered for a Coordinated Support Plan runs in opposition to the foundations of the Additional Support for Learning Act – namely that a diagnosis is not required in order to be considered to have an additional support need, and that support should be provided based on a child’s individual needs rather than a specific diagnosis.’ (My Rights, My Say)

COSLA also argued that such a right may undermine the assessment process.

There was however support for a strengthening and broadening of the effect of a CSP – essentially to ensure that the necessary support from whichever agency was provided, and that this could be enforced.

The Health and Education Chamber (the ASN Tribunal) wrote that:

> ‘One key way to strengthen the position of children and young people with these conditions is to widen and deepen the prevalence and role of the CSP under the 2004 Act. Unless commitments to support are contained in a CSP, they do not have statutory force, meaning that there is no direct mechanism to ensure that the required support for vulnerable pupils is provided. For this reason, we support the Review Report’s endorsement of the Rome Review’s recommendations on CSPs.
>
> There is evidence of success in the use of a statutory education plan to include health and social care. The Rome Review considered the use of Education, Health and Care (EHC) Plans then being trialled in the First-tier Tribunal Special Education Needs and Disability (SEND), in England. The SEND Tribunal is the equivalent of the HEC Additional Support Needs jurisdiction.
>
> From April 2018 to August 2021, the SEND Tribunal National Trial tested the extended powers of the SEND Tribunal to hear appeals and make non-binding recommendations about health and social care aspects of EHC plans, provided those appeals also include education elements. An independent evaluation of the national trial found positive findings and on 20 July 2021, the Department for Education confirmed the extended powers given to the SEND would continue.’

My Rights My Say also highlighted the English developments and said:

> ‘We strongly agree that statutory duties towards children who have Co-ordinated Support Plans should extend to all public agencies – certainly to all public agencies named within any given CSP. It is counter intuitive and inefficient for a multi-agency plan to identify a child’s needs, their educational objectives, and the support required to achieve those objectives, only to impose duties on only one agency among the various agencies who are (necessarily) involved in the plan’s delivery.’

12.11.3: These are our final recommendations

This Review’s overall approach is to recommend a shift away from a focus on diagnosis to a needs and rights based framework, to ensure that people get the help they need, including in situations where their ability to make an autonomous decision may be impaired.

We note the concerns expressed about amending the provisions about when a Co-ordinated Support Plan be prepared. We make no recommendation on this point – but would stress that the matter was considered in more depth by the Rome Review, and we believe their recommendations merit serious consideration.

We discuss later in this chapter our general view that the legal frameworks for children who need support and care, including for their mental health, are fragmentary, complex and confusing. It would be beyond our remit to range too far into the law concerning additional support needs and child care, but we do believe that serious consideration should be given to reforms which ensure that any co-ordinated assessment of need bites on all the agencies involved – by which we mean that they should have duties to meet the assessed needs, and these should be justiciable in the appropriate legal forum.

We recommend

Recommendation 12.20: The statutory duties flowing from a Co-ordinated Support Plan should extend to all statutory agencies in the plan, and should be subject to review by the Additional Support Needs Tribunal.

12.12: Safeguards for treatment

12.12.1: This is where we started

Part 16 of the Mental Health Act contains safeguards in relation to some kinds of treatment when given to someone who is subject to compulsory treatment under the Mental Health Act. These safeguards apply to children in the same way as adults. We make recommendations in Chapter 9 about strengthening these safeguards, including in relation to restraint and seclusion.

These reforms would also apply to children, but we felt that children may need additional protection. For example, the threshold for what constitutes 'inhuman or degrading treatment' may be lower for children than adults. We also received evidence as to the huge distress that restraint can cause to other young people in a ward, as well as the patient who is subject to restraint.

We therefore sought views on whether any further safeguards may be needed for children.

We were aware that concerns about restraint and seclusion were not confined to mental health settings. There was an investigation by the Children and Young People's Commissioner Scotland into restraint in educational settings, and a major campaign by ENABLE Scotland – In Safe Hands. Following these, the Scottish Government is consulting on new guidance on physical intervention in schools. The Children and Young People's Commissioner has called for guidance to be put on a statutory footing.

12.12.2: This is what we heard

There was wide agreement that there should be stronger safeguards where children are subject to restrictive interventions including restraint and seclusion, and that there should be a consistency of approach across educational, healthcare and childcare settings.

> ‘Includem strongly supports the position of the Children and Young People’s Commissioner Scotland to end the use of restraint for children in education settings. The children and young people we support have experienced restraint in a range of settings including residential, secure, education, mental health and justice. As children and young people who have experienced significant adversity and trauma, they describe this experience or witnessing it use on others as further trauma. Includem strongly urges that standards and safeguards are developed for all children, including those experiencing hospital detention, but not limited to this.’

Other responses supporting consistent standards across settings included the Children and Young People’s Centre for Justice, Social Work Scotland, the Care Inspectorate and the Health and Education Chamber of the First-Tier. COSLA said:

> ‘COSLA is…supportive of understanding and progressing standards and safeguards across mental health and care settings and would welcome the opportunity to work with the Scottish Government in this area. It is important that there is consistency in the approaches taken to restraint across services and settings in order that children and young people understand and receive the same care and support regardless of where they are at the time where restraint is deemed necessary.’

BDA Scotland highlighted particular concerns about physical restraint being used on deaf British Sign Language (BSL) users:

> ‘Violent outbursts requiring restraining may in fact be due to communication frustrations because hearing members of staff do not understand what Deaf service users are trying to say to them. BDA Scotland feel it is essential that

> Deaf BSL service users have access to BSL throughout any mental health support, which could substantially reduce the need to use physical restraint in the first place.’

Glasgow City Council raised similar concerns about the practice of seclusion, and restrictions on access to the internet:

> ‘Respondents would particularly welcome clarity around use of seclusion and also specified persons (relating to social media) for those in hospital…If there was a national approach to this, rather than left to local policy and procedures then this would contribute to upholding the rights of those subject to these circumstances. Respondents ultimately do not think use of seclusion and very limited access to telecommunications contributes to recovery for a child or young person. Respondents suggested that a DMP could have oversight of safeguards in relation to policy and procedure for the above-mentioned issues.’

We discuss the ‘specified persons’ regulations in Chapter 10 on forensic mental health law.

One respondent highlighted that safeguards may also need to be strengthened for some treatments of children who are informal patients being treated on the basis of parental consent This can be done by regulations under section 244 of the Act. (Safeguards in general are discussed in Chapter 9)

12.12.3: These are our final recommendations

We recommend

Recommendation 12.21: The review of safeguards under Part 16 of the Mental Health Act which we propose at Recommendation 9.7 should also consider whether further safeguards may be necessary for children being treated under the Mental Health Act, or as informal patients.

Recommendation 12.22: The Scottish Government should co-ordinate further work on the use of restraint and isolation to ensure consistent standards across education, healthcare, childcare and justice settings, which reflect human rights-based best practice.

12.13: Perinatal mental illness

12.13.1: This is where we started

Section 24 of the Mental Health Act creates a duty on Health Boards to provide support to allow mothers in hospital with post-natal depression or similar conditions to care for their babies. This duty has had some impact, but is limited in its scope, and the evidence of the MWC's themed visit in 2016 was that services needed to be significantly expanded and improved.

There is now a Perinatal Mental Health Network in Scotland which in 2019 produced a needs assessment report setting out how services need to be developed, and which has subsequently produced further guidance for services.

This is encouraging progress, but we believed there may need to be a stronger duty and a stronger accountability framework, recognising the complex interaction of duties towards mothers and children.

12.13.2: This is what we heard

We received a detailed response on this issue from Support in Mind

> ‘We agree that the existing duty to support mothers in hospital with postnatal depression and similar conditions should be broadened to ensure a wider range of in-patient and community supports for women who need perinatal mental health care and their children. The Royal College of Midwives Perinatal Mental Health Scotland Survey Responses 2019 highlighted the prevalence of mothers experiencing mental health problems during and after their pregnancy in Scotland…
>
> Currently, Scotland’s only two Mother and Baby Units specialising in perinatal mental health care are in the central belt: Livingston and Glasgow. As a result, expecting and new mothers experiencing mental health problems in rural and remote communities can face barriers to accessing specialist inpatient care. The long distance, and the cost, time and practicality of travel being prominent challenges to admission. Furthermore, if women from rural and remote communities are admitted to either of the Mother and Baby Units, they are then isolated away from their community experiencing limited face-to-face contact with family and friends, impeding on their recovery.
>
> However, we believe that the Review’s recommendations on perinatal mental health should also extend to non-birthing partners. Research has determined that non-birthing partners can also experience perinatal mental health problems. We also call for specialised support and services to be established and tailored for non-birthing partner’s specific mental health needs relating to pregnancy and becoming a parent.
>
> Additionally, in Scotland family structures vary greatly…currently perinatal mental health care and services in Scotland exclude some gender identities who give birth, by solely focusing on women who give birth. For example, transsexual men who are pregnant or postnatal can also experience perinatal health issues and require tailored support to suit their needs.’

The MWC argued for a legislative duty to notify them when a woman is admitted without her baby.

The Equality and Human Rights Commission highlighted gaps in relation to women with protected characteristics:

> ‘As per the Equality Impact Assessment carried out by the Scottish Government as part of the ongoing work of the Perinatal Mental Health Programme Board (PNIMH-PB), significant data gaps exist in relation to perinatal mental health and some protected characteristics. The Mental Welfare Commission’s Racial Equality and Mental Health report suggests wider issues around ethnicity and access to mental health provision that are applicable to the perinatal period. The Health, Social Care and Sport Committee’s Inquiry report into perinatal mental health has exposed various issues for ethnic minorities, which exist despite the NES Perinatal Mental Health curricular framework. It seems that despite the core principles of the Perinatal and Infant Mental Health Programme Board and specific actions for the Board set out by the Scottish Government, including in the Peer Support in Perinatal Mental Health Action Plan, there is little public information available on what actions have been taken to reducing health inequalities and stigmas specific to parents from ethnic minority backgrounds.’

We discuss in Chapters 1, 9 and 11 the need for much better data on equality issues, of which this is one example.

12.13.3: This is what we recommend

We recommend

Recommendation 12.23: The duty in section 24 of the Mental Health Act to support mothers in hospital with postnatal depression and similar conditions

should be broadened to ensure a wider range of in-patient and community supports for parents who need perinatal mental health care and their children.

12.14:Relationships between parents and children

12.14.1: This is where we started

Section 278 of the Mental Health Act imposes a duty on the NHS, local authorities and others to take steps to mitigate the impact of detention on family relationships.

The duty applies where a child under 18 is subject to detention or compulsory mental health treatment, and the measure will impair or will be likely to impair personal relations or contact between the child and any person with parental responsibility for them. The duty also applies in the opposite direction, where a parent is subject to compulsory mental health interventions. In these circumstances, the Mental Health Act requires ‘every person having functions by virtue of this Act’ to take steps to mitigate any adverse effect on personal relationships or contact with the child.

Research by the MWC in 2013 on the operation of these duties when parents are detained left the MWC with ‘many unanswered questions’. They found that staff were often unaware of their duties under this section, and made a number of recommendations including that care plans of a patient who is a parent should consider the impact of mental health interventions on family life.

We felt that this duty may need to be strengthened, and that the law may need to go further to respect human rights, including Article 23 of the UNCRPD on respect for home and family life. The current duty only bites after a compulsory intervention is in place, and we felt it may be necessary to go further, to ensure, for example, that parents and children are never separated by hospital detention as a consequence of inadequate resources in the community.

12.14.2: This is what we heard

There was widespread agreement, including from the Care Inspectorate, Support in Mind Scotland and the Health and Education Chamber of the importance both of keeping families together wherever this is safe and of maintaining as good a parent-child relationship as is possible.

The Children and Young People's Centre for Justice and Advocard highlighted the need to ensure that parents and children are not separated by detention because of inadequate resources in the community – particularly when specialist places for children may often be a long way from their homes.

Several responses highlighted links to the Promise and the Independent Care Review:

> 'The Promise Plan 21-24 opens with the statement – "There will be deliberate, persistent attention to upholding safe, loving relationships that are important to children and young people."' (Salvesen Mindroom Centre)
>
> 'As the Independent Care Review states that "Where children are safe in their families and feel loved they must stay – and families must be given support together to nurture that love and overcome the difficulties which get in the way".' (Children and Young People's Centre for Justice; also cited by Includem)

Includem also highlighted the relevance of the UNCRC:

> 'In relation to children being separated from their families due to their own admission to hospital, we would again urge that this be framed under the UNCRC rather than other measures. In line with the intention to incorporate UNCRC into Scots Law, consideration needs to be given to how detention impacts on the child's right to parental guidance (Article 5), to not be separated from their parents (Article 9), government support for parents by creating support services for children and giving parents the help they need to raise their children (Article 18) and government support for disabled children and their families (Article 23).'

See Me injected one cautionary note – that the rights of the child should always be given primacy over the rights of others when making decisions about their mental health care.

12.14.3: These are our final recommendations

We recommend

Recommendation 12.24: Section 278 of the Mental Health Act should be strengthened and broadened to provide that

- **The duty to support family relationships should apply in considering alternatives to compulsion, not only after compulsion has been authorised**
- **It fully reflects the obligations of the UNCRC and UNCRPD.**

Recommendation 12.25: There should be a related duty on Scottish Government and health and social care agencies to ensure services are provided and co-ordinated in such a way as to reflect the requirements of the UNCRC and UNCRPD to support the family life of children or adults with mental or intellectual disabilities.

12.15: Exploring integration of child law and mental health law

12.15.1: This is where we started

The general approach of this Review is to widen the focus of mental health law, from a concern primarily with compulsory medical care towards a legal framework which secures the full range of human rights for people with mental or intellectual disabilities.

For children, this requires us to consider the UNCRC as well as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the UNCRPD; and to look at the Mental Health Act alongside other provisions affecting children with mental or intellectual disabilities, particularly those involving detention or other compulsory interventions.

The evidence we received suggested that a large proportion of children subject to the child protection and additional support for learning systems have mental or intellectual disabilities – significantly more than are formally subject to measures under the Mental Health Act.

This might not be a problem if each child’s needs could be simply classified as ‘mental health’ or ‘educational’ or ‘care and support’. But of course, many children’s needs cover all these issues. We were concerned that the different legal frameworks were structured more around professional and service boundaries than a holistic overview of what a child needs and how it should be secured.

In some cases, the legal route used appears to depend more on the professionals who happen to take action than the child’s underlying needs. Even more importantly, each legal body only has the ability to order certain remedies. A Children’s Hearing may authorise secure care; a Mental Health Tribunal may authorise detention; and an Additional Support for Learning Tribunal may authorise a residential school place. None has the ability to look across all the professional boundaries, and to require that the full range of flexible supports that a child needs is provided.

At its worst, this can lead to children not receiving the range of support they deserve, and sometimes bouncing around different legal and service systems.

We felt there was an opportunity for the reform to children’s services which is underway following the Care Review to join up with reform of mental health law. This could ultimately lead to the development of a unified legal and judicial framework with responsibility for overseeing decisions on all aspects of the health, education and welfare needs for children and young people, particularly where there is some element of compulsory provision.

That said, we identified a number of difficulties with the proposal. It would be a hugely complex undertaking. There is a risk that moving to an all-purpose children’s tribunal dilutes the expertise which the Mental Health Tribunal for Scotland can bring for the small number of children with severe mental illness. It would be challenging to take forward such reform when decisions have yet to be taken on the relationship of children's services to the planned National Care Service.

Perhaps most significantly, joining mental health law for children with other child law would separate it from mental health law for adults. It has been argued that the fact that the law operates across the life course is a benefit, particularly at the stage of transition from child to adult services. Transitions are widely seen as difficult stages which are not adequately managed at present.

Against that, if a fusion of mental health and capacity law were ultimately to be taken forward (see Chapter 3), it may be necessary to make separate provision for children anyway – as has been found in Northern Ireland.

We presented this idea to the Scottish Government's Children and Families Collective Leadership Group on 9th September 2021, and we met with Sheriff Mackie, the Independent Chair of the Hearing Systems Working Group.

Although this is wider in scope than our review, we felt it was an important issue which we did not want again to fall between different parts of policy development in government.

12.15.2: This is what we heard

There was agreement that our perception of a problem for children whose needs did not fit into one legal framework was accurate.

> 'Includem welcomes the opening of the conversation about how to develop a holistic and child-centred system of care and support for children. Includem are committed to #KeepingThePromise, in particularly ensuring that the policy and legislative context in which children live their lives is simplified and easy to understand and access.

> The experience of the children and young people we support is that they are often subject to numerous requirements under several pieces of legislation at the same time. This causes considerable confusion and for some young people consequences in the adult justice system as they have not understood what they have needed to comply with.
>
> We appreciate the commitment to reduce transitions for children, particularly into adult systems and acknowledge the current unknowns of implications of the National Care Service, however fundamentally we believe that children have unique vulnerabilities and require special protection of their rights in order to be the best versions of themselves. Wherever possible we believe that children should be protected by laws that are developed with and for them.'

However there was widespread concern that seeking to subsume mental health law for children into a wider child law framework risked losing much for an unclear benefit.

The Royal College of Psychiatrists strongly argued that mental health law should continue to apply across the age range. Their arguments against putting children's mental health law into a separate child law framework included:

- The risk of reducing safeguards and a loss of protections, including the technical and detailed safeguards that the Mental Health Act provides
- Fusion would be an 'incredibly complex' piece of work and leave children and young people waiting for legislation for years
- It would harm transitions between children's and adult mental health services.

This general view was supported by the MWC, the Forensic Network, and the Royal College of Psychiatrists' Scottish Faculty for Eating Disorders. SAMH and Advocard were also opposed:

> ‘Taking children out of mental health law could weaken law that should be applying across a lifetime, and may possibly lead to disadvantage for young people in their mental health treatment.’ (SAMH)
>
> ‘In terms of continuity of mental health care, separating the two age groups does interrupt the whole life approach. The transitions are very difficult for many under the current Act, even without separation, and having two acts would only serve to worsen the gaps.’ (AdvoCard)

We have concluded that there is not currently a consensus which would justify the complex work involved in seeking to join mental health law for children with other measures which authorise compulsory interventions.

However, the problem we identified is real. Also, if our recommendations for reforming mental health law to give more weight to economic, social and cultural rights are taken forward, the overlap with other parts of the legal framework for the protection and support for children will be even greater.

There was support for greater alignment between systems.

Several social work respondents, including Social Work Scotland and SASW, did generally support aligning mental health law to frameworks for children, particularly GIRFEC, so that ‘no child or young person is disadvantaged’. They particularly supported greater input from Mental Health Officers in children’s services to better inform practice with children and young people.

SCLD said:

> ‘In line with ensuring UNCRC and UNCRPD rights are realised for children and young people with learning disabilities we believe it may be sensible to align, not integrate, the mental health, education and social care laws impacting children…
>
> Parents of children and young people with learning disabilities welcomed the idea of a ‘consistency of approach’ and an ’easier pathway for families and

> professionals to follow'. However, we also heard concerns from legal professionals who expressed that there was a risk specialism would be lost in a more universalist approach. Given this, and a lack of clarity on the proposal within the review document on what this proposal would mean in practice, SCLD believes further detailed stakeholder engagement is required on this issue with the Scottish children's and legal sector to ensure the rights of children and young people in Scotland are best realised.'

The Health and Education Chamber was supportive of substantial reform, and gave a detailed suggestion as to how concerns could be addressed. Importantly, they did not believe that it was necessary to separate out mental health law for adults and children. Mental health law already deals with children differently to some extent, and the Mental Health Tribunal for Scotland has a distinct approach to child and adolescent hearings. In their view, the way forward lay in unifying the judicial framework which oversees decisions on health, education and welfare needs for children and young people. They argued:

> 'There would be no need for an all-purpose children's tribunal to 'dilute the expertise' which the MHTS can bring. Tribunal members suitably trained and experienced in mental health law can replicate that expertise within an all-purpose tribunal.
>
> There are a number of Single Chambers in the First-tier Tribunal for Scotland where multiple jurisdictions are transferred (likewise in the UK First-tier Tribunal). The HEC is designed for a similar purpose.
>
> Tribunal members are assigned to Chambers and trained in the range of jurisdictions which sit within the Chamber. Some members are trained and equipped to sit in more than one jurisdiction. A similar approach could be taken to a children's tribunal, with members trained across the relevant likely jurisdictions (for example, mental health, child welfare and protection, juvenile offending, education, additional support needs, adult capacity). It is not uncommon for these and other non-jurisdictional issues to arise in the course of HEC proceedings.

> Each tribunal in the HEC is comprised of three members, drawn from the bank of expertise within the Chamber. The President allocates members according to case type, expertise and relevance. Allocation to a children's tribunal could be comprised of members with the relevant range of skills, experience and expertise.
>
> We do not accept that separation of mental health law for adults and children is a necessary consequence of a separate tribunal – the law applicable to children can be exactly the same as that applicable to adults; it is the forum and context in which it would be applied which would be different.'

There was tentative support for this from My Rights My Say:

> 'There is much to be said for a unified legal and judicial framework with responsibility for overseeing decisions on all aspects of the health, education and welfare needs for children and young people, whether or not there is an element of compulsory provision. However, care must be taken to avoid losing or diluting the specialist knowledge and experience held by the various jurisdictions' members.'

12.15.3: These are our final recommendations

The concerns we have raised are one aspect of a wider issue identified by the Independent Care Review that the law governing support for children and young people is made up of rules which are 'complex and often contradictory', resulting in their recommendation that the legal framework be replaced with a set of legal rules that reflect a holistic understanding of children's and families' lives.

This applies with even greater force for children with mental or intellectual disabilities. It cannot be finally resolved by our review, and it is vital that it is given further attention.

We recommend in Chapter 3 that there should be a staged process of alignment of mental health and capacity law for adults, including the development of shared principles and key concepts including Human rights enablement, and extending the jurisdiction of the Mental Health Tribunal for Scotland to include AWI cases.

A similar approach to alignment could also be adopted for children, which would retain the distinct legal provisions for compulsory mental health interventions but look at how to make the framework for these align with the wider system. This would include consideration of the possibility of a unified tribunal overseeing different legal provisions affecting children. A particular benefit of a tribunal covering more than one legal jurisdiction could be that it could consider different legal outcomes together, providing a ‘one stop shop’ to address all the child’s needs.

This would need to be developed in the context of the wider changes to services and structures which are already underway.

We recommend

Recommendation 12.26: The work of the Scottish Government and its partners to develop a holistic and child-centred system of care and support for children, including the implementation of the Promise, and the incorporation of the UNCRC, should include a focus on how to better align care and support for children and young people with mental or intellectual disabilities, including where compulsory measures are required.

Recommendation 12.27: This work should include consideration of a unified tribunal jurisdiction for different compulsory interventions or provisions to enforce the rights of the child.

Chapter 12: recommendations

Principles

Recommendation 12.1: That the principles of future mental health and incapacity legislation include one of Respect for the rights of the child: Any interventions concerning a person aged under 18 shall respect the rights of that person under the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities.

Recommendation 12.2: Before finalising the wording of the principle of respect for the rights of the child, and developing related guidance, there should be a process of consultation and engagement with children and young people.

Rights to support

Recommendation 12.3: There should clear and attributable statutory duties on Scottish Ministers and on NHS Boards, local authorities and integration authorities, to provide or secure such care, support and services as are needed to secure the human rights of children with mental or intellectual disability, including but not restricted to the right to the highest attainable standards of mental and physical health. This should include specific care and support for children who have, or have had, a mental or intellectual disability, alongside measures to prevent mental ill-health and promote the wellbeing of all children.

Recommendation 12.4: These duties should reflect agreed minimum core obligations developed through engagement with experts including experts by experience, alongside duties and a framework for progressive realisation of

those rights. The development of these duties and associated standards should draw on human rights approaches including applying the PANEL principles and use of the AAAQ framework. Services should be age-appropriate.

Recommendation 12.5: In line with the recommendations of the National Taskforce for Human Rights Leadership, there should be accessible, affordable, timely and effective remedies and routes to remedy where any of the above duties are not upheld. This should include the ability of individuals to raise a legal action in the civil courts.

Recommendation 12.6: Education authorities should have a duty to secure appropriate education for all children with mental or intellectual disabilities, including but not restricted to children in hospital or subject to compulsory care. This should be enforceable at the Additional Support Needs Tribunal.

Crisis services

Recommendation 12.7: The Scottish Government should lead systemic reform of services available to children and young people experiencing acute mental distress, including the provision of safe and child-centred alternatives to admission to psychiatric care.

Emergency detention safeguards

Recommendation 12.8: Section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be amended to make clear that emergency

detention without MHO consent should only take place in exceptional circumstances. These circumstances should be recorded and monitored by the Mental Welfare Commission

- **Scottish Ministers should, as part of the duty of progressive realisation, ensure that there are sufficient MHOs with expertise in child and family services to realise this expectation**

- **In any case where an MHO has not given consent, there should be a review by an MHO within 24 hours**

- **Within 12 hours of emergency or short term detention, a child should be given access to an experienced independent advocate**

16 and 17 year olds in CAMHS

Recommendation 12.9: The existing service standard that CAMH Services should be available to children who require them up to age 18 should be considered for inclusion in the minimum core obligations for those services.

Recommendation 12.10: As already happens for the placement of children in adult wards, any decision to transfer someone to adult services before age 18 should be recorded and subject to oversight by the Mental Welfare Commission.

Recommendation 12.11: In defining those duties subject to progressive realisation, consideration should be given to ensuring that young people who have accessed CAMH Services continue to have access to support if they require it up to age 26.

Recommendation 12.12: There should be a programme of improvement to transitions between CAMHS and adult services, to ensure that transitions are well planned, maintain relationships which are important to the young person, and reflect the developing capacities and needs of the young person.

Interaction between child and adult legal provision

Recommendation 12.13: The Scottish Government should take forward detailed analysis of the implications of changes in age limits in the child welfare system for the interface with adult support and protection.

Supported decision making, Human rights enablement and Autonomous decision making

Recommendation 12.14: Our proposals regarding Supported decision making, Human rights enablement and Autonomous decision making should apply to children who are subject to mental health law.

Recommendation 12.15: Before legislation on SDM / HRE / ADM is introduced, there should be a detailed process of further policy development, involving children with lived experience, their families and professionals, to address particular issues affecting children, including the interaction between the ADM test and the Age of Legal Capacity (Scotland) Act 1991.

Independent Advocacy

Recommendation 12.16: The duties in the Mental Health Act to secure advocacy should be strengthened to ensure that any child with a mental or intellectual disability is made aware of their right to independent advocacy and is able to obtain this when needed.

Recommendation 12.17: The various duties in respect of advocacy (in mental health, in Children's Hearings, and in additional support for learning) should be streamlined to ensure comprehensive, holistic and child-centred individual advocacy services. These duties should be integrated with broader duties to ensure support for decision-making

Recommendation 12.18: There should be a new duty on Scottish Ministers to support collective advocacy for children with mental or intellectual disability.

Accountability

Recommendation 12.19: The scrutiny network which we propose at recommendation 11.2 [Chapter 11] should also oversee the scrutiny of outcomes for children with mental and intellectual disabilities across health, care and education settings. In doing so it should add agencies including Education Scotland, the Children and Young People's Commissioner Scotland, and collective advocacy organisations representing children and young people.

Autism, intellectual disability and other neurodevelopmental differences

Recommendation 12.20: 12.19: The statutory duties flowing from a Co-ordinated Support Plan should extend to all statutory agencies in the plan, and should be subject to review by the Additional Support Needs Tribunal.

Safeguards for treatment

Recommendation 12.21: The review of safeguards under Part 16 of the Mental Health Act which we propose at Recommendation 9.7 should also consider whether further safeguards may be necessary for children being treated under the Mental Health Act, or as informal patients.

Recommendation 12.22: The Scottish Government should co-ordinate further work on the use of restraint and isolation to ensure consistent standards across education, healthcare, childcare and justice settings, which reflect human rights-based best practice.

Perinatal mental illness

Recommendation 12.23: The duty in section 24 of the Mental Health Act to support mothers in hospital with postnatal depression and similar conditions should be broadened to ensure a wider range of in-patient and community supports for parents who need perinatal mental health care and their children.

Relationships between parents and children

Recommendation 12.24: Section 278 of the Mental Health Act should be strengthened and broadened to provide that

- **The duty to support family relationships should apply in considering alternatives to compulsion, not only after compulsion has been authorised**
- **It fully reflects the obligations of the UNCRC and UNCRPD.**

Recommendation 12.25: There should be a related duty on Scottish Government and health and social care agencies to ensure services are provided and co-ordinated in such a way as to reflect the requirements of the UNCRC and UNCRPD to support the family life of children or adults with mental or intellectual disabilities.

Exploring integration of child law and mental health law

Recommendation 12.26: The work of the Scottish Government and its partners to develop a holistic and child-centred system of care and support for children, including the implementation of the Promise, and the incorporation of the UNCRC, should include a focus on how to better align care and support for children and young people with mental or intellectual disabilities, including where compulsory measures are required.

Recommendation 12.27: This work should include consideration of a unified tribunal jurisdiction for different compulsory interventions or provisions to enforce the rights of the child.

Chapter 13: Adults with Incapacity proposals

This chapter considers proposals for amending the current Adults with Incapacity (Scotland) Act 2000 (AWI Act). The chapter contains various sections, which follow the order of the AWI Act, commencing with the AWI Act consultation of 2018.

13.1: AWI Act Consultation 2018

Between January and April 2018, the Scottish Government carried out a consultation on the AWI Act. The purpose of that consultation was to seek views on changes to the legislation and practice around AWI. These changes aimed to address both the need to reflect the requirements of the UN Convention on the Rights of Persons with Disabilities, and concerns that many of the processes within the legislation had become overly cumbersome and were no longer fit for purpose. The Executive Team are grateful for the views offered by a range of AWI practitioners as part of that AWI Act review. A summary of the findings of the AWI Act review are at Appendix A. The full report can be found here.

The Minister, in her announcement of a review of Scottish mental health law (SMHLR), included a remit for the Review Team to consider the position with adult capacity law.

This chapter takes account of views expressed as part of the 2018 AWI Act consultation, so far as these extend to this Review's remit, as well as responses to the AWI Act chapter in the March 2022 consultation conducted by this Review.

13.2: Principles

As set out earlier, we anticipate that our complete agenda for legislative reforms legislation will take several years to develop. We have set out in chapter 3 proposals for new principles across reformed mental health and capacity law. However, as we set out in this chapter we consider more , urgent reforms are needed to the AWI Act..

If these are brought forward ahead of any more radical alignment, we propose some updating of the AWI principles, drawing on the recommendations of the Three Jurisdictions Report, highlighted by the Law Society of Scotland.

Recommendation 1 of that report said that there should be a 'rebuttable presumption that effect should be given to the person's reasonably ascertainable will and preferences, subject to the constraints of possibility and non-criminality. The presumption should be rebuttable only if stringent criteria are satisfied. Action which contravenes the person's known will and preferences should only be permissible if it is shown to be a proportional and necessary means of effectively protecting the full range of the person's rights, freedoms and interests.'

At the moment the AWI Act does require consideration to be given to the adult's past and present views, but this duty is not given precedence over any other duties, such as to consider the views of other interested parties. The UNCRPD requires, and we believe, that the will and preferences of the adult must be given a higher priority.

13.2.1: Our recommendation

Recommendation 13.1: Section 1 should be amended in line with the recommendations of the Three Jurisdictions Report to give greater priority to the will and preferences of the adult.

13.3 Power of Attorney

13.3.1 Where we started

The current system for the granting and use of power of attorney (POA) is generally well received and effective; criticism, when levelled, includes

- Uptake is lower than may be desirable and particularly amongst younger people.

- It’s costly.
- It’s unnecessary – largely this emanates from a range of myths, for example that it’s unnecessary for you to have a POA if you are younger, or unnecessary if you are in a partnership, or unnecessary if you don’t have large sums of money that will need managing if you are no longer able.
- You should not always have to use a solicitor, template versions should be available.
- It’s not clear when an attorney has started acting on their powers - primarily the criticism here is that an attorney does not have to report when they have started acting, so there is no official or central record of this, for example, on the public register.
- The role of attorneys is unclear – this stems from a view that many attorneys are not always aware of their legal obligations, what this means, when they may act, and, indeed, when they may not. Essentially this is because they receive minimal support and guidance and are not aware of sources of such support or guidance.
- Attorneys should be supervised – currently an attorney can only be supervised by order of the court, although there are some attorneys who voluntarily agree to supervision, where complaints have arisen and been investigated, seeing this as advantageous in their case.
- Lack of awareness about reporting of concerns – people are not necessarily aware that they can report a concern about how an attorney is acting, or not, to whom, when, with what detail.
- The current system of investigation when concerns are reported is fragmented, with an artificial division between welfare and finance. Currently, the AWI Act provides that the Office of the Public Guardian (OPG) is the recipient of concerns about a financial (continuing) attorney, although, in reality, there are more reports of financial concerns made to Local Authorities,

under the authority provided to them by the Adult Support and Protection legislation. Local Authorities are the recipient of concerns about a welfare attorney. This division between OPG and Local Authority is seen as artificial in that, where there is one type of harm, for example welfare abuse, there is often also financial abuse. It has been suggested that there should be a single investigatory agent, or at least a closer reporting requirement between a Local Authority investigating a welfare concern and the OPG when they are investigating a financial concern.

- Uncertainty as to whether a welfare attorney may authorise a deprivation of liberty, or if this is incompatible with Article 5 of the European Convention on Human Rights. Please see Chapter 8 for the current position, commentary and recommendations on deprivation of liberty.

The consultation questions focused on obtaining wider views on these areas of concern.

13.2.2: What people told us

Increasing uptake

The overwhelming consensus was for the need to increase awareness in order to increase uptake. Mentioned too, a number of times, was the issue of POA myths, i.e. that one of the reasons why people did not create a POA was because they did not see it as necessary, for example, because they are married and if anything happened to them their partner would advocate for them; to rectify such myths would assist in increasing uptake.

A number of agencies, for example Social Work Scotland and a Health and Social Care Partnership suggested national campaigns, including TV advertising. There was a view that the OPG and Scottish Government could collaborate, to expand the publicity led by the MyPOA campaign. Dedicated funding should be provided to allow expansion of the work into wider areas, including key partners with vested interest in supporting people to take this forward. One individual commented, however, that public campaigns can sometimes overlook giving warnings, for example, on the pitfalls of appointing a person with the wrong motivation.

Training / wider education, in this case for potential granters, was mentioned by a high percentage of the individual respondents. “Ethical” and “impartial” were words used to describe the training requirement.

Other suggestions included freely available information in a wide range of public venues including GPs surgeries, access to a You Tube type guide to what POA is; the benefits, as well as the warnings.

The Law Society of Scotland suggested further development of the “mypowerofattorney” campaign.

The Scottish Association of Social Work commented that awareness and understanding should be focused on areas where this is particularly low.

For example, a recent study by Which? found that a quarter (26%) of people aged 18 to 34 and one in five (20%) who earn under £21,000 a year said they did not know what power of attorney was, compared to just seven per cent of those aged over 55 and one in 10 (10%) of those who earn over £56,000.

Consequently, the Scottish Association of Social Work commented that any public awareness campaigns must therefore consider how to increase understanding amongst younger people and those on lower incomes. There are likely to be many different ways to target communications to these demographics, such as digital campaigns and adverts. The types of messaging being used is also important. For example, information on how to access support with the cost for those on low incomes needs to be made clear.

Having considered these various suggestions, we agree a campaign to increase general public awareness is important, but it should include targeted engagement, using a range of media with focused messaging for specific groups who may benefit more from having a POA or at times when they can be encouraged to complete one – for example, at relevant life events such as going to hospital or retiring.

Information should cover the advantages, how to minimise the potential of misuse, dispelling common myths, and actively encouraging all citizens to grant a POA, early, as part of lifestyle planning.

Cost / process

As well as lack of awareness and myths, cost was cited as a barrier to uptake, for example by the Mental Welfare Commission for Scotland (MWC) ‘the financial cost to making a power of attorney should be removed as it is a barrier to adults engaging with and granting a POA’.

Much of the cost saving from having a power of attorney available is not quantifiable, but various studies, including by the ‘my power of attorney’ campaign demonstrate that increasing the uptake of POAs will save significant sums, in a variety of ways, for example on court/tribunal (as the case may be) applications for the appointment of a guardian and the subsequent cost of supervision of that guardian. It may also reduce delays in discharge from hospital. There are also acknowledged, but unresearched and unquantifiable hidden ‘costs’, for example time and stress, which are higher for a guardian than for an attorney. These have consequential costs, for example, in increased ill health and lost working time.

A Health and Social Care Partnership suggested a standard cost at a level that would be accessible to most. They also suggested encouraging Local Authorities to enter into an agreement with local solicitors who can draft a POA for a person, identifying a package of legal support at a fixed cost. The local authority would then incorporate this information into care planning arrangements for adults who would benefit from the appointment of a POA.

Aligned with cost were comments about the process. Currently the drafting of a POA is something for which most people instruct a solicitor. There was a view that, if there were templates or proformas, this would reduce the cost – and increase uptake. People can draft their own POA, or use templates from the internet and other sources but most do not. We are in favour of a simple, accessible, process but acknowledge that granting a power of attorney is an important step which requires careful consideration, and independent advice is very important. Involving a third party such as a solicitor can also reduce the risk that people may be pressured into granting powers when they do not want to, or do not appreciate the implications.

Increased use of templates, however, would likely result in an increased number of people approaching their GP for the necessary capacity certification. Perhaps mindful of this, the Royal College of GPs for Scotland commented that ‘this is not currently a funded NHS service for GPs. Power Of Attorney will become increasingly important going forward because of our ageing demographic. GPs are frequently approached to oversee POA, but it is often offered as a private service – which then has the potential to create inequality for those with less financial security and adds to high workload. This can - and has – sometimes led to practices simply ceasing to offer this service in the face of huge other workloads, despite GPs being well placed to offer this service because of their long-term relationships with patients’.

Clarity on role of attorneys

The question asked ‘what guidance needed to be given to attorneys’; there was a vast number of topics mentioned in response.

- That they [attorneys] can only exercise those powers which they have been granted
- The Power of Attorney is acting on behalf of the granter
- That it involves more work than anticipated
- Attorney is required to do their best for the granter at all times
- An understanding of the principles and how to apply, particularly in respect of encouraging the individual to make or be involved in decisions as much as possible.
- Knowing when to start acting / how to determine capacity

- Help the person to express their will, preferences and feelings
- Encourage the person to use their skills and develop new ones
- Be aware of possible conflicts of interest (i.e. the attorney's own)
- Understanding issues around consent to treatment
- Duty to the person and others on their behalf
- When the powers may be used; what the limitations are.
- What to record and report; who to report to
- Where to get support and where to report concerns.

One organisation, who have allowed us to quote them anonymously, commented

> ‘It is essential that attorneys understand when they can use their powers. They also need clear guidance about documenting any action taken on behalf of the vulnerable adult along with clear reasons for that. Attorneys need to be guided by the decision-making framework to allow the person centred approach for Supported decision making to be continued through the process. They should be supported by the local authority or other professional care management team allocated to the subject’.

Despite there being a wide range of things which people felt were the key things for an attorney to be aware of, there was a consistency to the suggestions as to how to provide awareness for attorneys:

- Attorneys to be provided with guidance and education, in a single easy to read document
- Training and support should be provided
- A phone number, a clear and concise process map. Details of support agencies.

- A legal requirement for attorneys to attend an introductory training course, to understand their rights and responsibilities - attorneys should be provided with clear and concise guidance on their responsibilities, key principles, and what will be expected of them in the role.

The British Deaf Association Scotland expressed a willingness to assist with training, and any other information that may be needed, to empower attorneys to support the Deaf BSL user.

In terms of the new approach we recommend in this report, guidance should include the primary role as supporter, when powers of decision-making may be used, as well as the limitation of powers. The attorney should be aware of the need to support the person’s decision-making (covered in chapter 4). Whilst an attorney is not expected to undertake a formal review of HRE or and ADM test before each intervention, information on HRE and ADM, as well as SDM, should form part of the guidance being recommended here as. An attorney should be aware of the principles of HRE (chapter 8), and the concept of autonomous decision-making (see chapter 8) before proceeding to make any decisions, or take actions, on the person’s behalf.

Written guidance is not always useful on its own, and we believe a dedicated helpline would also be useful. This helpline should be clearly referenced in guidance, with attorneys and Decision Making Representatives (see below) actively encouraged to use it whenever they are unsure of a matter. Helpline staff will need to be experienced as they should be able to offer guidance on any topic that an attorney or Decision Making Representative may call about, including what matters to consider when approaching a particular decision, how to deal with family disputes or conflicting issues. Helpline staff should know of alternative sources of support, for example, how carers may obtain emotional support, or when and where to obtain additional financial support. We recognise there is a cost to such an advice line but there is currently a significant cost expended on cases that go badly awry for lack of appropriate and timeous support and require extensive intervention by the OPG, Local Authorities, the MWC and even the courts.

Supervision of attorneys

Currently, there is no routine supervision for attorneys. As mentioned above, this lack is seen as a weakness in the current system. The consultation asked for views on this.

Individuals expressed polarised views “I’m not convinced this [supervision] is necessary” to “This makes sense to ensure that the attorney is ethical, and not stealing money from the person being supported”.

There were differing views over who should supervise, should supervision be recommended. For example, various individuals suggesting this should be the Local Authority, contrasted to East Ayrshire Health and Social Care Partnership commenting ‘it would be unrealistic to place additional supervisory responsibilities on the existing Local Authority Social Work workforce without substantial investment to increase resources’. We make recommendations in the section below in respect of supervision.

Investigation

In respect of the current investigation process, there was general dissatisfaction, perhaps best summed up by Support in Mind who commented “The current system is unfit for purpose and requires changes or increased accountability measures”.

AdvoCard commented ‘It [the investigation process] should be unified, with specialists working across welfare, finance and human rights’.

An organisation commented ‘At present there is no clear investigation structure with Social Work, Police, OPG etc. all working independently” “First contact should be clearly specified, and the escalation process marked out. It needs simplified and perhaps to be directed through one main body’.

Again from an organisation who has allowed us to quote them anonymously, ‘Investigations for concerns needs to be clearer in terms of which professional body is the identified organisation to lead these investigations and the formal processes to be implemented for these'.

Support in Mind commented

> 'The thoughts of the investigation structure of Power of Attorney (POA) from our respondents were extremely negative. It was expressed that people do not know who to report their concerns to'.

One respondent reported that 'when financial abuse happens, we often hear from social workers that it is a police matter. Yet, the police say it is a social work matter'.

There was criticism of both the Local Authorities and the OPG.

> 'Local Authorities must be accountable when they refuse to take up concerns, they should not be able to just 'sweep them under the carpet'. Support in Mind.

> 'The OPG needs to better investigate areas of concern'. Individual.

Social Work Scotland and Scottish Association of Social Work made similar comments about lack of consistency of OPG investigations.

> 'We would suggest that sufficient powers exist for the Office of the Public Guardian to take forward investigations, however these are not consistently applied'.

> 'The Office of the Public Guardian have the opportunity to respond quickly to reports of concern and to work jointly with local authorities through the Adult Support and Protection framework and we would be in support of their taking forward this role'. (Social Work Scotland).

Factors which any revised investigation system should encompass included:

> 'This needs to be by a non-partisan unrelated organisation that is in no financial or corporate relation to the agency or person being investigated' – an individual.

> ‘Hopefully this can combine meaningful support for those genuinely struggling with a new system and supervision/prosecution of those wilfully neglecting duties they ostensibly took on willingly in support of someone in need of such assistance. It is imperative that there is a clear pathway for investigations including possible outcomes, which is well communicated to all who may be taking part at every stage, so as to reduce uncertainty and worry about the process’. (Scottish Association of Mental Health).

13.2.3: Our final recommendations

Recommendation 13.2: The Scottish Government should as a priority , amend the Adults with Incapacity (Scotland) Act 2000.

Recommendation 13.3: The Scottish Government should amend the Power of Attorney scheme as follows:

> **13.3.1: The granter should state when a POA should come into force.**
>
> **13.3.2: A person’s ability to grant a POA should be carried out in accordance with the ADM test in Chapter 8, within the framework of HRE and SDM.**
>
> **13.3.3: The certificate accompanying a POA should be called a ‘Certificate of Autonomous Decision Making Ability’.**
>
> **13.3.4: The act of a GP completing a POA certificate should be included as an NHS funded service.**

13.3.5: A comprehensive investigatory framework should be developed with OPG, Local authorities, the MWC and Police Scotland and full and equal participation with persons with lived experience including unpaid carers.

13.3.6: Provision should be made in law for an attorney to be subject to supervision should an investigation determine this is required.

13.3.7: As per the recommendation in chapter 3 updating of the AWI Act principles is required.

Recommendation 13.4: The Scottish Government, together with the OPG, MWC, local authorities and such other agencies as necessary, along with the full and equal participation of persons with lived experience including unpaid carers, should develop support , training and guidance for attorneys. This should include

13.4.1: Awareness of the role and obligations of an attorney.

13.4.2: Information on the new HRE/SDM/ADM framework.

13.4.3: Provision of an advice helpline/ online support.

13.4.4: Consideration of ways in which access to granting a power of attorney may be eased.

13.4.5: Consideration of ways in which the cost of a POA can be eased.

Recommendation 13.5: The Scottish Government should ensure there is increased awareness of the importance of a POA, with targeted engagement, and multimedia involvement, with focussed messaging for groups who may benefit more from having a POA, actively encouraging all citizens to grant a POA early, as part of lifestyle planning.

13.3: Access to funds and management of residents' finances,

These matters, which form part 3 and 4 of the current AWI Act respectively, are dealt with below under 'guardianship'.

13.4: Medical Treatment and Research

13.4.1: Introduction – general approach

This section discusses medical treatment authorised under the AWI Act. This is a particular form of decision-making and acting which has its own statutory provisions in Part 5 of the Act, but which is also affected by the wider legal framework affecting people with impairments to their decision-making ability.

This section sets out proposals for reforms to Part 5. We also intend that many of the wider recommendations of our report would apply to this specific issue of medical treatment, although they may not be implemented until later. Provisions in Part 5 which turn on the person lacking decision-making capacity would in our scheme be based on whether the person is able to make an autonomous decision, with appropriate decision-making support, including advocacy. [See Chapter 4]. As with other aspects of AWI Act, we recommend that the judicial forum for any cases arising out of Part 5 should ultimately be a reformed tribunal, rather than the sheriff court. We discuss in the guardianship section below the role of a decision-making supporter in relation to medical treatment, and, in Chapter 4, how advance statements would relate to medical treatment.

In line with our intention ultimately to unify mental health and capacity law, we believe that the safeguards for non-consensual medical treatment in the two legal regimes should be aligned.

13.4.2: Part 5 in general

Where we started

Our general view is that Part 5 of the AWI Act provides a pragmatic and fair process to authorise medical treatment, in situations where the adult is unable to give informed consent, and to resolve disputes where they arise.

Many of the problems do not arise from the legislation, but from the way it is understood or applied. This may be partly attributable to the fact that Part 5 is a part of the AWI Act which is very likely to be operated by clinicians and GPs who are not specialists in mental health. There are significant issues of training, guidance and supervision which we believe need to be addressed.

What we were told

This general approach was widely supported in responses to our consultation, with the Royal College of Psychiatrists saying ‘minor clarifications and alignments are what is required.’ Several respondents stressed areas where they felt safeguards should be strengthened, particularly on the right of the adult to challenge a decision, and on stronger safeguards for interventions such as the use of force.

Social Work Scotland commented that:

> ‘We would support a review of use and practice around issuing section 47 certificates and believe it is integral to ensuring practices around use of these certificates reflect considerations of a human-rights based approach. Practice experience suggests that the use of section 47 certificates is not well understood across the professionals who issue them, or with the individuals and family/next of kin who may be subject to them. A certified medic, from our members’ experiences, does not always undertake the measures and

> requirement for issuing a section 47 certificate and this should be considered as part of the integrity of its use. There have been experiences of blanket approaches to use of section 47 certificates based on the age of the individual, and this is frequently reported for those living in care homes to support practices and systems in the home, over the individual need of the person'.

13.4.3: Section 47 – authority to treat patient who lacks capacity

Where we started

Currently Section 47 states that, once a certificate is granted, the practitioner may do 'what is reasonable in the circumstances … to safeguard or promote the physical or mental health of the adult.' In our view this is too broadly worded and suggestive of a paternalistic 'best interests' approach. We suggested the wording of the legislation should reflect our approach to maximising the autonomy of the adult and respecting their will and preferences.

What we were told

This attracted support from consultees including AdvoCard although the MWC said that there also 'needs to be a consideration of the patient's rights and needs and crossing over all these, benefit.' They went on to say that their guidance endorses Baroness Hale's expression of this in the leading court case of *Aintree University Hospitals NHS Trust v James*.

The Royal College of Nursing questioned our view, saying that regulated practitioners are comprehensively governed by their own Code of Practice and Standards and that the statutory Code of Practice provided more detailed guidance on how to properly apply the legal provisions.

On balance, though, we still feel it is important that the statutory power itself is worded in a way which reflects the increased respect for patient autonomy found both in developments in medical practice and the CRPD. Additionally, it would of course operate within the proposed framework that includes Human Rights Enablement, Supported decision making and Autonomous decision making as described in Chapters 4 and 8.

We consider that the MWC suggestion has merit. The full formulation in Article 12 of the CRPD is that ‘measures relating to the exercise of legal capacity respect the rights, will and preferences of the person’, and it is reasonable to include rights alongside will and preferences. We also believe that this is compatible with Baroness Hale’s approach in **Aintree***,* which was, essentially, that in determining what is in the best interests of the patient, it was necessary to consider matters from the patient’s point of view (para 45). We have therefore adjusted our recommendation (see below).

13.4.4: Common law power to treat

Where we started

Section 47 provides that the powers contained in it do not affect ‘any authority conferred by any other enactment or rule of law’. We understand that this is intended to preserve the common law power to treat in an emergency, under the principle of necessity.

We recognise that there will be many occasions where there is no time to carry out the section 47 certification process before offering treatment. But there appears to be widely differing practice on when section 47 is used, even in cases which are not emergencies.

This can sometimes result from confusion over whether Part 5 should operate where a person’s inability to consent is not caused by a condition such as dementia, but a physical condition such as a stroke or fever. In our view, Part 5, with its requirements for proper certification and a clear treatment plan, should generally be preferred to common law powers, including in such cases.

What we were told

The MWC response cited their guidance that ‘wherever it is reasonable and practicable for the procedure or intervention to take place under a statutory process (most commonly the AWI Act) that provision should be used.’ Apart from the potential for confusion, the fact that treatment can be given at common law rather than under the Mental Health Act means that the principles of the Mental Health Act do not apply when this is done.

Now that the statutory scheme is well established, we believe it is time to remove a vague and potentially wide common law alternative. Instead, we propose that the legislation should set out the circumstances where the formal procedures do not need to be completed, including where treatment is so urgent that to do so could harm the patient. See Chapter 8 on urgent use of the Autonomous decision making process.

13.4.5: Who can grant a section 47 certificate?

Where we started

The s47 certificate can be signed by the medical practitioner primarily responsible for the treatment, or by a dentist, ophthalmologist or nurse who has been appropriately trained and is responsible for the particular treatment in question.

In our consultation we suggested that, provided they are suitably trained and supervised, other practitioners, including psychologists, should be authorised to issue a section 47 certificate relating to the treatment they offer.

What we were told

One respondent questioned the justification for this, on the grounds that psychologists do not recommend medical treatment, and they were uncertain of the appropriateness of psychological treatments being issued under incapacity legislation – although they agreed that psychologists could contribute to a multidisciplinary view of a person’s capacity. Others, however, supported the addition of psychologists. Dumfries and Galloway Council stressed that robust training would be required to ensure appropriate use by new groups of people.

It is our understanding that some psychological interventions are given to people who would be incapable of consenting, and we are still in favour of extending the classes of people who can grant a s47 certificate. We believe the signer should continue to be the person primarily responsible for the treatment in question. They may need to take expert advice in complex cases, and this is one of the issues that could be brought out in a redesigned form.

13.4.6: Audit

Where we started

Currently, there is no process of review or audit of section 47 certificates. We recognise that the huge number of such certificates makes it almost impossible for them to be individually monitored. However, technology may make it possible to build in checks during completion to ensure that practitioners address themselves to the right issues, and for the certificates to be electronically recorded in a way which would support targeted audit and analysis of practice.

What we were told

The Law Society response said that

> ‘there must be safeguards against mass and automatic issue of section 47 certificates, for example all residents in a care home having identical section 47 certificates referring to dementia, even those – such as stroke victims – for whom there is no reason for such a diagnosis.’ We hope that an audit process would help to prevent such misuse of the process’.

This could be supported by improvements to the design of the AWI Act forms to more clearly remind those signing of the requirements and principles of the legislation.

We propose that the MWC could oversee arrangements for a proportionate process of audit of s47 certificates, in line with its extended role outlined in Chapter 11.

13.4.7: Force, detention and the relationship with the Mental Health Act

Where we started

Section 47(7) provides that the treatment authority does not authorise ‘the use of force or detention, unless it is immediately necessary and only for so long as is necessary in the circumstances’ or ‘placing an adult in a hospital for the treatment of mental disorder against his will’.

It is sometimes assumed that the Mental Health Act is more concerned with requiring a patient to accept treatment which they do not want, while the AWI Act is a means of providing treatment authority for treatment of physical conditions for a patient who cannot consent.

However, section 47 can and does authorise forcible treatment, including for mental disorder, and arguably contains fewer safeguards than the Mental Health Act. There is no specification of how long is ‘so long as is necessary’, and this could cover multiple interventions over a substantial period.

The section 47 authority might also cover physical or mechanical restraint, if it is felt to be part of a ‘procedure designed to safeguard or promote physical or mental health’. The Code of Practice (para 2.47) encourages doctors to consider use of the Mental Health Act where giving treatment for mental disorder to an unwilling patient, but does not require this.

Antipsychotic medication is regularly prescribed under section 47, and there is particular concern that this may be done in community settings to control stressed and distressed behaviour without adequate safeguards rather than use alternative measures to alleviate such stress or distress.

The AWI Act does not make specific provision for covert medication. The MWC has issued guidance on this, but it has no statutory force.

There is a difference between treatment for mental disorder and physical conditions. Where the person is being treated for a mental disorder, the issue is whether it is acceptable to use s47 as an alternative to using the Mental Health Act, with its greater safeguards. Where the treatment is for a physical condition, any longer-term authorisation of force or detention would presumably require to be given by a welfare guardian, welfare attorney or sheriff court.

What we were told

There was widespread agreement amongst respondents that there needed to be a tightening of the legislation and practice.

The MWC commented that s47 is ‘far too permissive currently’. They were concerned with the way it is used to provide ‘initial’, ‘one-off’ or ‘irregular’ treatments requiring force, outside the safeguards of the Mental Health Act. AdvoCard and the Forensic Network both supported improved safeguards more closely aligned with mental health legislation. The Care Inspectorate commented that

> ‘Where force is necessary beyond one-off emergency situations, this should be open to wider examination, and judicial oversight and review’.

The Royal College of Psychiatrists said

> ‘There is the potential for considerable ambiguity and debate about the extent of common law emergency authorisation, what interventions involving force were permissible under the AWI Act, and which required the use of the Mental Health Act (in the absence of other alternatives available in clinical timescales). The need to resolve this issue via statute or guidance was a major concern for practitioners’.

The Faculty of Eating Disorders in the Royal College of Psychiatrists supported the following comment by the College and added that these confusions can arise during the treatment of eating disorders:

> ‘Priority needed for clarification of powers of force and detention’. The main deficiency in the current process is the lack of any powers to authorise and appropriately oversee use of force and detention. Currently, the use of force and detention is authorised under the 2000 Act but only when “immediately necessary and only for so long as is necessary in the circumstances”. This leads to significant ambiguities in the law with need for use of the Mental Health Act EDC and STDO powers. Clarity in this area and intervention powers clearly stated in one statute is desirable’.

The Scottish Human Rights Commission highlighted that the use of force or detention engages Article 8 ECHR (right to private and family life) and, in severe cases, could engage the prohibition of inhuman and degrading treatment (Article 3). They argued that additional safeguards are required, and that force or detention should be subject to judicial consideration.

At the same time, there was concern about the practical implications in emergency situations. The Royal College of GPs said:

> ‘Clinicians who are not using this legislation on a regular basis (e.g. GPs) can find the relationship between these Acts confusing, especially in a crisis situation. It is not easy to know where to gain specialist advice quickly. Consideration should be made of any unintended consequences of making use of Section 47 more complicated for simple healthcare needs, e.g. wound care, routine vaccination, pain relief, antibiotics. If processes are made unduly burdensome within existing workload constraints then patient care may suffer’.

The Royal College of Psychiatrists highlighted the need for a balance between rapid access to powers, which may be required urgently, and the need for meaningful scrutiny, including a right of appeal.

13.4.8: Access to justice

Where we started

It is open to the adult or another interested party to challenge a decision as to incapacity under section 47 by appealing to the sheriff under section 14 of the AWI Act. They can also appeal to the sheriff under section 52 about a specific treatment. This appears to be rarely, if ever, done, and the patient has no access to the dispute resolution procedure in section 50 (discussed below).

Article 5 and 6 ECHR case law requires that there be 'practical and effective' access to a court/tribunal and Art 13 of the CRPD also requires effective access to justice for persons with disabilities, including the provision of procedural accommodations.

We believe greater safeguards are required for the adult, who may find it difficult to access and instruct an application to the sheriff.

13.4.9: Section 48: Exceptions to authority to treat

Where we started

Ministers have made regulations specifying additional safeguards for the following treatments:

- Sterilisation where there is no serious malfunction or disease of the reproductive organs
- Surgical implantation of hormones to reduce sex drive
- Drug treatment to reduce sex drive

- ECT
- Abortion
- Any medical treatment leading unavoidably to sterilisation.

(The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002 (SI 275) as amended)

The first two procedures require the approval of the Court of Session. The others require approval by an independent medical practitioner approved by the Mental Welfare Commission.

We sought views on keeping these and on whether any new treatments should be added, particularly Transcranial Magnetic Stimulation (TMS).

What we were told

Several individuals expressed concern that ECT or abortions should ever be given without the adult’s consent. Against that, one consultee commented that ECT should be removed from the list, as in many ways it had fewer side effects and more benefits than antipsychotics which could be prescribed without this additional safeguard.

Few people had a particular view on TMS, although Dumfries and Galloway Council made the point that the limited knowledge and utilisation of the procedure in itself would be a ground for inclusion. The Royal College of Psychiatrists said there were concerns as to the evidence base for TMS which would need to be fully scrutinised.

The Royal College of GPs suggested adding IVF and organ donation to the list, and one respondent suggested adding forced nutrition for eating disorders.

One organisation commented that the list should never be exhaustive, with constant review and consideration of new treatments. Similarly, the Royal College of Psychiatrists said: ‘

> ‘It is hoped there will be significant improvements and innovations in treatments in the coming years and the process by which treatments are added to, and removed from, the list needed to be responsive’.

The MWC commented that safeguards should be universal and apply across the AWI Act and Mental Health Act. We agree with this in principle, although aligning the provisions is not straightforward.

The Mental Health Act provides additional safeguards in Part 16 for the following treatments

- Neurosurgery for mental disorder and deep brain stimulation: can only be given to an incapable patient if they do not resist, and requires authorisation of the Court of Session
- ECT, vagal nerve stimulation, and TMS: requires authorisation by a Designated Medical Practitioner, and can only be given to an incapable patient who resists or objects to save life, prevent serious deterioration or alleviate serious suffering
- Artificial nutrition and medication to reduce sex drive: requires authorisation by a Designated Medical Practitioner
- Drug treatment for mental disorder: Once given for two months, requires authorisation by a Designated Medical Practitioner.

The provisions regarding neurosurgery in the Mental Health Act apply to voluntary as well as detained patients, so are universal in effect. We propose that the provisions regarding ECT in AWI Act should be adjusted to provide the stronger safeguards in the Mental Health Act and extended to vagal nerve stimulation and TMS. Medication to reduce sex drive attracts essentially the same safeguards in both Acts.

In relation to artificial nutrition, MWC guidance is that the Mental Health Act, which requires authorisation by a Designated Medical Practitioner (DMP) should be used where this is being given to treat an eating disorder, while the AWI Act should be used where the treatment is for a physical condition.

In principle, we believe the same treatment should attract the same safeguards, but this may require further consultation with medical professionals who more commonly deal with artificial feeding for physical conditions, given when the patient is not in a position to consent.

Drug treatment for mental disorder is a particularly complex area. It is not uncommon for doctors, including GPs, to prescribe psychoactive medication under the AWI Act, particularly for people with dementia, whether in care homes or their own home. Requiring any such medication to be authorised after two months by a DMP is likely to be impractical, as there simply are not enough consultant psychiatrists to carry out the task.

On the other hand, there is considerable concern about the level of such prescriptions, and particularly that they may be used, not to treat an underlying and treatable mental disorder, but to manage behaviour which may be felt to be disruptive.

Our suggestion is that, where the person is deprived of liberty, whether under incapacity or mental health law, equivalent safeguards should apply. This would mean that anyone who is in a care home, under the authorisation of a decision-making representative or a court, should only be given medication for a mental or intellectual disability for more than two months if authorised by a DMP. There may be exceptions for some less intensive treatments. The requirements set out in the Human rights enablement framework in Chapter 8 would also apply mean]

This would not apply to people in their own home, who have consented to be in a care home, or where the conditions do not amount to a deprivation of liberty. Other measures could be used to address concerns about inappropriate use of psychotropic medication in older people generally, including improved professional guidance and monitoring, and oversight by the Care Inspectorate.

13.4.10: Section 49 – Treatment during application to court

Where we started

This section provides that section 47 does not authorise medical treatment where an application has been made and not determined for guardianship or an intervention order with powers relating to the treatment, unless it is authorised by another enactment or rule of law (e.g. common law for emergencies) ‘for the preservation of the life of the adult or the prevention of serious deterioration in his medical condition’.

Our consultation suggested that this restriction on treatment is too wide, particularly given the length of time many guardianship applications can take. It may delay important treatment, even where there is no dispute about the treatment.

What we were told

The MWC responded extensively on this point, confirming that the current provisions cause difficulty. In their view, the purpose of s49 was to ensure a *particular* treatment was not given while a court application was under way to allow a guardian to consent or refuse consent to the treatment. But in many cases, the applicant and the medical professionals agreed with the treatment. The option of interim guardianship to authorise the treatment was disproportionate and caused undue delay.

13.4.11: Section 50 – disputes with guardians and attorneys

Where we started

Under section 50, where a guardian, welfare attorney or person authorised under an intervention order has been appointed in relation to medical treatment, the treating clinician is expected to obtain the consent of that person ‘where it is reasonable and practicable’ to do so. Concerns have been expressed by the MWC in the past that attorneys and guardians are not always routinely consulted about medical treatment.

If the proxy decision maker does not consent to the proposed treatment, the clinician can ask the MWC to nominate an independent medical practitioner with relevant expertise to give an opinion as to the treatment proposed. If the nominated doctor decides that the treatment should or should not be given, this determines the issue, unless there is an appeal to the Court of Session.

There are a number of issues which arise.

- It is different from the general rule that the guardian or attorney has the same authority as the adult would have to make a treatment decision.
- It is designed for situations where the doctor wants to give treatment, but the proxy refuses to consent. It would not seem to apply where the doctor is unwilling to treat, but the proxy wants treatment to be given.
- It is not clear whether or how the procedure operates in relation to the withdrawal of treatment, e.g. taking a person off a ventilator.
- The Act requires the MWC to maintain a list of practitioners who can be nominated to give an opinion. This is impractical, because there are few cases, and it is impossible to know in advance which specialty will be required.

We sought views on this although, on balance, we felt the procedure works reasonably well and does not require to be substantially amended.

What we were told

The Royal College of Psychiatrists commented that the procedure was infrequently used but expressed no concerns about its operation in principle.

In relation to the process of appointing an independent practitioner, the MWC said that they intended to write to professional bodies seeking input into the process, but saw merit in their retaining the final say in who was appointed. They believed that the procedure was not appropriate in cases where the welfare proxy objected to the non-provision of treatment – in that case they advised that the proxy seek a clinical second opinion from the Health Board.

Some respondents commented that the lack of reported disputes may reflect a failure by doctors to consult with proxies when they should.

Overall, we continue to believe that the procedure requires little modification, although changes may be needed to align it with our proposals regarding advance statements [see Chapter 4]. The issues raised by the Commission about failure to consult guardians and attorneys should, we hope, be addressed by the greater emphasis on Supported decision making and our new proposals to replace guardianship.

We also note that the Law Society of Scotland has issued a discussion paper on medical treatment in intensive care. Any changes to that area of law may have implications for the powers of a welfare proxy in relation to a clinician’s ability to withdraw treatment when they regard it as no longer benefitting the patient.

13.4.12: Disputes between the proxy and the adult

A recent court case has brought to light another concern – whether a guardian’s view on treatment replaces the adult’s view, even in cases where the adult has capacity to make the treatment decision in question. It has been argued that this is the effect of s67 of the AWI Act, which says that ‘The adult shall have no capacity to enter into any transaction in relation to any matter which is within the scope of the authority conferred on the guardian except in a case where he has been authorised by the guardian’.

We understand that the court case was settled without the issue being finally determined by the courts. In terms of future law, though, we believe that when an adult is able to make an autonomous decision, this should take precedence over the view of the welfare guardian. This is consistent with the existing provisions regarding welfare attorneys (see s16(5)), and with our approach to Support for decision making.

13.4.13: Section 51 – Research

In their response, Parkinson’s UK Scotland argued for provisions to support research, saying:

> ‘We believe it is important to include people who lack capacity in research because some of the most problematic and hard-to-treat Parkinson’s symptoms concern cognitive and mental health symptoms. Improving lives for people with advanced Parkinson's will require the development of effective treatments for Parkinson's dementia and for hallucinations and delusions, …. We recognise that there are ethical issues around the participation of people who lack capacity in medical research, but would highlight that many people with Parkinson's want to take part in research, and would want to make sure that they are able to continue to participate in legitimate research at a time when they may no longer have capacity to consent’.

They proposed

> ‘that advanced directives, statements of will and powers of attorney should all include provisions enabling people to make their wishes known about research participation in the future’.

We recognise that the issue of whether and when to include persons who lack capacity to consent to participate in research presents ethical challenges. On the one hand, research may well benefit a particular cohort of persons who are unable to provide consent. On the other hand, there is the argument that nothing ought to be done without the person’s consent in order to respect autonomy. We consider that adopting the approach we propose in Chapter 4 on SDM should increase, with appropriate safeguards, the number of persons participating in important research whilst at the same time protecting their choices to agree or not to agree to participate. We do not make a specific recommendation on research, but this matter may require further discussion with the research community and people with lived experience.

13.4.14: Conveying to hospital/deprivation of liberty in hospital

Where we started

Part 5 of the AWI Act gives authority to provide treatment, but it does not specifically mention conveying a person to hospital to receive treatment. The Code of Practice states that 'where it is not against the patient's will, treatment by way of admission to hospital may be permitted under the 2000 Act'. This statement refers to admission for treatment for mental disorder, but presumably the same principle is thought by the authors of the Code to apply to admission to hospital for physical treatment.

The Scottish Law Commission (SLC) report in 2014 on Adults with Incapacity noted that concern had been expressed on this, but concluded that conveying a person to hospital could normally be justified under common law powers or the authority of a s47 certificate (providing one already exists which covers the treatment in question) (Para 4.11).

However, the SLC recognised that Scots law currently lacked a specific process to authorise measures to prevent a person being treated for a physical condition from leaving hospital, whether temporarily or permanently. This is potentially just as much a deprivation of liberty in Article 5 terms as being moved to a care home. The SLC proposed (Chapter 5) a new procedure whereby a doctor could certify that an adult was incapable in relation to a decision as to whether or not to go out of the hospital, which would last so long as the need for it is 'manifest'. Once treatment or assessment has come to an end, the patient or other interested party could apply to the sheriff to set an end date. There would also be a duty to review on the clinician and a right of appeal ((Report on Adults with Incapacity - SLC 204, Chapter 5 and draft bill section 1).

The Scottish Government's consultation on AWI Act proposals for reform proposed a modified version of this: that the scope of a s47 certificate should be extended to allow the medical practitioner to authorise that an incapable adult patient be prevented from leaving hospital whilst undergoing medical treatment for a physical illness. They sought views on whether this should extend to authorising the removal to hospital. The order would require to be reviewed and renewed after 28 days, and there would be a limit on the number of times this could happen without judicial involvement. The Section 50 procedure could be invoked in the event of disagreement between the clinician and any proxy decision-maker.

What we were told

We discussed these concerns with a group of (mainly professional) stakeholders.

There was a general view that it was necessary to make specific provision to authorise conveying a person to hospital, and that the ‘place of safety’ powers in the Mental Health Act might provide a model. These include the power of a constable to take a person in need of care to a place of safety, and powers for a sheriff or Justice of the Peace to grant a warrant or order to authorise entry to premises and authorising a mental health officer, constable or other specified person to convey the person to a place of safety.

In relation to being required to remain in hospital, there was agreement that this is a significant gap in the law which must be closed. It was generally agreed that, where the person is unable to make an autonomous decision to remain in hospital, and there is no-one else who can consent on their behalf, it would be disproportionate to require a Deprivation of Liberty order to be sought from a court. But there need to be safeguards against people being made to stay in hospital, potentially against their will, without access to proper review.

The majority (albeit not a large majority) of responses to the consultation agreed that there should be provision to authorise the removal of a person to hospital for treatment for a physical condition or for diagnostic tests. There also appears to have been broad support for broadening the s47 certificate, although there were differing views about whether the 28 day period was appropriate.

Our views

We generally support as much alignment as possible between mental health and capacity law as possible. However, in relation to conveying people to hospital for treatment for a physical condition, we are not persuaded that the Mental Health Act model can be directly transposed. In many situations it may be GPs, community nurses or paramedics who have to decide, often in a situation of great urgency, whether a person should be admitted to hospital, even if they are too unwell to agree or may be resisting admission.

We propose an adapted s47 certificate should be used to grant authority to convey a person who appears to be unable to consent to admission. This would record the reasons the person was felt to be unable to consent, why admission was felt to be necessary, and what attempt was made to ascertain the will and preferences of the adult. It would also be important to identify whether the person was simply unable to agree, or actively unwilling to go to hospital. In the latter case in particular, the adult should be supported to challenge their remaining in hospital, if they continue to be unwilling to say.

We do not suggest that this would be necessary in cases where a person was unconscious, and there was no indication of any reluctance to be admitted to hospital.

However, further consultation would be needed, both with groups representing potential patients, and with professionals including emergency services.

In relation to deprivation of liberty once in hospital, we believe the Scottish Government proposals represent a practical way forward and should be developed further.

13.4.15: Our final recommendations

These are all short-term recommendations.

Recommendation 13.6: The Scottish Government should ensure that Part 5 and associated guidance and forms should require a certifying practitioner to demonstrate that they have considered and adhered to the principles of the AWI Act when issuing a section 47 certificate.

Recommendation 13.7: The Scottish Government should ensure that guidance gives greater clarity on the support that is required to be given to the person in assisting them to make an autonomous decision, before engaging section 47.

Recommendation 13.8: NHS Education Scotland should review the training of doctors and other professionals who are authorised to grant section 47 certificates. This should include their understanding of relevant human rights issues, and the principles of the legislation.

Recommendation 13.9: Section 47, 47A and associated regulations should be amended as follows:

> **13.9.1: The authority currently granted by section 47 should be reframed to make clear that treatment which is authorised should be that which would reflect the best interpretation of the adult's rights, will and preferences.**
>
> **13.9.2: To specify the circumstances in which it is not necessary to complete AWI Act documentation when treating a patient who is unable to consent, and make clear that in all cases the principles of the legislation apply.**
>
> **13.9.3: To widen the categories of healthcare professional who can assess incapacity and issue a section 47 certificate, including registered psychologists where appropriate.**
>
> **13.9.4: To provide a process of electronic recording and auditing of section 47 certificates, overseen by the Mental Welfare Commission.**

13.9.5: To provide that force, detention, or covert medication should require explicit authorisation by a legal process with a right of appeal to the tribunal, unless there is a genuine emergency.

13.9.6: Section 47 should operate within the Human Rights Enablement, Supported decision making and Autonomous decision making framework.

Recommendation 13.10: Scottish Government should undertake further consultation to develop

13.10.1: A clear process to authorise conveying an adult to hospital for physical treatment or diagnostic tests where they are unable to make an autonomous decision

13.10.2: An extension to s47 to authorise restrictions on a person leaving hospital while they are receiving treatment for a physical condition or diagnostic tests, with provision for review after 28 days, and an appeal process.

Recommendation 13.11: In all cases, including emergencies, force, detention or covert medication should be recorded and subject to monitoring and audit, overseen by the MWC.

Recommendation 13.12: The MWC should issue guidance on the use of force, detention and covert medication which should have the same legal effect as the statutory Code of Practice.

Recommendation 13.13: An adult, or someone acting on their behalf, including a carer or advocate should have practical and effective access to a court or

tribunal by a simple procedure to challenge a decision to grant a section 47 certificate, or a treatment authorised under that certificate.

Recommendation 13.14: The safeguards for specified treatments under s48 should be adjusted so that the same safeguards apply as under the MHA for

1.1:ECT, vagal nerve stimulation and transcranial magnetic stimulation

1.2:(Subject to further consultation) artificial nutrition and hydration: we propose these should be the same as under the MHA

1.3:Drug treatment for mental and intellectual disability given for more than two months to a person subject to a deprivation of liberty.

Recommendation 13.15: It should be lawful to give treatment which is reasonably necessary to a patient under Part 5 (section 49) where an application for a Decision Making Representative is in train, provided the application does not involve a dispute regarding the particular treatment.

Recommendation 13.16: The law should make clear that a decision-making representative cannot override the adult in relation to a decision where the adult is able to make an autonomous decision regarding the particular treatment.

Recommendation 13.17: We recommend that the reformed system should include a straightforward process by which an adult who believes they can take an autonomous decision about their medical treatment can access the tribunal. [See chapter 5 on support that is available where an ability to instruct a solicitor is limited]. In addition, any stated opposition to a particular treatment by the adult should bring into play the same safeguards as opposition by a decision-making representative.

Recommendation 13.18: Scottish Government should ensure adequate resourcing to realise these recommendations.

13.5: Intervention Orders and Guardianship

13.5.1: Where we started

We acknowledge the difficulties which were identified in the previous AWI Act consultation (Scottish Government, 2018) with the current guardianship system. In summary, the current guardianship application process is bound by delays on all fronts; the process can be cumbersome; it lacks the flexibility to meet the needs of those subject to guardianship; it is costly; and it cannot be delivered quickly.

The process to obtain an intervention order is the same, so faces the same challenges, even though an intervention order is for a specific issue.

The person subject to guardianship can be lost in the process. Whilst the AWI Act requires that account must be taken of the person's present and past ascertainable wishes and feelings, this has to compete with other principles. Although those exercising functions under the AWI Act, or any sheriff court order relating to the person, must encourage the person to exercise and develop whatever skills they have concerning their property, financial affairs or personal welfare, there are no specific provisions relating to supporting the person to exercise their legal capacity.

Additionally, it would appear that a guardian may exercise their powers even where the person has capacity. The AWI Act does not therefore provide a framework that ensures that the person's will and preferences are respected on an equal basis with others .This raises clear Article 12 CRPD compatibility issues even if one disputes the Committee on the Rights of Persons with Disabilities' position that guardianship will always be a substituted decision-making mechanism that denies the equal enjoyment of the exercise of legal capacity.

We accept that some processes are required to authorise decision-making on behalf of someone where they cannot do this themselves, even with significant support, whilst at the same time still trying to maximise and give effect to the person’s will and preferences on an equal basis with others. This requires a range of measures to cover situations where a person is unable to indicate their will and preferences at a given time which is integrated with supported decision-making.

13.5.2: A new decision-making model

In our March 2022 consultation we outlined a new decision-making model. We proposed that:

1. The current guardianship model, including the term ‘guardianship’, ceases. This includes too the process for applying for an intervention order.
2. The person should be supported under a new decision-making framework.
3. There needs to be provision within the decision-making model for an emergency application.
4. The current orders for specific intervention, access to funds and management of residents’ finances are subsumed with the reframed decision-making model.
5. Appropriate supervision for the newly appointed Decision Making Representatives (DM Representatives) will be reviewed.
6. A Code of Practice will underpin the operation of the reframed process.

These proposals followed consideration of various models of what to date has been referred to as ‘graded guardianship’, which would allow for either more limited decision-making powers to be granted to a representative, or different forms of support and consultation to be recognised. We wanted to see new ways in which family members and trusted individuals can have a greater role in decision-making and proposed the new decision-making framework as a way of achieving this.

The proposed model is different to the current guardianship system in that it will operate within the Human rights enablement, Supported decision-making and Autonomous decision-making framework discussed in Chapters 4 and 8, which ensures that the person’s will and preferences and needs at a given time are given effect on an equal basis with others.

We proposed that there be three ‘tiers’ of supporting agent, which would apply in respect of finance and/or property and/or welfare decisions, as follows:

1. Decision-Making Supporter;
2. Person appointed under a Power of Attorney (covered above); and
3. Decision-Making Representative

We considered whether to include a co-decision maker within this framework. A person may appoint someone to assist them with decision-making should they experience decision-making difficulties. Examples can be found in the Irish Assisted Decision Making (Capacity) Act 2015 and the Adult Guardianship and Trusteeship Act in Alberta, Canada. However, following earlier stakeholder feedback, we decided to omit this role from the proposals. Concerns were expressed that the role of co-decision maker was not sufficiently distinct from that of Decision Making Supporter and Decision Making Representative, or indeed the co-decision support of an attorney under a Power of Attorney, which could lead to co-decision makers assuming a representative role without them having been formally appointed to that role. There were also concerns about what would happen if, or when, the co-decision maker and person had a difference of opinion or there was a conflict of interest.

Decision Making Supporter

We proposed that the Decision Making Supporter (DM Supporter) would offer such assistance as may be required to allow the person to arrive at an autonomous decision. The decision remains entirely that of the individual. The role of the DM Supporter is to assist the person to make their own decision, maximising the person’s ability to be able to do so. This could involve the supporter ensuring that the person has all the appropriate information needed to make the decision, providing explanations, agreeing time frames within which decisions needs to be made, establishing a person’s will and preferences, supporting the person to communicate and action their decision and monitoring and following up on the decision to ensure it is implemented.

The person would nominate whoever they wished as their supporter, or supporters, and this would be registered, very likely as part of the Office of the Public Guardian (OPG) registration system, to offer legitimacy to the supporter. The nomination form would include details of the authority given to the supporter or supporters. In the event the person is not able to make an autonomous decision, even with support, the supporter’s role may be valuable in terms of offering a best interpretation of the person’s likely decision. The DM Supporter however has no formal powers of representation, making this role different to that of a person appointed under a Power of Attorney.

We also proposed that the Public Guardian/Local Authority and the MWC should have investigatory powers where there are concerns about the actions of a supporter.

Decision Making Representative

We believe that judicial oversight is required where an individual is appointed without the consent of the adult to take decisions for them. We therefore proposed that when a person of 16 or over is unable to make an autonomous decision or decisions (see Chapter 8 for ADM test) an application can be made to the court or tribunal for a Decision Making Representative (DM Representative). As with DM Supporter more than one DM Representative may be appointed and the application would specify the authority to be given to each. A DM Representative may have health and welfare and/or property and/or financial powers which will be clearly narrated in separate lists in the court [and ultimately the tribunal] order.

The DM Representative must act within the framework of Supported decision making and respecting the Autonomous decision making test (see Chapters 4 and 8 respectively) and, where it is applicable, ensure the person’s human rights are enabled, in line with the Human Rights Enablement (see Chapter 8).

The role of the DM Representative would be to take decisions based on the will and preferences of the person, or the best interpretation of these, not necessarily the decision the representative believes is right. This would be achieved through their engagement with, and knowledge of, the adult and using information from the person’s loved ones, carers, other family members and close friends in order to establish the person’s likely will and preferences.

A DM Representative would only be appointed in the following circumstances: a DM Supporter requiring formal powers of representation; where no DM Supporter or attorney has been nominated; where the necessary powers are outside those granted under an existing Power of Attorney; or an attorney can no longer fulfil the role.

Although the DM Representative may be someone other than the DM Supporter or attorney the fact that a DM Supporter or attorney was chosen by the person is highly relevant and important when considering who may be an appropriate DM Representative, should one be required.

We proposed that supervision of the DM Representative by the Public Guardian in respect of financial actions, and the Local Authority in respect of welfare decisions, as well as the role of Mental Welfare Commission, would remain unchanged, although we felt that their primary role should be one of support for DM Representatives. That being said, we recognise that, because of the growth of guardianship, the level of welfare supervision particularly has greatly reduced.

Responding to criticism of the current guardianship model’s inability to apply in a case of urgency, we also proposed that, with the new model, a judicial decision could be made on the papers as lodged where there is evidence of urgency.

Intervention Orders

In our March 2022 consultation we sought views as to whether the reframed model should allow for the grant of a specific or one-off order (currently called an intervention order).

Access to Funds

We proposed the current access to funds scheme (Part 3 of AWI Act) be subsumed within the new decision-making model. This would include the current application to access information in order to proceed with an access to funds application.

Management of residents’ finances

We proposed the current Management of residents’ finances option (Part 4 of AWI Act) be subsumed within the new decision-making model.

To underpin all of the above, we proposed that Codes of Practice and Guidance will offer more detailed explanation and guidance. This would include guidance on the role and responsibilities of DM Supporters and DM Representatives, and what to do if their powers seem insufficient; the avoidance of undue pressure; how to deal with conflicts of interest; and where they can access support.

Finally, future legislation would need to include transitional provisions to address the position of current guardians under the AWI Act.

13.5.3: What people told us

About the model

Whilst some respondents felt that what we were proposing could be achieved if the existing guardianship system were better resourced and made to work more efficiently, the proposed decision-making model was largely supported in principle by respondents to the consultation. This was not, however, without some reservations at this stage. Such reservations, which were also often shared by those who did not support the proposal, were that, at present, the proposal seems ‘overly legalistic’ and required greater clarity and detail in order to understand fully how it would actually work in practice in health and social care settings so that it can be better understood.

Although there was a great deal of support for the proposal’s objective of actively ensuring that the person’s will and preferences are given effect and removing the ability of guardians to substitute their own views for those of the person a significant number, and range, of organisations expressed concerns that the new model may be confusing and create additional, unnecessary, bureaucracy. These organisations included See Me, AdvoCard, Royal College of General Practitioners for Scotland, the Care Inspectorate, Inclusion Scotland, People First, Scottish Human Rights Commission, Royal College of Psychiatrists, Scottish Commission for people with Learning Disabilities (SCLD) and the Mental Welfare Commission.

Several respondents felt that the distinction between DM Supporter and an Attorney under a Power of Attorney needed to be clarified as both are appointed by the person. Similarly, Thrive Edinburgh, along with other respondents, also questioned how a DM Supporter will differ from independent advocacy. The need for clarity as to how conflicts of interest and disagreements between the person and their DM Supporter or DM Representative was also commented on.

The need to use different terminology and clarity around the roles was seen as essential if a change of culture is to be effected via the new system.

Several respondents mentioned deprivation of liberty and moving persons from hospital to social care settings and the need to include this within the model. This is addressed in Chapter 8.

Most respondents agreed in principle that the proposed model is an improvement on the existing guardianship system. SCLD, for example, were supportive of the suggested replacement system and stated that the current system inhibits the person's Article 12(4) UNCRPD and Article 8 ECHR right to choice. However, they, and others, cautioned that close supervision and monitoring of the new system will be required to ensure that such rights are given effect.

The proposed streamlined application system was also largely welcomed. For example, the Royal College of Psychiatrists (RCPsych) commented

> 'the model does indeed seem to allow for 'streamlining' of an application. Firstly, a 'pro forma application', presumably describing a less bureaucratic process, might bring some time benefits. Secondly, the scope for the Court to consider granting emergency powers might be of real benefit in allowing for

> judicial oversight of emergency interventions while then preceding to a full application on the same process – rather than duplication of effort. And thirdly, the ability to ‘upgrade’ a supporter or attorney would potentially also bring time-savings if information from the previous application could be used directly’.

The RCPsych however also commented that

> ‘there are a number of areas where the ‘streamlined’ process could still lead to lengthy delays. Firstly, the HRE/SDM/ADM process, if not provided in an emergency form in legislation and alongside specific guidance to this effect, will provide a ’roadblock’ to intervention. Members reported frequent situations where a request for a clinician to provide a ‘formal capacity assessment’ appeared to provide an insuperable obstacle to further intervention and there was concern that the HRE process could provide a similar ‘pinch point’. More seriously, our members reflected the delays in the system were not so much about individual processes taking a long time but rather lengthy delays between processes: in allocating a social worker, in allocating an MHO, in delaying Local Authority intervention to allow a family member to be identified, in getting a court date. The lack of statutorily enforceable time scales and the lack of an immediately available judicial forum represented the reasons behind most of the reported delays and that unless these two issues are resolved in legislation, said delays would remain intractable’.

Similarly, an HSCP commented

> ‘The proposed streamlining would appear to offer a more efficient approach in principle but it is difficult to ascertain how or if this would be less bureaucratic or less susceptible to congestion and delay than the current system. The primary cause of the current delays is a human resource issue and without detail of the resource investment in these proposals, assessing the measurable benefit becomes challenging’.

Such concerns about resourcing were noted by a number of respondents.

Additionally, concerns about the centrality of the person were raised. A person's rights must not be reduced in the interest of operational efficiency. Similarly, the Law Society of Scotland warned against the use of a pro forma application as this can result in 'tick box' exercises and a person's needs being lost.

The MWC felt the model was "unclear currently how challenges at that stage might work, particularly from the person. The model is silent on time frames, legal aid application, roles and responsibilities etc. so, without more detail gives little assurance of streamlining."

Most respondents supported the proposals relating to emergency applications in principle but there were several requests for more information. For example, the MWC said

> ' the emergency powers ..seem reasonable looking at the model, but the difficulty will be if there are delays between the imposition of emergency powers and the full scrutiny/hearing, this could be a significant deprivation/restriction to a person; and the model is silent on time-frames again'.

Tribunal?

There also appeared to be a general consensus that applications under the proposed new system be made to a tribunal.

> 'We support that this is brought into the tribunal system as noted above (we note this is a query as yet) but expanding the tribunal to consider cases would fit within the direction of a single body overseeing deprivations/restrictions for people who are unable to make decisions despite support, due to a mental health condition (however caused)'. (Mental Welfare Commission).

The absence of a Co-Decision-Maker from the proposed model

Our decision not to include a Co-Decision-Maker in the proposed model was largely supported. This was mainly because this would otherwise cause confusion or be superfluous to the roles of D.M.Supporter, Attorney and D.M.Representative.

> ‘We agree that the role of co-decision maker would create confusion and conflicts’. (AdvoCard)

Intervention orders

There was general support for the retention of the ability to apply for an intervention order within the new system. The feeling was that such orders offer flexibility where only one specific action is necessary but that the current process for applying for intervention orders was cumbersome as it requires the same actions as for guardianship. This process must therefore be streamlined but not at the expense of the person’s rights. The RCPsych pointed out that intervention orders are useful given the requirement to adopt the least restrictive alternative when considering interventions. The Law Society of Scotland was in favour of retaining and enhancing intervention orders in the form of those currently granted by the court under section 53(3)(a) AWI Act (as opposed to those under Section 53(3)(b) granted by the court to another person) and made the only route for some areas, such as the terms of the person’s Will.

Access to funds and Management of residents’ finances processes

Respondents generally agreed in principle that the current access to funds and management of residents’ finances processes should be subsumed within the reframed model. However, clarity around the detail of this and the need for close scrutiny and monitoring of such processes was also mentioned.

Overall, then, we found support for our general approach, but concern that there was not yet enough detail to establish whether the new system will address the many practical problems faced by the current guardianship system.

We believe our overall scheme is more compatible with the CRPD, particularly in giving more weight to the autonomous wishes of the adult, and addressing some of the problems in making decisions quickly enough. However, we acknowledge that much more work needs to be done on the detail of the scheme, building on this review and the earlier detailed work undertaken by the Scottish Government.

13.5.4: Our final recommendations

Recommendation 13.19: The decision-making model should replace the current guardianship system.

> **13.19.1: The current access to funds and management of residents' finances processes should be subsumed within the model.**
>
> **13.19.2: The application for a specific issue intervention order should be retained, authorised by a judicial body.**

Recommendation 13.20: The Decision-Making model should operate within the Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework.

Recommendation 13.21: The Scottish Government should develop Codes of Practice and guidance to support the operational detail which offers clarity about processes, rights, roles and responsibilities, scrutiny and monitoring and includes information on managing and resolving conflicts of interest and disagreements between the person and/or D.M.Supporter, D.M.Representative, or attorneys.

Recommendation 13.22: The Mental Health Tribunal for Scotland should be the judicial body to whom such applications are made.

Recommendation 13.23: This work should be developed with key practitioners and the full and equal participation of people with lived experience including unpaid carers.

Recommendation 13.24: There should be adequate resourcing to ensure the effective delivery of this new model.

13.5.5: Miscellaneous AWI Act minor amendments

Over many years the Public Guardian acted as a repository for changes to the AWI Act that became evident were necessary, or at least desirable: the so called ‘wish list’. For information, the most recent iteration of the complete list is shown below at Appendix B, although many items on this list will now be negated by proposed changes.

Recommendation (short term)

Recommendation 13.25: The Scottish Government should refer to Appendix B as a check list when drafting adjusted primary, or secondary, legislation and updating Codes of Practice to ensure that all matters are incorporated as may remain relevant.

13.6:Appendix A

Summary of 2018 AWI Act consultation

The intention behind the proposed reforms to the AWI Act legislation was to maximise the autonomy and exercise of legal capacity of individuals with cognitive impairment so that genuine non - discriminatory respect may be afforded for a person's rights, will and preferences, in keeping with the provisions of the UN Convention on the Rights of Persons with Disabilities.

The consultation paper contained detailed proposals on the following matters:

- Enhanced principles within the AWI Act legislation to reflect the need for an adult to have support for the exercise of legal capacity
- Changes to the use of powers of attorney
- Creation of graded guardianships
- Change of judicial forum for AWI Act cases
- Creation of short term placement orders
- Creation of a right of appeal against a residential placement
- Changes to authorisation for medical treatment
- Definition of significant restrictions on liberty for persons lacking in capacity

The consultation also sought views on changes to authorisation for medical research under the AWI Act, support and supervision for guardians and attorneys and legislative provision for advance directives.

Summary of responses

317 responses were received in total. All responses which the Scottish Government has authority to publish can be accessed here:

The main themes emerging from the consultation were that there was strong support for change to the AWI Act legislation and practice. There was consensus on the need to make changes to meet the requirements of the UN Convention on the Rights of Persons with Disabilities, and to address problems around overly burdened, complex systems. There was a wide range of views as to how those changes may be achieved. Many respondents expressed concern that the proposals contained within the consultation did not go far enough in meeting the requirements of the UN Convention on the Rights of Persons with Disabilities and that actions are needed to provide Support for decision making, and support for carrying out decisions.

In particular, the model for graded guardianship within the consultation was heavily criticised, with many respondents suggesting that it did not provide enough safeguards, nor provide enough support to enable the adult to make their own decisions. Further, rather than making the process less complex, we ran the risk of creating more bureaucracy, which certainly was not the intention.

The need for multiagency training was a recurring theme, as was the need for independent advocacy to be given the same priority in AWI legislation as it has in mental health legislation.

Many respondents commented on the need to strike the right balance between supporting individuals and upholding their rights, and the viable provision of care, and were of the view that the consultation proposals did not do this.

What happens next?

At the time of drafting the 2018 summary it was the intention of the AWI Act Review Team to undertake the following activity

- Reframe the principles of the AWI Act legislation to ensure that the adult’s rights, will and preferences are paramount, that any intervention in an adult’s life is genuinely the least restrictive, and for the shortest period of time, and that the principles are adhered to by all persons involved in acting on behalf of, or in support of, the adult

- Work with a small group of stakeholders to firm up the policy around deprivation of liberty for persons lacking in capacity

- Provide a more flexible means of guardianship so that it can be more easily tailored to a person’s individual situation and be less restrictive than at present, ensuring that the system fully accommodates the need to ensure the adult’s rights, will and preferences are accounted for, but in doing so take account of the concerns that the consultation proposals are too wide ranging and risk creating more complex systems than before

- Address the anomalies around powers of attorney, ensuring that they are fit for purpose and both the granter and grantee are fully aware of the implications of the document

- Develop training and support models for both guardians and attorneys

- Improve the system of supervision of guardians

- Develop a strategy for Support for decision making that will underpin all changes to the legislation and provide the framework for ensuring a person ‘s ability to exercise their legal capacity is maximised

- Address the issues around capacity assessments

- In taking this work forward, we will also consider the need for independent advocacy to be available for all persons under AWI Act legislation, and the position of safeguarders in AWI cases, how they are appointed, trained and paid for.

Subsequently, Scottish Ministers established the Scottish Mental Health Law Review, which was asked to consider these issues in the context of the wider review of mental health, capacity and adult support and protection law. The Review's Executive Team took account of the findings of the 2018 AWI Act review in developing its proposals and final recommendations.

13.7:Appendix B

Miscellaneous AWI Act minor amendments

The [wish] list is in four sections

Section A: Matters already in the Act but which would benefit from minor amendment or clarity

Section B: Suggested new matters

Section C: Matters which, arguably, don't need primary legislative amendment but for which clarity could be offered in revised Codes of Practice of explanatory guidance.

Section D: Matters which are likely to be addressed by the Scottish Mental Health Law Review but, subject to the SMHLR proposals, this section would need to be reviewed to determine if there are consequential changes required.

Section A

It is likely that many of these items will not be impacted by the SMHLR, but are likely to be included in any adjusted legislation, so are matters that will remain to be clarified.

1. Ensure consistency on terminology throughout e.g. but not limited, to "adult" "AWI Act" thus, when they appear distinctly it is clear what is intended.
2. Section 6(2)(b) Clarify what is to be held on the public registers. It should also be noted that the Act of Sederunt regarding registration of international deeds spells out precisely what should be recorded but this is too much in the opinion of the Public Guardian (PG) as it leaves an incapable person at risk.

3. Section 6(2)(c)Clarify that the Act relates to live adults – as per public petition and when the Public Guardian's locus ends in respect of these investigations.
4. Sections 15,16,19 - Specify what checks the PG is required to do.
5. Bankruptcy (Section 15(5))

   Clarity required on various aspects of bankruptcy.

   - What is the intended meaning of "bankruptcy" (with so many forms of voluntary trust deed arrangements available)?

   - Can an attorney be reinstated when their bankruptcy is 'spent' (if POA deed is still extant i.e. if they had been a joint attorney)?

   - Bankruptcy of attorney and of granter to be distinguished.

   - Why does a continuing POA end on bankruptcy of attorney but no reference to a guardian's, intervener's or withdrawer's office ending if they become bankrupt?
6. Clarify that, to take office as power of attorney, a person must be over 16. Age of Legal Capacity Act covers it but nonetheless there was a POA put through with an under age attorney (2 yrs old!!) on basis that AWI Act does not expressly preclude it.
7. Clarify at what point a substitute attorney must be aged 16 i.e. before they can be nominated as substitute or before they can take office.
8. Section 19(2)(b) Delete reference to "copy" so OPG can return original deed with certificate and there would therefore be no requirement to store, securely, a burgeoning number of deeds.

9. Section 19 (2)(c) – once the Public register is publicly available can the OPG defer notifying Local Authorities and the MWC of the registration of a POA.?
10. Section 19(5)(b). Delete the requirement to send copies to specified persons (granter can send copies to whomsoever they wish).
11. Section 22A – to clarify that a capable granter may revoke an attorney, not just powers or the deed itself.
12. Confirm if two [or more] attorneys may act jointly and severally, unless expressly excluded in POA deed (consistent with s62 for guardianship)
13. Clarify if a substitute is “an attorney” and thus that the PG has to be satisfied that they are willing to act when doing the initial s19 checks – even though a substitute may they never actually have to act; or, are they only an attorney if and when they are required to act, and in which case the necessary checks can be undertaken at that point.
14. Section 57(2): time limit by which a Local Authority should apply when required to act as default applicants (cases reported to them and can be a lengthy delay in them initiating proceedings).
15. Section 59 (4) Re-order, or strengthen these matters.
16. Section 63: Clarity on how substitute mechanism works. Who can come in and when? Is it flexible? If it is a joint appointment, do both appointees need to go before substitute comes in, or can the substitute replace one of them to keep it joint?
17. Section 68: PG “fixes” remuneration but this section implies we must remunerate at the full published rate, no matter how unhappy we may be with guardian’s actings, unless we go to court to ask for a forfeiture of whole or part of the fee due to the guardian (section 69). Could the PG have authority to ‘fix’ remuneration taking account of all factors, which would thus include the

withholding of certain elements, on cause shown with the right of appeal for the guardian to the court i.e. delete section 69?

18. Section 71: clarity that partial revocation is permitted e.g. that the powers of a defaulting financial guardian can be removed leaving them as welfare guardian, assuming this remains appropriate.
19. Section 74(1) Delete “the powers conferred by” so that there is permission to vary any part of the order e.g., change status of guardian from substitute to joint – currently need to use other remedies to make variations where these are other than to the powers.
20. PG to be able to vary caution – in line with estate value. Currently many Sheriffs order this as 100% of the estate as at year end accounting, which *de facto* allows the PG to seek a variation but there are some still fixed at a set £rate, which means that any variation requires court approval; which the guardian may be disinclined to progress because of procedure and cost, which in turn leave the adult’s estate over, or under, insured.
21. Section 75A does not cover PGs requirements where the now deceased guardian was the sole guardian.
22. Section 76: Clarity on meaning of “habitual residence”.
23. S78 needs to be redrafted to give better effect to Parliament’s intentions in relation to the registration of orders relating to heritable property.
24. Section 81A this power to extend to other than fund holders, on cause shown e.g. DWP, pension providers, financial advisors – who are not fund “holders” but who nonetheless may have *bona fide* information about the adult’s funds which would assist with an inquiry. Currently their refusal to offer such information can fetter the statutory process.

25. Sch 2(6)(1): Clarity on the interpretation of “For the time being” and “dwelling house”. Suggest either all heritable property sales or purchases to be subject to PG approval, or at least a property which was, “at any time” the adult’s primary dwelling house, to be subject to the sale consent procedure.

26. Sch 2(6)(3): Preference is for PG to hear objections [to sale or purchase] first, as with other parts of Act, rather than an automatic remit to Court, or PG to be able to choose to remit to Court, again as per other parts of Act. PG decision appealable to Court.

27. Schedule 3(4) and (7): clarity required on this whole cross border position; to include also the obligations of the PG when an adult under a Scottish guardianship order transfers to another jurisdiction.

28. Clarity on interpretation of “claiming an interest” post *Re J*.

Section B

These are new matters which had been suggested, which may not be picked up by SMHLR recommendations so will need further consideration as to their merit in inclusion in any amended legislation.

29. Include a ‘Depute’ Public Guardian and an office of the Public Guardian; to permit delegation of authority, within an agreed scheme. On a strict interpretation of the current Act, there is no delegated authority permitted – which would see the Public Guardian undertaking all matters personally.

30. Ensure Act permits move to ‘digital by default’ in all aspects of business.

31. Clarify policy on Electoral voting by a proxy.

32. Specify things that are expressly excluded, instead of references just being in the Code of Practice. Will making power, or not, is the usual subject of this debate.

33. Section 15 Change the word “continuing” to something more meaningful; people don’t realise this refers to a financial power of attorney.

34. Section 15, power for PG to call for a medical report to comment on capacity, and to defer registration of a POA pending this, where there is dispute about the possible competency of a power of attorney or revocation thereof (instead of remit to court which has to be the remedy currently) – with right of appeal. No discretion for PG being proposed, PG simply to then register or decline registration based on medical opinion.

35. Should PG be notified when attorney commences acting? (note the significant resourcing of this suggestion).

36. Can there be any power, akin to section 81A, to allow the PG to compel a capacity certificate pursuant to a section 12 investigation? OPG has no locus to investigate unless incapacity is confirmed but increasingly GPs are unwilling to offer any assessment. Persons at risk are exposed whilst OPG negotiate this matter of bureaucracy. Alternatively, could the PG have power to commence inquiries where there is a ‘reasonable belief’ that a person lacks capacity (or autonomous decision making ability)?

37. Similar powers in respect of attorneys as exist in 64(7) for guardians i.e. the attorneys should be obliged to comply with order of the PG.

38. Section 19(4) Can an authenticated certificate be provided other than by the PG (ref to 11(3)(a) of MCA and 3(1)(b) of POA Act 1971)? Also, if something equivalent can be replicated for guardianship.

39. To introduce the concept of substitute attorneys, then clarify on what occasions PG must notify them.

40. Clarify what is / is not an amendment of a POA. People had been putting through almost fully reworked deeds under guise of an amendment. OPG have a policy on this. The fees order talks about a ‘deed of amendment’ which

is picked up from the OPG policy but that phrase is not given statutory meaning anywhere.

41. Section 24 POA needs to end on incapacity of a sole attorney (when the Autonomous decision making ability of a sole attorney is lost).

42. Should there be something within POA section which reflects 64(6) i.e. that an attorney can delegate certain matters but remains accountable, unless POA expressly excludes it?

43. Incorporate the Capacity certification [Certificate of Autonomous Decision making ability] as an integral part of the deed – will prevent all the ‘incorporation’ issues with the stand alone certificate.

44. Section 83: Offence for financial abuse not just welfare.

45. PG to supervise trusts set up to benefit incapable adults (these are currently, in some cases, being used to circumvent OPG supervision / costs etc). NB the same wording appears in 53(6) – which may go with the proposals to integrate intervention orders into the guardianship process.

Section C

These are matters which, pre SMHLR, had been suggested as useful additions to a revised Code of Practice. The drafting of a post SMHLR Code of Practice should review the value of including these items.

46. Change Rules of Court to allow PG to be ‘an officer of court’ for the purposes of intimation etc. (Citation Amendment (S) A 1882)

47. Where the Certificate provider cannot rely on their own knowledge of the adult and needs to seek another view, reiterate that this cannot be the nominated attorney (undue concentration of power).

48. AWI Act 2&8 Amend statutory form to allow for collection of email address and phone number for guardian.

49. Something which clarifies basis on which expenses of guardianship applications are award/taxed. Party/party (only what fees of solicitor are reasonable) or solicitor/client (all costs). Needs reference to Auditor of Court (may depend on defended v undefended petition).

Section D

These are matters which had been ‘wish list’ suggestions pre SMHLR but are likely now to be picked up by SMHLR recommendations. Nonetheless, this list should be checked in due course to confirm that there are no outstanding items that would benefit from inclusion in any adjusted legislation.

50. Review of s1 principles post UNCRPD

51. Include a general recognition that what applies to guardianship applies to POA and vice versa; there are some notable inconsistencies at the moment.

52. Broader powers for PG to suspend the appointment of an attorney, on cause shown, pending completion of an investigation under Section 6(2) (c) or (d).

53. Review of s5 of the Adult Support and Protection (Scotland) Act 2007 to remove the automatic referral that is currently required, which creates a duplication of inquiry.

54. PG to determine if they need to supervise an attorney – on cause shown after an investigation rather than needing a court order. Puts in a more immediate safeguard. PG’s decision may be appealed to Sheriff.

55. Clarity, in guidance or Code of Practice, on what is, and when one appoints, a safeguarder as opposed to an advocacy worker as opposed to a curator ad litem.

56. Section 1(6): Clarify definition of “adult” [the previous issue was that it was not clear that “adult” is both aged 16 or over and incapable].

57. Section 1(6)(a) Any further explanation on face of act about capacity?

58. Section 3(5) Strengthen importance of advocacy.

59. POA deed to specify how granter wishes capacity to be determined i.e. outcome of their current "consideration" (D Report recommendation).

60. Should we have a POA 'protector' [like they have in trust cases] which would see the granter ask for the POA to be supervised (would need to agree what that supervision would involve so as not to turn it into a pseudo guardianship)? Resource implications with this.

61. Extend the class of persons that can offer a capacity certificate for POAs.

62. Clarity on cross border protective measures, especially as far as this extends to powers of attorney (POA).

Access to Funds Issues

There were a range of changes suggested to the access to funds scheme but, if this is subsumed, as proposed, within the Decision Making Representative scheme, these suggestions will no longer have relevance.

63. 24B(2)(c) Make it clear that reference to Intervention Order (IO) is an extant order e.g. replace 'has been granted' with 'is in force' – people are interpreting this very literally and assuming it precludes AtF on any funds in respect of which an IO has ever previously been granted.

64. No mechanism, other than IO, to order a pension provider to transfer into another account their deposit of funds. So if the account into which a pension is paid is unsuitable for rest of AtF funds then effectively rules AtF out.

65. S25 Loophole where a person in a NH only has DWP income – which may have accrued to savings - can't use parts 4 or 3 (could be DWP appointee) (when does accrued income become savings?).

66. 26(1)(b): Account in adult's "sole name" is limiting organisational use.

67. 26A(1)(b) ? Too restrictive in its drafting e.g. on occasions when W. needs power to vary an existing SO which is to continue on the adults current account (without need to have to apply for full variation of order, under 26F).

68. 28(3) Reword to make intention clear – discretion or permission?

69. 31E No transition to AtF allowed from an IO. Needs 2 separate applications so encourages people to take guardianship.

70. For Sheriff to be able to approve AtF if guardianship is craved and AtF is deemed a lesser intervention.

71. LAs on occasion would like adults to continue to have access to their account as this assists with their rehabilitation but, as soon as incapacity recognised, adult's own account frozen. Any way of allowing access to continue?

Intervention Order Issues

72. Clarify that an IO is not supervised by PG, or express the supervisory powers ala sch 2/7 for guardianship (fee and remuneration would need addressing too).

73. Sheriff to be able to increase an IO app to guardianship

74. PG to be notified on death of an intervener.

75. Be specific about the finite character of an IO - to stop their use as [unsupervised] quasi guardianships.

76. See item 55 re terminology “for time being” [used as a dwelling house]. Something about ‘reasonable foreseeability’ Ayr case commentary

Guardianship Issues

There was a range of changes suggested to the guardianship scheme; these should now be picked up by the new Decision Making Representative model but this list may serve as a useful double check.

77. Some discretionary leeway on MHO reports would assist as per the med reports.
78. Discussion on use of interim guardianship / need for interim emergency powers.
79. Interim appointments granted quite randomly (and routinely) ?test for this appt to make it more stringent.
80. 57(4): Extend to financial also and have duty to notify OPG – so they can become involved in process earlier.
81. 60(3)(c)Need to include in PG report comment on need to continue with the financial order (not just on suitability of person).
82. 61(4) “copy” of interlocutor should be a “certified copy”
83. Joint and subs processes to apply to Interveners too
84. 68(3): Disparity between legally aided adults and those where the Local Authority progress an application – first get the application, at best free, or means tested, LA can reclaim their costs and in which case these adults have to pay – and maybe at 100%.
85. Requirement for 28 day hearing is inflexible.

86. S70: To be available to financial guardianship / attorneys and interveners not just WG.

87. Section 72 Omission to be remedied. Where the PG has recalled the powers (under s73), the guardian cannot apply for his discharge as this is not one of the categories included.

88. Section 74(4): Is a full s57 necessary if the guardian is to be the same person? Could there be some form of abridged procedure?

89. Make it clear that if guardianship is not renewed guardian cannot continue under doctrine of necessity.

90. Clarify if a Direct payment requires a welfare and/or financial guardianship (Code says welfare).

91. PG to be able to dispense with Management Plan. Reflect wording at Sch 2: 3(4). This will become necessary particularly if Grade 1 goes ahead, otherwise all grade 1s will have to provide a management plan, as there will be no way of dispensing with this, when a management plan may not be necessary with lower level simple estates.

92. Remedy situation where family members who are welfare guardians cannot pay themselves as carers under SDS – section 9 of SDS Regs. This is discriminatory in two ways i) a capable person receiving SDS could use this to pay a family member for care in certain cases ii) we approve payment from private funds to a welfare guardian family member where this person may have a loss of income say as a result of them being the carer e.g. if a person has had to reduce their hours of work to look after an elderly relative.

13.8: Chapter 13: recommendations

Recommendation 13.1: The Scottish Government should as a priority, amend the Adults with Incapacity (Scotland) Act 2000.

Recommendation 13.2: Principles:

Section 1 of the AWI Act should be amended in line with the recommendations of the Three Jurisdictions Report to give greater priority to the will and preferences of the adult.

Recommendation 13.3: The Scottish Government should amend the Power of Attorney scheme as follows:

> **13.3.1: The granter should state when a POA should come into force.**
>
> **13.3.2: A person's ability to grant a POA should be carried out in accordance with the ADM test in Chapter 8, within the framework of HRE and SDM.**
>
> **13.3.3: The certificate accompanying a POA should be called a 'Certificate of Autonomous Decision Making Ability'.**
>
> **13.3.4: The act of a GP completing a POA certificate should be included as an NHS funded service.**
>
> **13.3.5: A comprehensive investigatory framework should be developed with OPG, Local authorities, the MWC and Police Scotland and full and**

equal participation with persons with lived experience including unpaid carers.

13.3.6: Provision should be made in law for an attorney to be subject to supervision should an investigation determine this is required.

13.3.7: As per the recommendation in chapter 3 updating of the AWI Act principles is required.

Recommendation 13.4: The Scottish Government, together with the OPG, MWC, local authorities and such other agencies as necessary, along with the full and equal participation of persons with lived experience including unpaid carers, should develop support , training and guidance for attorneys. This should include

13.4.1: Awareness of the role and obligations of an attorney.

13.4.2: Information on the new HRE/SDM/ADM framework.

13.4.3: Provision of an advice helpline/ online support.

13.4.4: Consideration of ways in which access to granting a power of attorney may be eased.

13.4.5: Consideration of ways in which the cost of a POA can be eased.

Recommendation 13.5: The Scottish Government should ensure there is increased awareness of the importance of a POA, with targeted engagement, and multimedia involvement, with focussed messaging for groups who may

benefit more from having a POA, actively encouraging all citizens to grant a POA early, as part of lifestyle planning.

13.3: Access to funds and management of residents' finances,

These matters, which form part 3 and 4 of the current AWI Act respectively, are dealt with below under 'guardianship'.

13.4: Medical Treatment and Research

These are all short-term recommendations.

Recommendation 13.6: The Scottish Government should ensure that Part 5 and associated guidance and forms should require a certifying practitioner to demonstrate that they have considered and adhered to the principles of the AWI Act when issuing a section 47 certificate.

Recommendation 13.7: The Scottish Government should ensure that guidance gives greater clarity on the support that is required to be given to the person in assisting them to make an autonomous decision, before engaging section 47.

Recommendation 13.8: NHS Education Scotland should review the training of doctors and other professionals who are authorised to grant section 47 certificates. This should include their understanding of relevant human rights issues, and the principles of the legislation.

Recommendation 13.9: Section 47, 47A and associated regulations should be amended as follows:

13.9.1: The authority currently granted by section 47 should be reframed to make clear that treatment which is authorised should be that which would reflect the best interpretation of the adult's rights, will and preferences.

13.9.2: To specify the circumstances in which it is not necessary to complete AWI Act documentation when treating a patient who is unable to consent, and make clear that in all cases the principles of the legislation apply.

13.9.3: To widen the categories of healthcare professional who can assess incapacity and issue a section 47 certificate, including registered psychologists where appropriate.

13.9.4: To provide a process of electronic recording and auditing of section 47 certificates, overseen by the Mental Welfare Commission.

13.9.5: To provide that force, detention, or covert medication should require explicit authorisation by a legal process with a right of appeal to the tribunal, unless there is a genuine emergency.

13.9.6: Section 47 should operate within the Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework.

Recommendation 13.10: Scottish Government should undertake further consultation to develop

13.10.1: A clear process to authorise conveying an adult to hospital for physical treatment or diagnostic tests where they are unable to make an autonomous decision

13.10.2: An extension to s47 to authorise restrictions on a person leaving hospital while they are receiving treatment for a physical condition or diagnostic tests, with provision for review after 28 days, and an appeal process.

Recommendation 13.11: In all cases, including emergencies, force, detention or covert medication should be recorded and subject to monitoring and audit, overseen by the MWC.

Recommendation 13.12: The MWC should issue guidance on the use of force, detention and covert medication which should have the same legal effect as the statutory Code of Practice.

Recommendation 13.13: An adult, or someone acting on their behalf, including a carer or advocate should have practical and effective access to a court or tribunal by a simple procedure to challenge a decision to grant a section 47 certificate, or a treatment authorised under that certificate.

Recommendation 13.14: The safeguards for specified treatments under s48 should be adjusted so that the same safeguards apply as under the MHA for

1.4:ECT, vagal nerve stimulation and transcranial magnetic stimulation

1.5:(Subject to further consultation) artificial nutrition and hydration: we propose these should be the same as under the MHA

1.6:Drug treatment for mental and intellectual disability given for more than two months to a person subject to a deprivation of liberty.

Recommendation 13.15: It should be lawful to give treatment which is reasonably necessary to a patient under Part 5 (section 49) where an

application for a Decision Making Representative is in train, provided the application does not involve a dispute regarding the particular treatment.

Recommendation 13.16: The law should make clear that a decision-making representative cannot override the adult in relation to a decision where the adult is able to make an autonomous decision regarding the particular treatment.

Recommendation 13.17: We recommend that the reformed system should include a straightforward process by which an adult who believes they can take an autonomous decision about their medical treatment can access the tribunal. [See chapter 5 on support that is available where an ability to instruct a solicitor is limited]. In addition, any stated opposition to a particular treatment by the adult should bring into play the same safeguards as opposition by a decision-making representative.

Recommendation 13.18: Scottish Government should ensure adequate resourcing to realise these recommendations.

13.5: Intervention Orders and Guardianship

Recommendation 13.19: The decision-making model should replace the current guardianship system.

> **13.19.1: The current access to funds and management of residents' finances processes should be subsumed within the model.**

> **13.19.2: The application for a specific issue intervention order should be retained, authorised by a judicial body.**

Recommendation 13.20: The Decision-Making model should operate within the Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework.

Recommendation 13.21: The Scottish Government should develop Codes of Practice and guidance to support the operational detail which offers clarity about processes, rights, roles and responsibilities, scrutiny and monitoring and includes information on managing and resolving conflicts of interest and disagreements between the person and/or D.M.Supporter, D.M.Representative, or attorneys.

Recommendation 13.22: The Mental Health Tribunal for Scotland should be the judicial body to whom such applications are made.

Recommendation 13.23: This work should be developed with key practitioners and the full and equal participation of people with lived experience including unpaid carers.

Recommendation 13.24: There should be adequate resourcing to ensure the effective delivery of this new model.

13.5.2 Miscellaneous AWI Act minor amendments

Recommendation 13.25: The Scottish Government should refer to Appendix B as a check list when drafting adjusted primary, or secondary, legislation and

updating Codes of Practice to ensure that all matters are incorporated as may remain relevant.

Chapter 14: Adult Support and Protection Act

14.1:Where we started

The Review's Terms of Reference asked us to consider the need for convergence of mental health, incapacity and adult support and protection legislation. This had been prompted by developments concerning human rights, particularly the focus on non-discriminatory approaches, and by calls for greater consistency relating to the different interventions in a person's life. Where no single piece of legislation meets the needs of an individual, it can be difficult for practitioners to establish how best to help the individual.

The Adult Support and Protection (Scotland) Act 2007 (the ASP Act) was brought in to fill a perceived gap in the law which resulted in some adults at risk falling between general welfare and MH/AWI legislation despite their need for help and support. It followed the Scottish Law Commission Report of 1997 on Vulnerable Adults.

Although the ASP Act was originally envisaged as filling a relatively small gap, adult support and protection (ASP) has become a major part of social work practice.

The ASP Act provides for a range of measures to protect 'adults at risk'. These are defined as 'adults who (a) are unable to safeguard their own well-being, property, rights or other interests, (b) are at risk of harm, and (c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.' This is known as the '3 point test'.

Local authorities have the lead role in identifying where they may need to intervene to protect an adult at risk, and in co-ordinating a response from other agencies. They can visit and interview a person who may be at risk, and can seek a range of, usually short term, protective orders.

14.2:What we were told

Consideration of ASP issues began in the second half of the Review. We had several meetings with ASP experts, including social work practitioners, academics and local authority solicitors. We also were given access to research into the operation of the ASP system. Unfortunately, we did not have the capacity to engage with people affected by the ASP legislation and organisations which support them, and we recognise that our recommendations will require wider engagement if they are to be taken forward.

We initially focused on the possibility of the ASP Act converging with mental health and adult capacity legislation. Of course, at present, mental health and, to a large extent, capacity law, only apply to people with a mental disorder, while the ASP Act includes other people in its scope. However, since our reforms seek to move away from a focus on a diagnosis, it seemed to us possible that we could ultimately develop a single legal framework to support protective interventions for people whose ability to make autonomous decisions may be compromised, whether by illness or other pressures. We felt in particular that our framework of Human Rights Enablement, Supported decision Making and Autonomous decision Making might lend itself to a single system.

Even if that proved not to be desirable, we wanted to see if there were ways the different legal provisions could be more consistent and work together more effectively.

14.2.1: Fusion with mental health and capacity law

Overall, there was a broad consensus that bringing the ASP Act together with adult capacity and mental health legislation into one Act would be a retrograde step.

The Review was advised by the Mental Welfare Commission that a high proportion of adults supported by the ASP Act do have a mental disorder, and the ASP Act serves as a gateway for initial enquiry and investigation. This can lead to further interventions under mental health or capacity law, for example seeking welfare guardianship.

However, we also heard that the ASP Act was important in many other contexts, and that the role of ASP has evolved significantly since the ASP Act was passed. Only a third of referrals are direct ASP referrals. The ASP Act is a means of accessing support to a broad range of people with very different needs.

This broad approach has meant adult protection practitioners have formed links with the wider protection agenda, such as financial harm prevention groups, multi-agency public protection arrangements (MAPPA), and human trafficking. If anything, some argued, the scope of who could be classified as an ‘adult at risk’ should be widened. They supported strengthening the connections to other groups, for example victims of domestic violence, or people affected by substance misuse or homelessness, who may not fall within the current definition of ‘adult at risk’. People were concerned this wider perspective might be lost in the event of fusion.

The view of many social work practitioners is captured by this quote:

> ‘The wider scope the ASP Act offers with regard to supporting people who do not meet the criteria under mental health or adults with incapacity law has been a positive gain from its entry into the spectrum of protective legislation. Its wide use across key partners and the joint approach it encourages has been recognised through the most recent inspections of partnerships carrying forward its duties. There would be a loss in the tools partners can use to support vulnerable adults if the ASP act were to fuse with the other two laws’.

However, there was agreement about the need for the legislation to work better alongside mental health and capacity law, and that some changes are needed to enable this to happen.

We accept this argument and agree that for now, reform should concentrate on those areas where the law can be better aligned, to produce a more accessible range of remedies for people in need of support and protection, and on considering if there are any specific changes to the ASP Act which might be beneficial.

It may be that in the future, a single piece of law covering all aspects of mental health, capacity and ASP might be considered. If that were to be the case, the aligning the law in the way we propose would help inform such a process.

14.3:Applying our wider reforms to adult support and protection

In discussion with ASP practitioners, it became clear that the general approach of the proposals for change to mental health and capacity law was welcomed. The need for a human-rights based, person-centred approach to mental health and capacity law was agreed and in line with best practice in adult support and protection. There were a number of areas where it was felt that better aligned law would be beneficial to the people we are trying to help.

14.3.1: Definition of mental disorder

We have recommended replacing the term ‘mental disorder’ so that mental health and capacity law would apply to ‘a person with a mental or intellectual disability whether short or long term’. This change would also operate in respect of the term ‘mental disorder’ where it currently appears in the ASP Act.

14.3.2: Principles of the legislation

All three acts under consideration in this review include a set of principles to govern how people should exercise powers and duties under the respective legislation. They currently overlap to a considerable extent, but not entirely. The core principles of the ASP Act (sections 1 and 2 of the ASP Act) can be seen in Chapter 3, alongside those of the mental health and incapacity Acts.

The changes we recommend to adult capacity and mental health principles are set out in Chapter 3. There was broad agreement on the desirability of generally consistent principles, and the general approach of the review, but the precise wording of principles was felt to be important; there are some particular nuances with the ASP Act.

In terms of the UNCRPD, the principles of the ASP Act need to be informed by Article 16 – the duty on the state to protect persons with disabilities from exploitation, violence and abuse.

We recommend in Chapter 3 that the principles of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) be amended to give greater significance to the will and preferences of the adult. Longer term, we recommend a key principle, for mental health and capacity law, of respect for autonomy.

There was concern that to do likewise for the ASP Act might disturb the delicate balance between autonomy and protection in the ASP system. Practitioners have sought to move away from the approach that vulnerable people putting themselves at risk are exercising a ‘lifestyle choice’ which has to be respected, towards a focus on whether the person is able to safeguard themselves, and the effect on this of trauma and wider environmental factors. They would be concerned if legislative change undermined this shift. We discuss this further in relation to Autonomous decision making below.

If the ASP Act is to remain as standalone protective legislation, it would not face the same issue as mental health and capacity law of adjusting the principles to reflect economic, social and cultural rights. However, we did consider whether a principle of reciprocity should be included in the ASP Act.

We did not find strong support for adding this. It was pointed out that most ASP was informal, and there was a strong preference for seeking consent where possible. To that extent, the principle would be of limited effect.

There was concern that eligibility thresholds for social care sometimes meant that people who were at risk in ASP terms did not receive adequate support. However, without the additional duties and accountability mechanisms we recommend for mental health law, the addition of such a principle in the ASP Act would be unlikely to be the best way to address this.

On balance, then, we do not recommend any specific changes to the ASP Act principles, but we feel this should be kept under review as the wider implementation of the new human rights framework for Scotland proceeds, and in light of any further guidance from the United Nations Committee on the operation of Article 16.

14.3.3: Human rights enablement, and supported decision-making

We set out in Chapters 4 and 8 respectively a more systematic approach to Supported Decision Making (SDM) and a new approach to Human Rights Enablement (HRE). In line with our remit, we have considered these specifically in relation to people with mental or intellectual disabilities, but we believe the approaches can, indeed should, be applied generally across systems of care and support.

Our proposals for this new framework were welcomed by ASP practitioners. As one group said

> ‘We welcome the tone of HRE. This is a good fit with the core principles of ASP and the actions taken in relation to concerns as being both of benefit to an adult and representing the ‘least restrictive option’

HRE and SDM need to be seen as factors in a human rights-based approach that places the individual and their rights at the centre of decisions about them. This is very close to the approach promoted by ASP - arguably more so than is currently the case in mental health and capacity legislation.

Practitioners spoke of the time taken to build relationships with people to enable support to be provided in a way that the individual was comfortable with. It was noted that although there are options under the ASP Act to have recourse to court proceedings, by far the majority of support and protection was provided on a consensual basis. The development of the HRE model is arguably a natural extension of the work already undertaken by ASP practitioners. It could help in making the link between protection and wider support.

There was concern if HRE were to mean adding yet another assessment process on top of all the current, not always well integrated, assessments undertaken by services. However, as we explain in Chapter 8 this is not how we intend HRE should work.

It was also important to take a nuanced view of the right of an individual to refuse an HRE. The nature of the ASP Act is that some interventions, such as the duty to inquire, cannot be refused, and this is an important safeguard.

The Review is also proposing that SDM is fully embedded in mental health and capacity law to ensure that a person’s voice is fully heard. This enhances the principles in part 1 of the ASP Act of the need to have regard to the adult’s ascertainable wishes and feelings, the importance of the adult participating as fully as possible and providing the adult with the information and support to do so. Embedding SDM means it needs to be an integral part of practice –more than just ‘having regard’ to the need to provide support. This approach would build on the relational work already done by many practitioners following ASP referrals.

There was concern that independent advocacy was not as widely available to persons being supported by ASP as is currently the case with the existing mental health and capacity legislation.

At present section 6 of the ASP Act provides for a council to have regard to the importance of providing independent advocacy to an adult where it is considered an intervention is needed to protect that adult from harm. This appears to restrict the provision of advocacy to after the point at which a decision is taken. Practitioners felt that there was a need for greater access to independent advocacy and this needs to be harmonised across mental health, capacity and ASP legislation. See our recommendations at the close of Chapter 4.

Similarly, assistance with communication, including translation services needs to be freely available, and when seeking to support and protect individuals, awareness of cultural and ethnic norms is essential. As we highlighted in chapter 1, the public sector equality duty needs to be upheld, and resources put in place to ensure support is provided on a equitable basis for those with protected characteristics under the Equality Act.

14.3.4: Autonomous decision-making

We recommend, in Chapter 13, that the current tests of significantly impaired decision making (SIDMA) and capacity in the mental health and incapacity Acts be replaced with a new test of ‘autonomous decision-making’ (ADM).

The ADM test does rely on some impairment of decision-making as a justification for involuntary interventions but is intended to be broader in scope than a clinical test of capacity, taking account of other factors such as coercive and controlling behaviour, or undue influence, and with a greater emphasis on support for decision-making.

To an extent, it takes a more relational and less medicalised approach to decision-making ability, which is arguably more consistent with the ASP approach.

The ADM approach also seeks to better reflect the executional as well as the decisional aspects of autonomous decision-making – so not just whether the person is intellectually capable of making a choice, but are they able to put this choice into effect? This may be particularly pertinent for ASP clientele who may be in a position of being able to make a decision, but be unable to execute it, because of trauma, pressure from others, or other factors.

The ASP Act does not explicitly make ‘incapacity’ a basis for intervention. However, section 35 provides that the various protection orders cannot proceed if the affected person does not consent to the order. There is an exception where it is reasonably believed that the adult has been ‘unduly pressurised’ to refuse consent.

Although not explicit, it is assumed that if a person is incapable of refusing consent, the order can proceed. However, this can be a difficult practical question to resolve, particularly in cases where an order is necessary to establish whether the person has decision-making ability, and/or are being subject to undue pressure.

In principle, we believe the ADM test could be incorporated into the ASP Act so that interventions could proceed without the consent of the adult if there was reasonable evidence that the adult is not capable, even with support, of making an autonomous decision. This would address both incapacity and undue pressure. However we recognise that more detailed work will be needed on the drafting of any such provision, and on subsequent guidance and training.

14.3.5: Single judicial forum

Notwithstanding the general view that the ASP Act should not be fused with mental health and capacity law, there was some enthusiasm for a single judicial forum for all three Acts.

In some cases this might allow for orders to be conjoined, so that mental health or incapacity interventions could be made alongside ASP measures.

We recommend in Chapter 13 that the single forum for adult capacity and mental health measures would be a tribunal, so if we add in ASP, this would move from the sheriff court to a tribunal.

We are attracted to this approach, but there are some difficulties. ASP includes measures such as banning orders which are more typically ordered by a court. As we discuss above, the ASP Act would continue to apply more widely than to people with mental or intellectual disabilities. And crucially there would be significant operational, recruitment and training issues in adding a third legal framework to the tribunal. We would not want this to prejudice taking forward the creation of a single forum for mental health and capacity law.

On balance, then, we do not yet feel able to make a recommendation that the judicial forum for the ASP Act be shared with mental health and capacity law, but we recommend this should be kept under review.

14.3.6: Interaction of different provisions of the AWI Act and the ASP Act

It was suggested that it was often a difficult and lengthy process to remove a proxy decision-maker (an attorney or guardian) when seeking to protect an adult at risk. We are supportive of a suggestion that it should be possible for a court to suspend a proxy decision-maker as part of an ASP process.

14.4: Discrete ASP Act reforms

In addition to areas where change could be made to align the ASP Act with mental health and adult capacity legislation there was discussion around parts of the ASP Act that could be improved.

Some issues were raised with us which we were not able fully to investigate.

14.4.1: Powers and timescales

One of these was around whether ASP orders are broad enough in scope and powers.

Unlike Mental Health Act interventions and, to some degree, incapacity law, removal orders under sections 14-17 of the ASP Act appear to have limited powers of enforcement. The person once removed is at liberty to go back to the dangerous situation they were in.

The timescales for orders were questioned. At present there are options for a 7 day assessment order, a 7 day removal order and a 6 month banning order under the ASP Act.

It was suggested that the assessment and removal orders have been framed around an assumption that removing a person from a harmful situation for a short period will be enough to allow the person to gain insight into how their situation could change. This may be naïve and unrealistic in many cases, given the deep-rooted nature of the underlying causes of harm.

Another difficulty with the short timescales is that they may not allow time for an intervention under the AWI Act, such as welfare guardianship. The proposal in Chapter 13 for an urgent adult incapacity order should help with this.

There is concern that the maximum of 6 months for a banning order does not give a person time to safeguard themselves fully. Also, a person can go from being protected to having no protection whatsoever when an order runs out. Currently cases cannot extend for more than 6 months so local authorities can apply for end on end banning orders. It was suggested that now was the time to look at the possibility of the court being able to extend banning orders for a further period.

The focus of banning orders on a particular geographical location was also felt to be too limited given the other ways, such as via social media, that an abuser may continue to manipulate a person at risk.

14.4.2: Monitoring by the Mental Welfare Commission

Currently the Mental Welfare Commission (MWC) has limited statutory powers in relation to ASP, beyond a duty to cooperate with councils and powers to liaise with Adult Protection Committees. We investigated whether it should have stronger powers, for example in monitoring the operation of the ASP Act, or in promoting best practice.

We did not find strong support for a significant change in the MWC’s role – given that the ASP Act applies to people outwith the MWC’s remit, and that there is already has a framework of inspection (via the Care Inspectorate) and governance (via Adult Protection Committees). It was however felt important that the MWC connected into the ASP world, and that it should be able to use its expertise to influence matters concerned with mental or intellectual disability, including investigations into adverse incidents, but this did not require a fundamental change in role.

14.4.3: The 3 point test

Finally, consideration was given as to whether the ‘3 point test’ which limits who can be an ‘adult at risk’ was still fit for purpose.

As we discuss above, there was a view among some practitioners that this test may be too restrictive to capture the ways in which a person may be vulnerable, particularly the rather medicalised wording of the third leg of the test. The term ‘infirmity’ was also felt to be dated. Others felt the test worked reasonably well, and was flexible enough to be applied creatively where needed.

We propose above that the term ‘mental disorder’ be replaced. We are not best placed to comment on other changes, which will no doubt continue to be debated in future development of the ASP Act.

Chapter 14: recommendations

Recommendation 14.1: Adult Support and Protection legislation should not be fused with mental health and capacity legislation but the Scottish Government should ensure that wherever possible there is alignment of principles and definitions, timescales and procedures.

Recommendation 14.2: The Scottish Government should ensure that the term ‘mental disorder’ in the ASP Act should be replaced by ‘mental or intellectual disability, whether short or long term’.

Recommendation 14.3: The ASP Act principles should be reviewed as part of the implementation of the Human Rights Bill, to ensure they fully reflect the requirements of international human rights law, particularly the UNCRPD

Recommendation 14.4: The Scottish Government should ensure our recommended approach of Human rights enablement and Supported decision making (chapters 4 and 8) should be adopted in the practice of Adult Support and Protection

Recommendation 14.5: The Scottish Government should consider amending the provisions regarding ‘consent’ in the ASP Act to reflect our proposed test of Autonomous decision making

Recommendation 14.6: We do not recommend that ASP interventions transfer from the sheriff court to a tribunal, but this should be kept under review by the Scottish Government.

Recommendation 14.7: Legislation should provide for the power to seek an urgent court order suspending some or all of the powers of a welfare or financial guardian or attorney as part of ASP proceedings.

Recommendation 14.8: The Scottish Government should consider whether banning orders under the ASP Act should be extended where the court is satisfied this is necessary to protect the adult.

Chapter 15: List of recommendations

Chapter 1: A law built on equality and human rights

Chapter 1 recommendations

Recommendation 1.1: The Scottish Government in taking forward recommendations from this Report, should do so with the full and equal participation of persons with lived experience including unpaid carers with lived experience.

Recommendation 1.2: The Scottish Government should work with people with lived experience, including unpaid carers, to reach agreement as to how our recommendation for full and equal participation of people with lived experience, including unpaid carers, can be achieved in the future.

Recommendation 1.3: The Scottish Government should provide resource to ensure people with lived experience and unpaid carers with lived experience can participate in work to implement recommendations on an equal footing with others.

Recommendation 1.4: The Scottish Government should adopt a human rights-based approach to budgeting for mental health and capacity law and services.

Recommendation 1.5: The Scottish Government should ensure that all recommendations in this report be implemented in such a way as to protect, respect and fulfil the rights of those with protected characteristics equitably.

Recommendation 1.6: The Scottish Government should consider addressing racial discrimination in relation to coercion in mental health services through a targeted approach which develops the PCREF approach , with monitoring and enforcement through the Equality and Human Rights Commission, the Mental Welfare Commission, the Care Inspectorate and Healthcare Improvement Scotland.

Recommendation 1.7: The Scottish Government should consider legislation which requires public authorities to ensure that practitioners and paid carers are adequately trained to recognise and address racism, including structural racism.

Recommendation 1.8: The Scottish Government should promote the Equality Act and UNCRPD duties to collect data on protected characteristics and should ensure this data is disaggregated in a way which evidences the inequalities experienced by geographically and culturally distinct groups.

Recommendation 1.9: The Scottish Government should strengthen accountability for public bodies delivering mental health services where they fail to demonstrate progress in relation to equality outcomes in accordance with Regulation 4 of the Equality Act 2010 (specific duties) (Scotland) Regulations 2012.

Recommendation 1.10: The Scottish Government should consider steps to improve the recruitment and retention of ethnic minority staff, across different professions within mental health services.

Recommendation 1.11: The Scottish Government should consider the additional needs for remote and rural communities to enable delivery of mental health services on an equitable basis.

Recommendation 1.12: The Scottish Government should resource and empower leaders of Scotland's minoritised ethnic communities to lead in finding, developing and implementing solutions which ensure access to mental or intellectual disability services for their communities.

Chapter 2: What is the purpose of the law and who is it for?

Chapter 2 recommendations

Recommendation 2.1: The law should apply to persons with a mental or intellectual disability (and otherwise included under the AWI) whether short or long term.

Recommendation 2.2: The new purpose for mental health and capacity law should be to ensure that all the human rights of people with mental and intellectual disability (and otherwise included under AWI) are respected, protected and fulfilled.

Chapter 3: What should the law look like ?
Principles and unified legislation

Chapter 3 recommendations

Recommendation 3.1: Fused, or unified, mental health and capacity legislation should be the ultimate long term goal in Scotland.

Recommendation 3.2: To support the above recommendation, active steps should be taken to align existing mental health, capacity and adult support and protection law. Such alignment will require the Scottish Government to:

- **work with professionals and people with lived experience, including unpaid carers, to overcome barriers and misunderstanding regarding information sharing.**

- **move towards a joint set of principles across all 3 Acts.**

- **develop the Human rights enablement approach, Supported decision making and Autonomous decision making systems across all 3 Acts.**

- **expand the jurisdiction of the Mental Health Tribunal for Scotland to include capacity cases, including sustained and appropriate resourcing to accompany this extended remit of the Mental Health Tribunal for Scotland.**

Principles

Recommendation 3.3: Future mental health, capacity and adult support and protection law should expressly provide that anyone discharging a function under it should have regard to the following principles:

10. **Dignity: The importance of respecting the inherent dignity of any individual who may seek or be offered support for a mental or intellectual disability.**

11. **Inclusion: The importance of facilitating full and effective participation and inclusion of people with a mental or intellectual disability in society and in all decisions affecting them individually and collectively.**

12. **Autonomy: Respect for the individual autonomy of people with a mental or intellectual disability, and their will and preferences including past and present wishes. This should include the freedom to make one's own choices.**

13. **Equality: Respect for difference, and acceptance of people with a mental or intellectual disability as part of human diversity and humanity who retain the same rights and entitlements as those with other health needs.**

14. **Non-discrimination: The need to avoid discrimination on the basis of disability or any other characteristic, including age, gender, sex, sexual orientation, religious persuasion, racial origin, ethnic group and cultural and linguistic heritage.**

15. **Respect for carers: Consider the needs of anyone who is a carer (as defined in the Carers (Scotland) Act 2016 and the importance of providing them with such information as may assist them to care for the individual and engaging with any unpaid carer in the care planning process, where this is practicable to do so.**

16. **Respect for the rights of the child: Any interventions concerning a person aged under 18 shall respect the rights of that person under the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities. (see also chapter 12)**

For non-consensual treatment

Anyone considering or making an intervention with a person who has not consented or may be unable to autonomously consent to that intervention shall have regard to the following principles:

17. **Benefit: The intervention must provide benefit to the person which could not reasonably be provided otherwise and which can be justified with respect to the human rights of the person overall.**

18. **Least restrictive alternative: The intervention is the least restrictive alternative of the options likely to fulfil the aims of the intervention.**

In addition, the following principle shall apply to the NHS and any local authority or other agency defined in regulations who may have powers or responsibilities to provide care, treatment or support to the person:

10. Reciprocity: Where an individual is required under the legislation to comply with a programme of treatment and care, there shall be a parallel obligation on health and social care authorities to provide suitable care and support, including, but not restricted to, after compulsion.

Chapter 4: Supported decision making

Chapter 4 recommendations

Recommendation 4.1: The Scottish Government should develop a comprehensive scheme of Supported decision making (SDM) which should apply across mental health, capacity, and adult support and protection legislation, and especially where non-consensual interventions are needed. The scheme should build on existing good practices already in use across Scotland.

Recommendation 4.2: The Scottish Government should progress the SDM scheme with a central point for development, promotion and oversight determined as the first step in this process. This could be developed as part of the new mental health model within the National Care Service .

Recommendation 4.3: The development of the SDM scheme must take place in with the full and equal participation of people with lived experience, including unpaid carers.

Recommendation 4.4: The SDM approach needs to be built into all training for practitioners at every level in the delivery of care, support and treatment in the field of mental health, capacity, and adult support and protection law.

4.2: Advance statements

Recommendation 4.5: The Scottish Government should change Advance Statements to a model of Advance Choices, reflecting an individual's will and preferences.

> **This new model should apply to any support , care or treatment the person may need across all areas of their life and should operate as follows:**
>
> **If a person, having been given appropriate support, is not able to make an autonomous decision and an Advance Choice exists, the Advance Choice should normally be respected. It should have the same status in law as a decision taken at the time by a competent adult, unless one of the following reasons justify it not being followed:**
>
> - **The person has acted in a way which is clearly inconsistent with the Advance Choice, which suggests it may no longer be their fixed view.**
> - **The person's current will and preferences seem to be more pertinent than those expressed in an earlier Advance Choice.**
> - **A position on the person's will or preferences on a given matter cannot reasonably be concluded from matters included in the Advance Choice.**
> - **There are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making the Advance Choice, which would have affected their decision had they anticipated them.**
> - **There is evidence that the person's ability to make an autonomous decision at the time of the Advance Choice was compromised, for example because of significant illness or undue pressure being applied.**

- **Treatment which is inconsistent with the Advance Choice is necessary to save the patient's life or to prevent serious suffering on the part of the patient.**
- **It should not be possible to refuse normal hygiene, nutrition, hydration or the relief of severe pain.**
- **An Advance Choice refusing treatment is not applicable to life-sustaining treatment unless it makes clear that this is intended.**
- **An Advance Choice would not require a treatment to be offered where it isn't available or clinically justified but should be given significant weight as to the preferences of the granter.**
- **Except in an emergency, a clinician should not be able to overrule an Advance Choice at their own initiative. We propose a model based on s50 of the AWI Act, that an independent clinician be appointed by the MWC to review whether a ground for not following the Advance Choice has been made out. In addition to this, any interested party could seek a ruling from a judicial body (short to medium term)**
- **In advance of the introduction of this wider model, the Scottish Government should work with the Mental Welfare Commission, the NHS, local authorities and advocacy and peer support organisations to promote awareness of advance statements and to support people in making them.**
- **The Mental Welfare Commission should issue further guidance on the circumstances in which it is acceptable not to follow an advance statement and should continue to monitor the system.**

Independent advocacy recommendations

Recommendation 4.6: The Scottish Government should align legislation and policy to ensure consistency regarding the definition of Independent Advocacy, the right to access it and how it is commissioned and funded for adults. This should include consideration of an opt -out service of independent advocacy. An equivalent process should take place for children and young people.

Recommendation 4.7: The Scottish Government should ensure independent individual and collective advocacy is sustainably funded. The Scottish Government must ensure culturally appropriate independent individual and collective advocacy provision.

Recommendation 4.8: The Scottish Government should consider a national advocacy service.

Recommendation 4.9: The Scottish Government and the Scottish Independent Advocacy Alliance, working with other independent individual advocacy groups should develop a national register of independent individual advocates.

Recommendation 4.10: The Scottish Government and the Scottish Independent Advocacy Alliance, working with other independent individual advocacy groups should develop a national training programme for independent individual advocates that recognises the need to ensure access to all those who would wish to work in this field.

Recommendation 4.11: The Scottish Government should assure an existing or new organisation should have responsibility for monitoring and continuing development of independent individual advocacy.

Aids to communication recommendations

Recommendation 4.12: Assistance with communication as appropriate to the needs of the individual should be a guaranteed right . This is particularly necessary for those who use non-verbal methods of communication to express their will and preferences. Work in developing this must be done in partnership with relevant sectors such as the deaf community.

Chapter 5: Specialist support in legal and administrative proceedings

Chapter 5 recommendations

Specialist support in legal and administrative meetings

Recommendation 5.1: The Scottish Government should introduce intermediaries. This should be subject to review and assessment of an expanded use of the Appropriate Adult scheme and independent advocacy

- **The use of the existing Appropriate Adult Scheme should be expanded to increase the support for individuals throughout current justice processes.**

- **Work should be done to explore the possibility of using independent advocates to assist in providing support for individuals going through justice processes.**

- **Subject to the review of whether the expanded use of appropriate adults and independent advocates set out above proves sufficient to provide the necessary support, a scheme for the use of intermediaries should be introduced to provide support from start to finish in justice processes.**

Named Person Recommendations

Recommendation 5.2: Where no named person has been appointed the Scottish Government should consider allocating powers to the tribunal to appoint a named person.

Recommendation 5.3: Subject to changes above being carried out, the Scottish Government should abolish the role of the listed initiator

Recommendation 5.4: Scottish Government should ensure that that named persons have access to

- **independent advocacy and legal representation**
- **accessible guidance**

Recommendation 5.5: The process of appointing of Power of Attorney (POA) or guardian should include consideration of appointment of a named person, should that become necessary.

Curator ad litem recommendations

Recommendation 5.6: The Scottish Government should increase governance over the role of a curator ad litem. This should include:

- **a statutory duty on the curator ad litem to report the actions they have taken to ascertain the will and preference of the individuals**
- **mandatory training for curators**

- **establish a process for ensuring that there is no conflict of interest where a curator ad litem also acts as a solicitor**

Safeguarder Recommendations

Recommendation 5.7: The Scottish Government should:

- **Review guidance to ensure that there is a consistent approach to appointing safeguarders between sheriffdoms**
- **Review guidance to ensure that the role of the safeguarder is unambiguous**
- **Create a uniform training programme with a requirement that the training is completed before being accepted as a safeguarder.**
- **Create a system of national standards for the work being done which would enable best practice to be shared across the country .**
- **Revise the payments system for safeguarders to place it on a more equitable footing.**

If the above changes have occurred, the Scottish Government should undertake a further review to consider if the combination of roles available meets the needs of mentally or intellectually disabled individuals appearing in court or before the MHTS.

Chapter 6: Economic, social and cultural rights - enabling people to live fulfilling lives

Chapter 6 recommendations

Changes to mental health law including new duties

Recommendation 6.1: There should be a legal requirement for the Scottish Government to establish minimum core obligations to people with mental or intellectual disabilities to secure their human rights, including but not restricted to the right to the highest attainable standards of mental and physical health, and the right to independent living, alongside a framework for progressive realisation of those rights.

Recommendation 6.2: Sections 25 to 27 of the 2003 Act should be extended and reframed to set out clear and attributable duties on NHS Boards, local authorities and integration authorities to provide or secure support to individuals with past or present experience of mental or intellectual disability. The duties should include:

- **Personal care, support and treatment to maximise mental and physical health**
- **Housing which is appropriate for the person's needs**
- **Provision to support living and inclusion in the community and prevent isolation or segregation**
- **Education, training and support for employment**

- **Assistance with travel to any of the above supports**
- **Access to financial advice and anti-poverty initiatives.**

Recommendation 6.3: NHS Boards, local authorities, integration authorities and the Scottish Prison Service should be under a duty to secure similar supports to people with mental or intellectual disabilities who are in prison or being discharged from prison.

Recommendation 6.4: There should be a systematic process of monitoring to assess whether these obligations are being met.

Recommendation 6.5: The duties under sections 260 and 261 of the Mental Health Act should be extended to ensure that people with mental or intellectual disabilities have effective access to information about their rights whenever they need it, including translation or interpretation where required.

Recommendation 6.6: There should be a legal duty on Scottish Ministers to adopt specific measures to address the requirements of Article 8 of CRPD (Awareness raising) in respect of people with mental or intellectual disabilities, including fostering respect for their rights and dignity and combating stereotypes, prejudices and harmful practice. The duty should be supported by specific actions in the minimum core obligations.

Recommendation 6.7: In line with the recommendations of the National Taskforce for Human Rights Leadership, there should be accessible, affordable, timely and effective remedies and routes to remedy where any of the above duties to provide services, support or information are not upheld.

This should include the ability of individuals to raise a legal action in the civil courts.

Wider changes

Recommendation 6.8: The Scottish Mental Health Strategy should be recast to set out a clear human rights framework including the development of minimum core obligations and the progressive realisation of economic, social and cultural rights for people with mental or intellectual disabilities.

Recommendation 6.9: This should not be confined to health and social care services, but address other relevant government policies and strategies, including housing, poverty, social security, employment and community support.

Recommendation 6.10: The development of these minimum core obligations and the framework for progressive realisation should be carried out with the full participation of people with mental or intellectual disabilities and their representative organisations.

Recommendation 6.11: As the minimum core obligations are developed, the Scottish Government should identify any other public bodies who should be subject to a specific responsibility to fulfil the economic, social and cultural rights of people with mental or intellectual disabilities.

Recommendation 6.12: Duties to provide health and social care should be reframed in terms of human rights standards, including the AAAQ (availability, adequacy, acceptability and quality) framework set out at paragraph 12 of ICESCR General Comment Number 14 (United Nations, 2000). Since many of

these duties apply more widely than to mental or intellectual disability, this may require to be considered as part of the general implementation of the proposed Human Rights Bill.

Chapter 7: The role and rights of unpaid carers

Chapter 7 recommendations

Carer Awareness Training

Recommendation 7.1: NHS Education for Scotland in partnership with unpaid carers and National Carers' Organisations should develop Carer Awareness Training for all staff working with people with mental or intellectual disability across health and social care settings.

This training should:

- **Cover the rights of all unpaid carers as enshrined in legislation.**
- **Have local unpaid carers and carer services involved in its delivery at local levels where this is possible.**
- **Become best practice within pre-registration requirements for professionals across health and social care settings.**
- **Become best practice in the induction process for staff in third sector organisations.**
- **Become best practice in continuing professional development**
- **Respect and value the diversity and intersecting characteristics of unpaid carers, including cultural differences and the needs of young carers.**

- **Be supported by the development of measures to monitor and assess its effectiveness in improving outcomes for carers and staff, including levels of staff awareness, knowledge and confidence in protecting, promoting and fulfilling the rights of unpaid cares of all ages, and the difference it makes to the experience of unpaid carers.**

Best practice engagement framework

Recommendation 7.2: The Scottish Government should support the development of a national framework to ensure the identification and meaningful engagement of unpaid carers to be used in all services supporting people with a mental or intellectual disability, including Child and Adolescent Mental Health Services. Its development and implementation should be coordinated by Carers Trust Scotland with support from National Carer Organisations, including Scottish Young Carers Services Alliance.

The framework should:

- **adopt and extend the Triangle of Care.**

- **include quality indicators for monitoring impact, compliance and criteria which reflect the rights of unpaid carers, enshrined in the Carers (Scotland) Act and human rights entitlements. Healthcare Improvement Scotland should be involved in the development of these quality indicators in partnership with Carers Trust Scotland and inform an improvement approach to implementation.**

Involving, valuing and supporting unpaid carers

Recommendation 7.3: The Scottish Government should support the development of a national dedicated independent advocacy service for unpaid carers. This service should include culturally accessible advocacy for carers of ethnic minority people.

Recommendation 7.4: The Scottish Government must ensure the development of culturally appropriate respite services.

Chapter 8: Human rights enablement,
Autonomous decision-making and Deprivation of liberty

8.1:Human Rights Enablement

Chapter 8 recommendations

Recommendation 8.1: The Scottish Government should develop and adopt the HRE approach.

HRE maximises a person's ability to make an autonomous decision and thereby ensuring that priority or 'special regard' is given to a person's will and preferences. An HRE approach

a) Ensures that the person's will and preferences are known in respect of the given issue;

b) Identifies what rights, if any, are in need of protection, including the rights of others or another;

c) Considers whether all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment;

d) Weighs advantages to human rights against harms to human rights. Significant harms to certain human rights would be justifiable only exceptionally, on the basis of very significant advantages in the respect, protection and fulfilment of the person's human rights overall;

e) Provides a plan of action for giving effect to such identified right or rights in order to meet the person's needs at that time.

Recommendation 8.2: The HRE approach should be developed with the full and equal participation of people with lived experience, including unpaid carers, and practitioners.

Recommendation 8.3: The HRE approach should cover the full range of a person's rights and operate as a framework together with SDM and ADM.

It should be accompanied by guidance, Codes of Practice and training

Recommendation 8.4: The Scottish Government should ensure sufficient resourcing to realise this HRE approach.

Autonomous decision-making

Recommendation 8.5: The Scottish Government should replace the existing capacity and SIDMA tests with the test of ADM to provide a more rights-based criterion for non-consensual intervention.

- **The new ADM test would offer a more rights-based criterion for non-consensual intervention. The test should establish whether the person is able to make an autonomous decision on the matter in question, having regard to:**
- **The ability of the person to understand information relevant to the decision.**
- **The ability of the person to use or weigh the information in order to make a decision.**
- **The ability of the person to communicate the decision.**

- **The ability of the person to act on their decision, or otherwise act to safeguard themselves from harm.**
- **The extent to which any apparent decision, or expression of will and preferences, may be undermined by one or more of the following controlling influences, if they cannot be sufficiently mitigated.**
- **Undue influence by another person or persons.**
- **The impact of any illness, disability or health condition, including a health care crisis.**
- **The impact of any situational or environmental factors.**

Recommendation 8.6: ADM should be developed with the full and equal participation of people with lived experience, including unpaid carers, and practitioners.

Recommendation 8.7: ADM should be accompanied by guidance, Codes of Practice and training.

Recommendation 8.8: The Scottish Government should ensure sufficient resourcing to realise ADM.

Deprivation of liberty

Recommendation 8.9: The Scottish Government should establish a legislative framework for situations where a person may be deprived of their liberty. This is a short-term recommendation. Longer term, this framework should be revised as the HRE, SDM, ADM are developed.

Recommendation 8.10: The framework should include provision as follows:

8.10.1: Where a person cannot make an autonomous decision but can, with support, express a will and preference to remain in their current living arrangements, even if these arrangements would otherwise constitute a DOL, this must be respected.

8.10.2: There must be a standalone right of review available to the adult, or a person acting on their behalf if they are not subject to any order but are or may in fact deprived of their liberty.

8.10.3: The MWC may intervene in such cases if they have concerns. This ability to challenge the lawfulness of this actual or perceived DOL must be practical and effective.

8.10.4: A POA, with prescribed wording, may grant advance consent for the attorney to deprive the granter of their liberty, where the deprivation is proportionate and will demonstrably lead to more respect, protection, and fulfilment of the person's rights overall. This should be accompanied by regular review and registration with an external body such as the MWC or the OPG.

8.10.5: A court or tribunal may authorise a Decision making representative (DM representative), or an intervention order, to deprive the person of their liberty. The court or tribunal should also be able to grant this power in advance to a DM Representative but only where the need for this can be reasonably foreseen. This power must not be automatically included in a grant of powers to a DM Representative.

8.10.6: Where a person cannot consent to their care arrangements, even with support, and is being deprived of their liberty but does not have a welfare attorney or a DM Representative, a court/tribunal may grant a Standard Order for Deprivation of Liberty in order to preserve the person's overall human rights or an Urgent Order for Deprivation of Liberty in order to preserve life or health.

8.10.7: A carer, proposed DM Representative, local authority, allocated clinician for a residential care home, hospital clinical staff (where the matter is outside section 47 AWI Act and The MWC should all be entitled to apply for the order.

8.10.8: The order must be granted only to the extent it is needed and only for as long as needed to achieve the protection required, with regular review dates and a right of appeal at the time of granting.

8.10.9: The details of the duration of both orders will be for subsequent legislation to determine but should be aligned to commensurate timescales in mental health legislation.

8.10.10: Before proceeding to apply for a standard order for deprivation of liberty, an evaluation of the human rights implications must be completed as set out in earlier in this chapter.

8.10.11: The record of any DOL order, its duration and review date should be stored in the person's records in accordance with the HRE approach.

Recommendation 8.11: The Scottish Government must ensure that the above framework is supported by clear and targeted guidance, Codes of Practice and training detailing processes, and roles and responsibilities in relation to the range of different settings.

Chapter 9: Reduction of coercion

Chapter 9 recommendations

Reducing coercion, including reducing the use of involuntary treatment

Law reform to drive reduction of coercion

Recommendation 9.1: We recommend that the Scottish Government should make reduction of coercion a national priority over a period of years.

Recommendation 9.2: The Scottish Government should ensure effective recording, monitoring and action to reduce coercion across settings. This should include:

- **Mainstream alternatives to coercion with a view to legal reform**
- **Develop a well-stocked basket of non-coercive alternatives in practice**
- **Develop a road-map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders**
- **Establish an exchange of good practice between and within countries**
- **Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals**

Recommendation 9.3: The Scottish Government should set standards for trauma-informed mental and intellectual disability services, including access to psychology or other services which provide support for trauma that results from coercion.

Sense of belonging, connection and trust in society

Recommendation 9.4: The Scottish Government should ensure that:

- **Communities are enabled to develop their own forms of peer and community support**
- **Community wellbeing hubs are established to serve every community, both for people with a mental illness and to support the wellbeing of the general population**
- **A range of open, flexible and accessible crisis and crisis-prevention services is established**
- **Community mental health teams are fully integrated within communities**
- **Community and in-patient mental health services, and strategies for these, are developed through co-production by people with lived experience including unpaid carers**

Support, services, and approaches which reduce the use of coercion

Recommendation 9.5: The Scottish Government should lead a systematic improvement programme with the full and equal participation of people with

lived experience, including unpaid carers, and services and regulatory bodies. This should include:

- **Support, services and approaches which have been successful in reducing coercion in other countries are piloted, developed and then implemented across Scotland**
- **Ward-level interventions which reduce coercion including restraint, such as Safewards, are implemented**
- **Academic research which is led by people with lived experience is commissioned on approaches to reducing coercion**

Recommendation 9.6: The Scottish Government should ensure that all new buildings and services should be universally designed. Design and redesign processes should aim for the highest quality, as defined with the full and equal participation of people with lived experience including unpaid carers.

Recommendation 9.7: In practice, the general approach to mental health care and treatment should reflect the recovery approach as expressed by the WHO and also as developed by the lived experience movement.

Stronger safeguards when compulsion is authorised

Recommendation 9.8: The Scottish Government should undertake a detailed review of the safeguards for treatment contained in Part 16 of the Mental Health Act.

During this review, the following changes should be considered

- **Requiring authorisation by a DMP of any restraint, seclusion or covert medication, except in an emergency**
- **Broadening the category of who may act as a DMP, including the possibility of a suitably qualified psychologist reviewing restraint or seclusion**
- **Establishing safeguards derived from the Mental Health Units (Use of Force) Act 2018 for the Scottish context (see recommendation 9.10 below)**
- **Stronger duties on the DMP to consider and seek to give effect to the will and preference of the patient wherever possible**
- **A possible appeal to the Tribunal against the decision of a DMP to authorise treatment for some particularly serious interventions**
- **MWC monitoring and reporting on the use of restraint, seclusion and covert medication, whether authorised by MHA or AWI**
- **It should not be possible to give a specific treatment without the consent of a patient if the patient is able to make an autonomous decision about that treatment.**

Recommendation 9.9: Section 44 of the Mental Health Act (short-term detention) should be amended to separate out authorisation for detention and authorisation for the giving of treatment, with each being separately considered and justified on the short-term detention certificate, and it being possible to be detained without authorisation for non-consensual treatment.

Monitoring and scrutiny

Recommendation 9.10: The Scottish Government should establish a scrutiny system with sufficiently wide scope to consider evidence and data, and to identify underlying causes of coercive treatment. This should include:

- **Measures to address those underlying causes through systemic measures and measures for individual institutions**

- **Stronger requirements for services to record, reflect on and reduce coercive practices, and national monitoring of coercive practices which drives learning and improvement; and**

- **No undue bureaucracy and no perverse consequences**

Recommendation 9.11: The Scottish Government and relevant public authorities should consider other countries' laws and approaches for monitoring and regulating the use of coercive measures when developing a new system.

Recommendation 9.12: The Scottish Government should propose legislation for a national register of restraint to be set up and maintained by a central public authority which is capable of hosting the exchange of data between multiple public authorities, and which is capable of reporting publicly on trends in data from all of those authorities.

Recommendation 9.13: The Scottish Government should commission and resource the Mental Welfare Commission, and propose legislation where necessary:

- **to work with partner agencies and deliver recommendations on which further powers the Mental Welfare Commission requires to ensure that co-ordinated work delivers reductions in coercion across settings**
- **to co-ordinate the development of consistent and effective approaches to the reduction of coercion across health and social care settings which serve people with mental or intellectual disability**
- **to provide system leadership for data monitoring on reduction of coercion**

Rising rates of detention and community-based compulsory treatment

Racism and anti-racism

Recommendation 9.14: Legislation should require monitoring and scrutiny which specifically tracks and addresses ethnicity in rates of detention and compulsory treatment.

Recommendation 9.15: For people from ethnic minority communities, a human rights enablement approach should routinely consider whether:

- **all of the standard safeguards have been applied in full**
- **all assessments have been made on the same basis as for all people, and without any assumptions which could be related to race or ethnicity**

- **any challenge to the validity of assessments has been considered and resolved**
- **the person has been offered at least the same level of support for decision-making as for any other person**
- **the person’s cultural, linguistic and, religious or belief requirements have been identified and professionals can show how these needs will be met**
- **if the person or their supporters have indicated that racism or cultural insensitivity may be present in relation to the order or in relation to relevant services, these issues are being addressed**

Criteria for detention and involuntary treatment

In the medium term, the criteria for detention and involuntary treatment under the Mental Health Act; or for involuntary measures under the AWI Act, should be that:

- **a person has a mental or intellectual disability or for the purposes of an AWI intervention is unable to communicate because of a physical disability, whether short or long term,**

and is unable to make an autonomous decision as set out in Chapter 8;And for the purposes of a Mental Health Act intervention that:

- **treatment which would alleviate symptoms or prevent the disorder worsening is available, and**
- **without such treatment there would be significant risk to the health, safety or welfare of the patient or to the safety of any other person, and**
- **the order is necessary.**

Recommendation 9.16: In the longer term and in the context of fusing mental health and capacity law, other tests for detention and involuntary treatment under the Mental Health Act and for involuntary measures under the AWI Act should be redefined to fit with the new principles and the Human Rights Enablement framework.

Rising rates of detention and compulsion

In taking forward the following recommendations to address rising rates of detention and compulsory measures, the Scottish Government should be informed by the international human rights framework, including the ECHR and relevant UN treaties. These recommendations should be read with recommendations on accountability.

Recommendation 9.17: The Scottish Government should ensure that the Mental Welfare Commission and the Scottish Human Rights Commission, as independent bodies and in collaboration, are sufficiently empowered and resourced to monitor the extent to which future law meets its purpose of respecting, protecting and fulfilling human rights.

Recommendation 9.18: The Scottish Government should work with the Mental Welfare Commission and the Scottish Human Rights Commission to determine new requirements for data collection on detention and compulsory measures which should be set in law.

Recommendation 9.19: The Scottish Government should invest in establishing or developing a coherent, integrated system to achieve data collection on rates of detention and compulsion, with local authorities, health boards and

other public bodies sharing data, and should ensure public access to significant data and analysis.

Recommendation 9.20: The Scottish Government should commission ongoing monitoring, analysis and research on the effects and effectiveness of detention and compulsion for public protection in Scotland.

Recommendation 9.21: The Scottish Government should commission research to understand rising rates of detention and rates of community-based compulsion, and the large variation in the use of orders across different areas of Scotland. This work and research should be carried out with the full and equal participation of people with lived experience, including unpaid carers.

Recommendation 9.22: The Scottish Government should ensure that data is collected and analysed on the economic, social and cultural barriers that prevent or discourage people for using and benefitting from services, including people from diverse communities and people with protected characteristics.

Time limits on compulsory measures

Recommendation 9.23: In relation to approval for orders:

- **Professionals should ensure that people who are on orders, or who may be put on orders, are aware of Human rights enablement (HRE). Professionals should provide access to support to request or challenge HRE.**

- **Responsible Medical Officers (RMOs) and Tribunals should ensure that CTO care plans include a revocation strategy that outlines what needs to happen**

for that person to come off the CTO and what benefits the person is deriving from staying on it, expressed in terms of the Human rights enablement approach .

Recommendation 9.24: In relation to review points for orders:

- **In advance of legislation, the Scottish Government should commission the Mental Welfare Commission to work with a health board or boards, to test the practical effects of short time-limits for reviewing orders, or other processes for internal review during the life of an order.**

Recommendation 9.25: On post-legislative scrutiny:

The Scottish Government should propose law reform which includes provisions that enable future innovations to be developed through research and implemented across law, policy and practice, before major reforms to law.
9.2.5: Community-based compulsory treatment

Recommendation 9.26: Community-based compulsory treatment should continue to be allowed in Scottish mental health law and incapacity law. However, research, monitoring, inspection and individual scrutiny of CCTOs should be enhanced and should all be based on the international human rights framework as it applies to Scotland.

Recommendation 9.27: The Scottish Government should define a new purpose for community-based compulsory treatment: CCTOs should ensure access to recovery-focussed, trauma-informed, community-based services.

Recommendation 9.28: The Mental Welfare Commission should lead on embedding the new purpose of CCTOs in practice, through work with other organisations and through continuing scrutiny of the operation of CCTOs.

Recommendation 9.29: The Scottish Government should commission substantial and innovative research:

- **To explain why the use of CCT has continued to increase in Scotland**
- **To understand the circumstances which make CCT effective or ineffective**
- **To show which groups of people CCT tends to work for**
- **To understand the experiences of those who receive regular voluntary treatment in the community and who are not on a CCTO**
- **To explain why so many individuals are now being placed directly onto CCTOs with no previous order**

The findings of this research should be used to determine whether further law reform is needed in this area.

Suspension of detention and other transitions

The Scottish Government should revise statutory guidance to give direction to practitioners on how to involve family members and other unpaid carers in suspension of detention and other transitions. This is to ensure that transitions are effective and are respectful of all relevant human rights, such as the right to privacy including data protection.

Emergencies: reducing the impact of crises

Recommendation 9.30: Through the mental health strategy, Scottish Government should:

- **ensure adequate resourcing and multiagency training for detention in the community**
- **work with health and care agencies to develop alternative places of safety for people who are in distress and at risk, and whose needs are not met by in-patient psychiatric care**
- **further develop approaches to recovery**
- **develop person-centred safety planning, including joint crisis planning**

Recommendation 9.31: The Mental Welfare Commission should work with stakeholders to develop practice guidance on assessment in the community for detention.

Recommendation 9.32: The Scottish Government should propose legislation which creates duties on public authorities to provide or commission non-medical, age-appropriate and culturally-appropriate crisis support services.

Recommendation 9.33: The Scottish Government should review whether the place of safety powers should extend beyond suspected mental or intellectual disability to other people who may be at serious risk.

Recommendation 9.34: Health Boards should submit updated Psychiatric Emergency Plans every 2 years to the Mental Welfare Commission to be reviewed against the Commission's guidance.

Chapter 10: Forensic Mental Health Law

Chapter 10 recommendations

Diversion of those who have offended

Recommendation 10.1: The Scottish Government should ensure that processes and procedures to identify people with mental or intellectual disability who come into contact with the criminal justice system are effective in allowing for appropriate diversion to be considered. This should include the Scottish Government:

- **working with the Law Society of Scotland to ensure training programmes that increase solicitors' awareness and confidence in issues relating to representing people with a mental or intellectual disability. Similar training should be developed for other justice practitioners.**
- **reviewing the opportunities for screening and assessing people for a mental or intellectual disability within the criminal justice system, with particular attention paid to the earliest interactions with the person.**
- **overseeing better co-ordination and ethical data-sharing between justice and health partners.**
- **the development of community based interventions for offenders with mental health needs as an alternative to prison or diversion into the forensic mental health system.**

Recommendation 10.2: The Crown Office and Procurator Fiscal Service (COPFS) should develop and publish guidance on the prosecution of those with mental or intellectual disability who offend.

Pre-sentence

Changes to pre-sentencing orders

Recommendation 10.3: The court should be given the power to require the appropriate provision for the mental or intellectual disability of any remanded prisoner, including as to placement in a medical setting rather than prison.

> **Prior to legislative change existing arrangements and powers should be used to their maximum extent. Data should be kept about remands for inquiry into mental and intellectual disability and the outcomes of such cases.**
>
> **The legislation to introduce such a power should be, subject to an appropriate lead-in period for training, co-ordination between different parts of the justice systems and ensuring that legitimate concerns have been addressed prior to implementation.**

Recommendation 10.4: Time limits should be introduced for treatment orders. We recommend a time limit of six months to bring them in line with compulsory treatment orders.

Sentencing

Supervision and treatment order

Recommendation 10.5: The use of supervision and treatment orders should be monitored by the Mental Welfare Commission.

Recommendation 10.6: The Scottish Government should engage with the judiciary and the Judicial Institute to better understand any barriers to the use of these orders.

Criteria for forensic orders – overarching drive towards standardisation

Criteria for forensic orders: SIDMA (or ADM)

Recommendation 10.7: The Scottish Government should consider whether a lack of ability to make an autonomous decision about treatment should be added to the criteria for forensic orders once the Autonomous decision making test proposed by the Review has been suitably embedded within civil orders.

Criteria for forensic orders: harm to self

Recommendation 10.8: The removal of the 'harm to self' test from the criteria for forensic orders, excluding transfer for treatment directions and hospital directions. This should be subject to the following careful planning by the Scottish Government:

> **A mapping exercise of existing services for those who are at risk of harm to themselves – what and where they are; what criteria are currently used for access; how they operate.**
>
> **Planning across services to prepare for the recommended change and ensure that there are no gaps.**
>
> **Legislation introduced to remove this test.**

Criteria for forensic orders: seriousness of offence

Recommendation 10.9: That forensic orders should be reserved to offences punishable by imprisonment.

Criteria for restriction orders

Recommendation 10.10: The wording of the criteria for imposing a restriction order under Section 57 of the Criminal Procedure (Scotland) Act 1995 should be brought up to date and revised to remove any ambiguity about what these provisions mean.

Recommendation 10.11: A standardised process of risk assessment should be developed as a requirement for recommending restriction orders. This should be developed by the Scottish Government working alongside the Risk Management Authority, and relevant justice and health partners.

Ongoing management of people under forensic orders

Standardisation of effect

Recommendation 10.12: That compulsion orders (with or without a restriction order) should routinely be time limited. This time limit should be set by the sentencing judge to reflect the maximum reasonable time to address the risk presented by the offender. It should also take account of the gravity of the offence and ensure a degree of proportionality associated with that factor. For the avoidance of doubt, the order would end earlier than this if the criteria for the order are no longer met.

> **At or shortly before the expiry of the time limit for a compulsion order (with or without a restriction order), the offender could be referred by the Responsible Medical Officer to the Mental Health Tribunal for Scotland for consideration of whether a compulsory treatment order should be imposed**
>
> **A compulsion order should only ever be without limit of time where evidence is provided, under a systematic process of assessment, that the offender is likely to continue to present a serious risk of harm for an indefinite period.**

The ‘Serious Harm’ Test

Recommendation 10.13: That Section 193(2) of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be repealed, thereby removing the ‘serious harm’ test.

Restricted Patients – role of Scottish Ministers

Recommendation 10.14: The involvement of Scottish Ministers and the Mental Health Tribunal in the progression management, conditional discharge and recall of restricted patients should mirror the respective involvement of the Scottish Ministers and the Parole Board for Scotland in the management of life sentence and Order for Lifelong Restriction prisoners. This should include:

> **Review any data and other evidence on the current role of Scottish Ministers, to include information about delays and the impact on outcomes.**
>
> **Using data and other evidence on the current role of Scottish Ministers, in conjunction with the Mental Health Tribunal for Scotland and other relevant justice partners, examine any gaps that might be caused by reducing the role of Ministers and consider alternative options through the Tribunal.**
>
> **Amend the roles of Scottish Ministers and the Mental health Tribunal for Scotland.**

Restricted Patients – conditional discharge and recall powers

Recommendation 10.15: That the Mental Health Tribunal for Scotland should have the power to vary the conditions under which they have previously discharged a restricted patient.

Recommendation 10.16: That the Mental Health Tribunal for Scotland should have the power to discharge a restricted patient into conditions that amount to deprivation of liberty. The use of this power should be:

- **governed by clear criteria that can be understood and are accessible to patients and their unpaid carers and**
- **monitored by the Mental Welfare Commission.**

Cross-border transfers

We make no recommendation on this issue.

Duty on Scottish Ministers to ensure appropriate accommodation

Recommendation 10.17: There should be a duty on Scottish Ministers to ensure the safe and appropriate accommodation of prisoners with significant mental health needs.

Voting rights

Recommendation 10.18: That voting rights should be available and the blanket disenfranchisement ended for individuals detained under forensic orders provided for under of the Representation of the People Act 1983 should be ended. Appropriate legislation should be introduced, together with a comprehensive communications policy to raise awareness of the change.

Chapter 11: Accountability

Chapter 11 recommendations

Scrutiny and the regulatory landscape

The scrutiny landscape

Recommendation 11.1: There should be a duty on scrutiny bodies and complaint handling bodies to enhance access to justice and ensure human rights obligations are given effect by all public authorities involved in the provision of services for people with mental or intellectual disability. The Scottish Government should ensure these bodies are fully supported to build their capacity and confidence to play this part. (medium)

Recommendation 11.2: There should be a formalised network of bodies involved in the scrutiny of mental health services. This should include Healthcare Improvement Scotland, the Care Inspectorate, Audit Scotland, the Mental Welfare Commission, the Office of the Public Guardian, Public Health Scotland, the Scottish Public Services Ombudsman and collective advocacy organisations. Other members may include professional regulatory and training bodies.

Recommendation 11.3: The network should work with the Scottish Government to identify and remove any legislative barriers to this approach, such as unnecessary constraints on sharing information, or restrictions on the full involvement of people with lived experience, including their unpaid carers.

Recommendation 11.4: The Mental Welfare Commission should be the lead organisation for this network, with responsibility for co-ordination and reporting to Ministers and the Scottish Parliament.

Recommendation 11.5: This network should develop a cross-agency framework for monitoring outcomes in mental health and should ensure that:

- **the promotion, protection and realisation of people's human rights is a common aim for scrutiny bodies across the mental health landscape.**
- **there is development and support for sufficient human rights expertise within all scrutiny bodies.**
- **there are mechanisms to identify, report and address systemic issues across the work they do.**
- **people with lived experience, including unpaid carers play a leading role in determining what defines 'quality' in services as the foundation for each scrutiny body's monitoring, evaluation and inspection processes.**
- **effective monitoring of the extent to which scrutiny bodies are meaningfully fulfilling their duties under section 112 to 113 of the Public Services Reform Act 2010 in relation to user focus.**
- **there is a single entry point for the public to access the appropriate scrutiny body for any information, support or issue they want to raise.**

The Mental Welfare Commission for Scotland

Recommendation 11.6: The powers and responsibilities of the Mental Welfare Commission should be strengthened in legislation. The changes we recommend are:

- **Its core remit should be to protect and promote the human rights of people with mental or intellectual disabilities. This should include both protection of the rights of individuals and promoting systemic change.**
- **The MWC should have a statutory responsibility to monitor the operation of the adults with incapacity legislation.**
- **There should be a substantial increase in the statutory requirement to include people with lived experience as service users, or family carers on the Board of the MWC.**
- **The MWC should strengthen the involvement of people with lived experience in their management, staffing and wider engagement, and should have a responsibility to co-operate with collective advocacy organisations.**
- **The MWC should increase its work in community settings.**
- **The legislation should include a level of accountability directly to the Scottish Parliament. This would include the power to make a report to Parliament if there is a serious failure by a public body, including the Scottish Government, to follow a recommendation.**
- **The MWC should have the power to initiate legal proceedings to protect the human rights of any person or group covered by mental health and capacity law.**
- **Consideration should be given to a change of name for the MWC to reflect its focus on human rights**.

Data Collection

Recommendation 11.7: There should be a duty on Public Health Scotland to actively lead work with the Mental Welfare Commission, groups representing people with lived experience, other agencies holding data and the research community to determine what needs to be monitored across mental health services to ensure human rights obligations are being met.

Recommendation 11.8: There should a duty on organisations holding data, including Public Health Scotland, the Mental Welfare Commission, the Care Inspectorate, Health Improvement Scotland, the NHS, the Office of the Public Guardian, local authorities, Police Scotland, the Scottish Prison Service and any other relevant organisations to work together to gather and make available the structured, disaggregated, researchable data needed to monitor mental health services effectively and drive change.

The Mental Health Tribunal for Scotland

Recommendation 11.9: The Scottish Government and the Mental Health Tribunal for Scotland consider and respond to the recommendations of the research project: Mental Health Tribunal for Scotland: the views and experiences of Patients, Named Persons, Practitioners and Mental Health Tribunal for Scotland members.

Remedies and access to justice

Recommendation 11.10: Individuals who are subject to or wish to initiate legal proceedings under our proposals, or their unpaid carers or representatives, should have access to non-means tested expert legal representation. The Scottish Government, working with the Scottish Legal Aid Board and the Law Society of Scotland, should ensure that there is an adequate supply across the country of expert legal advice and representation.

Investigating Deaths

Recommendation 11.11: The Scottish Government make a timely response to the Mental Welfare Commission's proposals to allow improvements to be made to the investigation of deaths of people under compulsory care and treatment as soon as is practical.

Recommendation 11.12: The Scottish Government should ensure that the role of the Mental Welfare Commission in investigating these deaths is explicitly placed in legislation.

Recommendation 11.13: The Scottish Government should ensure there is a mechanism to monitor and review the investigations into these deaths using the experiences of the families of those who have died as a key measure.

Recommendation 11.14: The Scottish Government should ensure that the development of any independent body to investigate deaths of people in custody and the development of the proposals for investigating deaths of people under compulsory care and treatment progress together to ensure opportunities for further alignment and equity between the two processes are not missed. (short)

Recommendation 11.15: The Mental Welfare Commission's powers to request information and co-operation from other authorities should be amended explicitly to cover any organisation with which it needs to collaborate for the purpose of these investigations.

Recorded Matters

Recommendation 11.16: The existing powers of the Mental Health Tribunal for Scotland to make recorded matters under Section 64(4)(a)(ii) of the 2003 Act should be strengthened as follows:

> **The Mental Health Tribunal, in the event of non-compliance with a recorded matter should be given powers to direct the relevant provider to provide within a specified time such care and support as may be required to:**
>
> - **avoid the need for an individual's compulsion; or**
> - **ensure that compulsion respects the human rights of the patient.**
>
> **In reaching a decision as whether to issue such a direction, the Mental Health Tribunal will have due regard to:**
>
>   - **the core minimum obligations and any other relevant standards in place for the provision of mental health services,**
>   - **the Human Rights Enablement approach taken with the individual,**
>   - **and the wishes of the individual.**
>
> **The service provider will have an appeal to the Upper Tribunal against such a direction.**
>
> **Continued non-compliance with a direction will be a breach of a statutory duty which is justiciable in the Court of Session. (medium)**

Excessive security appeals

Recommendation 11.17: All patients subject to compulsion should have a right to appeal against being subjected to unjustified restrictions.

- **This right should extend beyond a person's right to move to a less restrictive care or treatment setting. People would also have the right to challenge the level of restrictions while staying in the same place.**
- **This right should extend to restrictions imposed by a Community-based Compulsory Treatment Order, or a Deprivation of Liberty under the AWI Act, as well as detention in hospital under the Mental Health Act or Criminal Procedure (Scotland) Act.**
- **The appeal procedures would be modelled on sections 264 to 273 of the Mental Health Act. However, there should be no need for the appeal to be supported by a medical report by an approved practitioner. Instead, there should be a sift process to ensure that groundless appeals are not pursued.**
- **Regulations should set out the nature, severity and duration of restrictions which would potentially be subject to an appeal.**
- **The use and outcome of these provisions should be monitored by the Mental Welfare Commission to identify whether there are any systemic issues giving rise to appeals which require wider investigation or action**.

Recommendation 11.18: The appeal process should ultimately replace the 'specified person' procedures in sections 281 - 286 of the Mental Health Act. Before then, the Scottish Government should urgently progress reforms to the specified person procedures to ensure they appropriately cover modern technology and better reflect human rights.

Complaints

Recommendation 11.19: The Scottish Public Services Ombudsman remit should be extended to allow it to:

- **Oversee and drive a more holistic and human rights based approach to considering complaints for people with a mental or intellectual disability across health, social care and other public services.**
- **Share learning and best practice on complaint resolution and handling across Scotland.**

Recommendation 11.20: The legislative restriction whereby the Scottish Public Services Ombudsman can only accept complaints in alternative formats 'in exceptional circumstances' should be removed.

Recommendation 11.21: The Scottish Public Services Ombudsman should work with provider organisations, the Care Inspectorate, Healthcare Improvement Scotland, the Mental Welfare Commission and the Office of the Public Guardian, to support a lived-experience led change project to design a

complaints system that better meets the needs of people with mental health and capacity issues and which is based in human rights. To support this:

> **We recommend an improvement methodology for testing this new model.**
>
> **Our work has shown that to be based within a human rights approach and to address barriers people experience in the current system, it should:**

- **Have complainants as active, trusted and valued participants in a dialogue about the decisions that affect them.**
- **Be developed by complainants and their families, with complaint handling bodies as partners.**
- **Look towards more solution-focused and collaborative ways to share concerns without necessarily having to escalate them to complaints.**
- **Have meaningful processes to monitor, follow-up and report on issues raised which allow us to:**
  - **Know the outcomes in terms of what difference was made to the individual or what changes were made to the services.**
  - **Identify patterns or themes which may indicate systemic issues and be fed back into the system for learning and development.**
  - **Gather equality data to understand and monitor who the system is working for and who it is excluding.**
- **Support people to share their experiences in the way that works best for them. This could include the involvement of peer workers, having access to specialist clinicians, or providing people with additional training on communication methods, mental illness or anti-racism.**
- **Have a single point of access for the system.**

Independent collective advocacy

Recommendation 11.22: People with mental or intellectual disability should have a right to collective advocacy.

Recommendation 11.23: There should be a legal duty on the Scottish Government to secure and support effective collective advocacy organisations for people with a mental or intellectual disability at a local and a national level.

Recommendation 11.24: The Scottish Independent Advocacy Alliance (SIAA) and collective advocacy organisations should work with collective advocacy members and workers to lead on the development of:

- **a system for supporting, monitoring and evaluating collective advocacy groups. This system needs to respect their independence and be meaningful to the groups, commissioners and the public. It may build on the existing SIAA standards.**
- **an opt-in programme of advocacy related learning to support the development of more advocacy workers and peer leaders. This will include training on anti-racism, intersectionality and human rights.**

Collective complaints

Recommendation 11.25: Individual and collective advocacy groups should have an explicit right to raise a court action for human right breaches.

Recommendation 11.26: This right must be supported by access to legal advice, guidance and support for groups who wish to take this step.

Recommendation 11.27: Individual and collective advocacy groups should be able to refer systemic human rights concerns to the Scottish Public Services Ombudsman. The Ombudsman's role should be extended to allow them to investigate these as a collective complaint.

Recommendation 11.28: The Mental Welfare Commission and advocacy groups should develop a participatory referral process to escalate human rights issues that remain unresolved and unaddressed by services to the

Mental Welfare Commission to investigate and, if appropriate, initiate legal action.

Chapter 12: Children and Young People

Chapter 12 recommendations

Principles

Recommendation 12.1: That the principles of future mental health and incapacity legislation include one of Respect for the rights of the child: Any interventions concerning a person aged under 18 shall respect the rights of that person under the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities.

Recommendation 12.2: Before finalising the wording of the principle of respect for the rights of the child, and developing related guidance, there should be a process of consultation and engagement with children and young people.

Rights to support

Recommendation 12.3: There should clear and attributable statutory duties on Scottish Ministers and on NHS Boards, local authorities and integration authorities, to provide or secure such care, support and services as are needed to secure the human rights of children with mental or intellectual disability, including but not restricted to the right to the highest attainable standards of mental and physical health. This should include specific care and support for children who have, or have had, a mental or intellectual disability, alongside measures to prevent mental ill-health and promote the wellbeing of all children.

Recommendation 12.4: These duties should reflect agreed minimum core obligations developed through engagement with experts including experts by experience, alongside duties and a framework for progressive realisation of those rights. The development of these duties and associated standards should draw on human rights approaches including applying the PANEL principles and use of the AAAQ framework. Services should be age-appropriate.

Recommendation 12.5: In line with the recommendations of the National Taskforce for Human Rights Leadership, there should be accessible, affordable, timely and effective remedies and routes to remedy where any of the above duties are not upheld. This should include the ability of individuals to raise a legal action in the civil courts.

Recommendation 12.6: Education authorities should have a duty to secure appropriate education for all children with mental or intellectual disabilities, including but not restricted to children in hospital or subject to compulsory care. This should be enforceable at the Additional Support Needs Tribunal.

Crisis services

Recommendation 12.7: The Scottish Government should lead systemic reform of services available to children and young people experiencing acute mental distress, including the provision of safe and child-centred alternatives to admission to psychiatric care.

Emergency detention safeguards

Recommendation 12.8: Section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be amended to make clear that emergency detention without MHO consent should only take place in exceptional circumstances. These circumstances should be recorded and monitored by the Mental Welfare Commission

- **Scottish Ministers should, as part of the duty of progressive realisation, ensure that there are sufficient MHOs with expertise in child and family services to realise this expectation**

- **In any case where an MHO has not given consent, there should be a review by an MHO within 24 hours**

- **Within 12 hours of emergency or short term detention, a child should be given access to an experienced independent advocate**

16 and 17 year olds in CAMHS

Recommendation 12.9: The existing service standard that CAMH Services should be available to children who require them up to age 18 should be considered for inclusion in the minimum core obligations for those services.

Recommendation 12.10: As already happens for the placement of children in adult wards, any decision to transfer someone to adult services before age 18 should be recorded and subject to oversight by the Mental Welfare Commission.

Recommendation 12.11: In defining those duties subject to progressive realisation, consideration should be given to ensuring that young people who have accessed CAMH Services continue to have access to support if they require it up to age 26.

Recommendation 12.12: There should be a programme of improvement to transitions between CAMHS and adult services, to ensure that transitions are well planned, maintain relationships which are important to the young person, and reflect the developing capacities and needs of the young person.

Interaction between child and adult legal provision

Recommendation 12.13: The Scottish Government should take forward detailed analysis of the implications of changes in age limits in the child welfare system for the interface with adult support and protection.

12.6: Supported decision making, Human rights enablement and Autonomous decision making

Recommendation 12.14: Our proposals regarding Supported decision making, Human rights enablement and Autonomous decision making should apply to children who are subject to mental health law.

Recommendation 12.15: 12.14: Before legislation on SDM / HRE / ADM is introduced, there should be a detailed process of further policy development, involving children with lived experience, their families and professionals, to address particular issues affecting children, including the interaction between the ADM test and the Age of Legal Capacity (Scotland) Act 1991.

Independent Advocacy

Recommendation 12.16: The duties in the Mental Health Act to secure advocacy should be strengthened to ensure that any child with a mental or intellectual disability is made aware of their right to independent advocacy and is able to obtain this when needed.

Recommendation 12.17: The various duties in respect of advocacy (in mental health, in Children's Hearings, and in additional support for learning) should be streamlined to ensure comprehensive, holistic and child-centred individual advocacy services. These duties should be integrated with broader duties to ensure support for decision-making

Recommendation 12.18: There should be a new duty on Scottish Ministers to support collective advocacy for children with mental or intellectual disability.

Accountability

Recommendation 12.19: The scrutiny network which we propose at recommendation 11.2 [Chapter 11] should also oversee the scrutiny of outcomes for children with mental and intellectual disabilities across health, care and education settings. In doing so it should add agencies including Education Scotland, the Children and Young People's Commissioner Scotland, and collective advocacy organisations representing children and young people.

Autism, intellectual disability and other neurodevelopmental differences

Recommendation 12.20: 12.19: The statutory duties flowing from a Co-ordinated Support Plan should extend to all statutory agencies in the plan, and should be subject to review by the Additional Support Needs Tribunal.

Safeguards for treatment

Recommendation 12.21: The review of safeguards under Part 16 of the Mental Health Act which we propose at Recommendation 9.7 should also consider whether further safeguards may be necessary for children being treated under the Mental Health Act, or as informal patients.

Recommendation 12.22: The Scottish Government should co-ordinate further work on the use of restraint and isolation to ensure consistent standards across education, healthcare, childcare and justice settings, which reflect human rights-based best practice.

Perinatal mental illness

Recommendation 12.23: The duty in section 24 of the Mental Health Act to support mothers in hospital with postnatal depression and similar conditions should be broadened to ensure a wider range of in-patient and community supports for parents who need perinatal mental health care and their children.

Relationships between parents and children

Recommendation 12.24: Section 278 of the Mental Health Act should be strengthened and broadened to provide that

- **The duty to support family relationships should apply in considering alternatives to compulsion, not only after compulsion has been authorised**
- **It fully reflects the obligations of the UNCRC and UNCRPD.**

Recommendation 12.25: There should be a related duty on Scottish Government and health and social care agencies to ensure services are provided and co-ordinated in such a way as to reflect the requirements of the UNCRC and UNCRPD to support the family life of children or adults with mental or intellectual disabilities.

Exploring integration of child law and mental health law

Recommendation 12.26: The work of the Scottish Government and its partners to develop a holistic and child-centred system of care and support for children, including the implementation of the Promise, and the incorporation of the UNCRC, should include a focus on how to better align care and support for children and young people with mental or intellectual disabilities, including where compulsory measures are required.

Recommendation 12.27: This work should include consideration of a unified tribunal jurisdiction for different compulsory interventions or provisions to enforce the rights of the child.

Chapter 13: Adults with Incapacity proposals

Chapter 13 recommendations

Recommendation 13.1: The Scottish Government should as a priority , amend the Adults with Incapacity (Scotland) Act 2000.

Recommendation 13.2: Principles:

Section 1 of the AWI Act should be amended in line with the recommendations of the Three Jurisdictions Report to give greater priority to the will and preferences of the adult.

Recommendation 13.3: The Scottish Government should amend the Power of Attorney scheme as follows:

- **The granter should state when a POA should come into force.**
- **A person's ability to grant a POA should be carried out in accordance with the ADM test in Chapter 8, within the framework of HRE and SDM.**
- **The certificate accompanying a POA should be called a 'Certificate of Autonomous Decision Making Ability'.**
- **The act of a GP completing a POA certificate should be included as an NHS funded service.**

- **A comprehensive investigatory framework should be developed with OPG, Local authorities, the MWC and Police Scotland and full and equal participation with persons with lived experience including unpaid carers.**

- **Provision should be made in law for an attorney to be subject to supervision should an investigation determine this is required.**

- **As per the recommendation in chapter 3 updating of the AWI Act principles is required.**

Recommendation 13.4: The Scottish Government, together with the OPG, MWC, local authorities and such other agencies as necessary, along with the full and equal participation of persons with lived experience including unpaid carers, should develop support , training and guidance for attorneys. This should include

- **Awareness of the role and obligations of an attorney.**

- **Information on the new HRE/SDM/ADM framework.**

- **Provision of an advice helpline/ online support.**

- **Consideration of ways in which access to granting a power of attorney may be eased.**

- **Consideration of ways in which the cost of a POA can be eased.**

Recommendation 13.5: The Scottish Government should ensure there is increased awareness of the importance of a POA, with targeted engagement, and multimedia involvement, with focussed messaging for groups who may benefit more from having a POA, actively encouraging all citizens to grant a POA early, as part of lifestyle planning.

Access to funds and management of residents' finances,

These matters, which form part 3 and 4 of the current AWI Act respectively, are dealt with below under 'guardianship'.

Medical Treatment and Research

These are all short-term recommendations.

Recommendation 13.6: The Scottish Government should ensure that Part 5 and associated guidance and forms should require a certifying practitioner to demonstrate that they have considered and adhered to the principles of the AWI Act when issuing a section 47 certificate.

Recommendation 13.7: The Scottish Government should ensure that guidance gives greater clarity on the support that is required to be given to the person in assisting them to make an autonomous decision, before engaging section 47.

Recommendation 13.8: NHS Education Scotland should review the training of doctors and other professionals who are authorised to grant section 47 certificates. This should include their understanding of relevant human rights issues, and the principles of the legislation.

Recommendation 13.9: Section 47, 47A and associated regulations should be amended as follows:

- **The authority currently granted by section 47 should be reframed to make clear that treatment which is authorised should be that which would reflect the best interpretation of the adult's rights, will and preferences.**

- **To specify the circumstances in which it is not necessary to complete AWI Act documentation when treating a patient who is unable to consent, and make clear that in all cases the principles of the legislation apply.**

- **To widen the categories of healthcare professional who can assess incapacity and issue a section 47 certificate, including registered psychologists where appropriate.**

- **To provide a process of electronic recording and auditing of section 47 certificates, overseen by the Mental Welfare Commission.**

- **To provide that force, detention, or covert medication should require explicit authorisation by a legal process with a right of appeal to the tribunal, unless there is a genuine emergency.**

- **Section 47 should operate within the Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework.**

Recommendation 13.10: Scottish Government should undertake further consultation to develop

- **A clear process to authorise conveying an adult to hospital for physical treatment or diagnostic tests where they are unable to make an autonomous decision**

- **An extension to s47 to authorise restrictions on a person leaving hospital while they are receiving treatment for a physical condition or diagnostic tests, with provision for review after 28 days, and an appeal process.**

Recommendation 13.11: In all cases, including emergencies, force, detention or covert medication should be recorded and subject to monitoring and audit, overseen by the MWC.

Recommendation 13.12: The MWC should issue guidance on the use of force, detention and covert medication which should have the same legal effect as the statutory Code of Practice.

Recommendation 13.13: An adult, or someone acting on their behalf, including a carer or advocate should have practical and effective access to a court or tribunal by a simple procedure to challenge a decision to grant a section 47 certificate, or a treatment authorised under that certificate.

Recommendation 13.14: The safeguards for specified treatments under s48 should be adjusted so that the same safeguards apply as under the MHA for

- **ECT, vagal nerve stimulation and transcranial magnetic stimulation**

- **(Subject to further consultation) artificial nutrition and hydration: we propose these should be the same as under the MHA**

- **Drug treatment for mental and intellectual disability given for more than two months to a person subject to a deprivation of liberty.**

Recommendation 13.15: It should be lawful to give treatment which is reasonably necessary to a patient under Part 5 (section 49) where an application for a Decision Making Representative is in train, provided the application does not involve a dispute regarding the particular treatment.

Recommendation 13.16: The law should make clear that a decision-making representative cannot override the adult in relation to a decision where the adult is able to make an autonomous decision regarding the particular treatment.

Recommendation 13.17: We recommend that the reformed system should include a straightforward process by which an adult who believes they can take an autonomous decision about their medical treatment can access the tribunal. [See chapter 5 on support that is available where an ability to instruct a solicitor is limited]. In addition, any stated opposition to a particular treatment by the adult should bring into play the same safeguards as opposition by a decision-making representative.

Recommendation 13.18: Scottish Government should ensure adequate resourcing to realise these recommendations.

13.5: Intervention Orders and Guardianship

Recommendation 13.19: The decision-making model should replace the current guardianship system.

> **13.19.1: The current access to funds and management of residents' finances processes should be subsumed within the model.**
>
> **13.19.2: The application for a specific issue intervention order should be retained, authorised by a judicial body.**

Recommendation 13.20: The Decision-Making model should operate within the Human Rights Enablement, Supported Decision Making and Autonomous Decision Making framework.

Recommendation 13.21: The Scottish Government should develop Codes of Practice and guidance to support the operational detail which offers clarity about processes, rights, roles and responsibilities, scrutiny and monitoring and includes information on managing and resolving conflicts of interest and disagreements between the person and/or D.M.Supporter, D.M.Representative, or attorneys.

Recommendation 13.22: The Mental Health Tribunal for Scotland should be the judicial body to whom such applications are made.

Recommendation 13.23: This work should be developed with key practitioners and the full and equal participation of people with lived experience including unpaid carers.

Recommendation 13.24: There should be adequate resourcing to ensure the effective delivery of this new model.

13.5.2 Miscellaneous AWI Act minor amendments

Recommendation 13.25: The Scottish Government should refer to Appendix B as a check list when drafting adjusted primary, or secondary, legislation and updating Codes of Practice to ensure that all matters are incorporated as may remain relevant.

Chapter 14: Adult Support and Protection Act

14.1:Chapter 14 recommendations

Recommendation 14.1: Adult Support and Protection legislation should not be fused with mental health and capacity legislation but the Scottish Government should ensure that wherever possible there is alignment of principles and definitions, timescales and procedures.

Recommendation 14.2: The Scottish Government should ensure that the term ‘mental disorder’ in the ASP Act should be replaced by ‘mental or intellectual disability, whether short or long term’.

Recommendation 14.3: The ASP Act principles should be reviewed as part of the implementation of the Human Rights Bill, to ensure they fully reflect the requirements of international human rights law, particularly the UNCRPD

Recommendation 14.4: The Scottish Government should ensure our recommended approach of Human rights enablement and Supported decision making (chapters 4 and 8) should be adopted in the practice of Adult Support and Protection

Recommendation 14.5: The Scottish Government should consider amending the provisions regarding ‘consent’ in the ASP Act to reflect our proposed test of Autonomous decision making

Recommendation 14.6: We do not recommend that ASP interventions transfer from the sheriff court to a tribunal, but this should be kept under review by the Scottish Government.

Recommendation 14.7: Legislation should provide for the power to seek an urgent court order suspending some or all of the powers of a welfare or financial guardian or attorney as part of ASP proceedings.

Recommendation 14.8: The Scottish Government should consider whether banning orders under the ASP Act should be extended where the court is satisfied this is necessary to protect the adult.

Annexes

Annex A: References

Chapter 3: References

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Chapter 6: References

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Annex B: How the Review was carried out

How The Review was carried out

This Review started in June 2019, when Lord Scott, (then John Scott, Solicitor-Advocate KC) was appointed by Scottish Ministers to chair the Review.

A team of civil servants were seconded from the Scottish Government to support the Review in the form of a secretariat.

It was vital that the Review be conducted with the equal participation of people with lived experience including, unpaid carers, of the legislation and practice under Review. The starting point for this was the appointment of an Executive team to support the chair, comprising of 2 members with professional experience and 2 members with lived experience, one of whom is an unpaid carer.

The team members with professional experience were selected directly by the Chair. We asked for notes of interest for the members with lived experience from a wide range of stakeholder groups and an informal interview process was carried out by the Chair. A third Executive team member with lived experience was appointed using the same process half way through the Review. The details of the Executive team can be found on the Review website.

In addition, a number of advisory groups were established, to steer and support the Review's work. Again, we asked for notes of interest from a wide range of stakeholders and practitioners.

The first group established was a communications and engagement group, comprised again of equal numbers of persons with lived experience including unpaid carers and persons with professional experience. This group provided the Executive team with advice on conveying the messages of the Review and their input was invaluable in developing the first consultation of the Review.

The second group established was tasked with looking at compulsory measures of care and treatment, again with a mix of persons with lived experience including unpaid carers and persons with professional experience. Given the focus this area of the law had in the terms of reference of the Review, it was felt important to prioritise this early on in the Review.

The first consultation was planned for March 2020. With the help of the communications and engagement group, a wide range of meetings took place with a cross section of people who had valuable contributions to make. However, our plans, along with those of the rest of the country, had to be abandoned as we entered a period of lockdown, which lasted in one shape or another for much of the remaining period of the Review.

In common with the rest of the country we had to adapt our work quickly. More than half of the secretariat returned to the Scottish Government to work on emergency covid issues. It was over a year before the secretariat returned to full capacity again.

We quickly learnt that as organisations struggled to meet the needs of people who turned to them for support, responding to a consultation was the last thing on people’s minds . Some groups adapted quickly to the new reality of Zoom, Teams and webinars, others simply did not have the capacity to move their work online. It took several months to develop new ways of working, adapt to moving everything online, and try to find workarounds for what, pre covid would have been relatively straightforward meetings. We extended the length of the consultation period by over a month. But even now, we are aware that there are some groups we just have not been able to engage with because face to face meetings have been reinstated only very recently.

The upside of moving to an online programme of work however has been that we have been able to engage with international colleagues more easily. Following the conclusion of the first consultation, several more advisory groups were established to assist the work of the Review. These looked at children and young people, capacity and Supported decision making and economic social and cultural rights. Later in the Review we also set up a group to look at specific issues around adults with incapacity legislation and adult support and protection legislation.

These groups all met online, and had a mix of persons with lived experience, including unpaid carers and practitioners, though not always in equal numbers. As they developed their work, participants recommended experts from around the world, as well as within Scotland who could help with our deliberations. The ease with which we can now connect globally online made such meetings more accessible than might have been the case pre Covid. The extent of engagement is detailed at the end of this section.

Halfway through the Review, on the recommendation of the Communication and Engagement group, we also established two reference groups, a lived experience and unpaid carers group and a practitioners group. These groups were tasked with giving early feedback on emerging ideas for reform from the Executive team. Their help made a huge difference to the work of the Review.

A second, wide ranging consultation was carried out in spring of 2022, and a small consultation on 3 particular matters, followed that in May/June 2022. For this, and the earlier consultation in 2020, we were obliged to use the citizen space framework which unfortunately does not lend itself to the kind of discursive consultation we needed to have to explore the ideas for reform. We are hugely grateful to those who persevered and completed all or indeed any of our consultations.

It is no exaggeration to say that without so many people giving up their time and being so willing to share their expertise from all walks of life we could not have completed this Review. Thanks are due to everyone who has contributed. The responses to the consultations, and information gathered from the many meetings and discussions inform the final recommendations of the Review.

Lessons learnt

Carrying out a Review like this brings its own challenges at the best of times, never mind when a global pandemic stops the world in its tracks. The Review had to develop in a way unimaginable at the outset.

What did not waiver though was the stated objective of ensuring persons with lived experience, including unpaid carers, were at the centre of this Review. But that statement of intent, has to be backed up with resources appropriate to the needs of the individual.

Our Executive team members with lived experience, have given of their time willingly, but due to staffing challenges in the secretariat, exacerbated by Covid, it was only halfway through the Review that we were able to provide those team members who needed it with the support they should have had from the outset. Consideration also needs to be given by the Scottish Government in the future as to what sort of recompense should be available for a role like this.

But beyond our Executive team members, we need to think about the impact contributing to work like this can have on people with lived experience, and unpaid carers. They are giving up their own time, working around their other commitments, including caring commitments and received nothing in return except our grateful thanks. We make recommendations through out the Report about the need for engaging with people with lived experience, including unpaid carers on an equal footing with others, This needs to include consideration of the costs, often unseen, linked to such participation. This can be anything from the right IT equipment, payment or recompense, a support person to talk things through with, culturally aware interpreters, respite care, replacement care costs or even simply allowing people a little more time – it will be different for every person but that needs to be recognised and accounted for. We did not do as well as we could have done in this respect, and we are sorry for that.

More online meetings meant less travel time, which was beneficial for many, but it did mean we were reliant on participants who had sufficient technology to participate in this way. This is unfair and is another area the Scottish Government needs to consider when looking at equal participation for people with lived experience, including unpaid carers

Online meetings also meant that though in some ways we were all finding our feet, as no one was immune from forgetting to release the mute button, it also meant that the checks and support that can be provided in the margins of meetings don't take place. Though we are moving towards more in person meetings the online and hybrid meetings will continue, and we need to learn how to meet the challenges these create. Many of our stakeholder groups have developed good ways of working, to make online and hybrid meetings more inclusive and we need to learn from these.

This is particularly important when, as was the case in a number of our meetings, sensitive topics were being discussed, which could be difficult for some to deal with. It is our regret that we did not manage to address this appropriately during the Review.

If the Scottish Government is truly committed to working with the full and equal participation of persons with lived experience, including unpaid carers, then proper planning and resourcing is required. We recommend this starts with working with people with lived experience, including unpaid carers, to develop clear guidelines for how such joint work should be undertaken in the future.

SMHLR
September 2022

Advisory Groups

Subject	Members	People with Lived Experience	Lived Experience Organisation	Professional Organisation	Meetings
Communications and Engagement Advisory Group	10	4	SeeMe	Health and Social Care Alliance Scotland (The Alliance)	20
	includes people with both professional and lived experience		The Alliance	SIAA	
				Royal College of Psychiatrists	
				Royal Edinburgh	
				SHRC	

Involuntary Care and Treatment Advisory Group	7	3	Mental Health Network Greater Glasgow	Mental Health Tribunal for Scotland	12
			The Alliance	Scottish Association for Social Workers	
				Royal College of Psychiatrists	
				SIAA	
Capacity and Supported Decision Making	10	5	Advocard	Mental Welfare Commission	17
				Napier University School of Health and Social Care	
				University of Glasgow School of Health and Wellbeing	

				Legal Services Agency	
				University of Edinburgh School of Social and Political Science	
Economic, Social and Cultural Rights	5	2 MH	See Me	SHRC	6
		1 Carer	CAPS		
			HUG		
Children and Young People	5	1MH		CAMHS	8
		1 Carer		Additional Support Needs Tribunal	

				Mental Welfare Commission	
				Childrens Hearings Scotland	
Adults with Incapacity Advisory Group	9			Mental Health Officers	6
				Office of the Public Guardian	
				Mental Welfare Commission	
				University of Stirling	
				Law Society of Scotland	
				SOLAR	
				Royal College of Psychiatrists	

Adult Support and Protection working gorup	15			ASP Leads and Convenors:	3
				Glasgow	
				Shetland	
				North Ayrshire	
				Perth and Kinross	
				Inverclyde	
				Argyll & Bute	
				Orkney	
				Renfrew	

				Shetland	
				University of Stirling	
				University of Edinburgh	

Reference Groups

Lived Experience Reference Group met on 11 occasions	
The membership of the group included 14 individuals people with lived experience of mental health and incapacity law, either personally or as a carer.	
Representation from lived experience organisations included	Scottish Youth Parliament
	Acumen Network
	Alliance
	Alzheimers Scotland
	People First
	Sikh Sanjog

Practitioners Reference Group met on 9 occasions	
Organisation	Name
MWC	Julie Paterson
Rpsych	Andrew Watson
Rpsych 2nd rep	Jana DeVilliers
Law Society	Helen McGinty

Law Society	Karen Kirk
Social Work Scotland	Greg Muldoon
Royal College of Occupational Therapists	Alan White
Lead Consultant - Assembly at Values into Action Scotland	Sonya Bewsher
Mental Health Nurses Forum	Peter Lerpiniere
Clinical Forensic Psychologist, NHS Lothian	Mark Ramm
Renfrewshire Council	Bob Leslie
MHTS 2nd rep	Jennifer Whyte
Scottish Human Rights Commission	Cathy Asante
Professional Social Work Adviser Adult Support and Protection	Jamie Aarons

Engagement activities supporting the work of the Review

The Review Team met with Lived Experience Organisations

Organisation	Date	Date	Date
Alma	15/01/2020		
Jeans Bothy	04/02/2020	12/02/2020	
SeeMe	13/02/2020		
Cairnfowk	18/02/2020		
Royal Edinbrugh Hospital	19/02/2020		
Hope Kitchen	05/03/2020		
Safe and Sound	06/03/2020		
Gartnaval Royal	10/03/2020		
SAMH	10/03/2020		
GAMH diverse voices	27/03/2020		
James Support Group	24/04/2020		
Bipolar Ayrshire	19/05/2020		
Highland Bipolar	11/06/2020	02/07/2020	
West Lothian Bipolar	18/06/2020	16/07/2020	21/04/2021
Dundee Bipolar	25/06/2020		
Glasgow West Bipolar	02/07/2020	09/05/2021	17/05/2021
Bipolar Forth and Fife	11/08/2020		

Borders Biolar	19/08/2020		
Royal Ed Patients Rights Group	07/12/2020		
Alzheimer's Scotland	19/01/2021	15/11/2021	
HUG	08/04/2021		
CAPS Independent Advocacy	16/04/2021		
Bipolar Scotland Paisley	10/05/2021		
SISCO	17/05/2021		
Bipolar Group Orkney and Shetland	21/05/2021		
Bipolar Dundee and Ayrshire	01/06/2021		
Bipolar Youth	11/08/2021		
Sikh Sanjog	19/10/2021		
PASDA (Parents of ASD Adults)	22/11/2021		
SCLD	24/11/2021		
Feniks	24/11/2021	26/07/2022	
People First	24/11/2021		
Grampian Regional Equality Council	17/01/2022		
SCLD	26/01/2022	30/03/2022	10/08/2022
Thrive Edinburgh	17/03/2022		

Carer's Trust	20/04/2022	27/04/2022	03/05/2022
MWC Lived Experience Group	28/04/2022		
Pachedu	10/05/2022		
Carer's Trust - Young carers	11/05/2022		
Edinburgh Voluntary Organisations Council	18/05/2022		
Conyach	04/08/2022		

The Review Team met with Professional Organisations

Learning Disabilities and Autism Review
Royal College of Nursing
National Taskforce for Human Rights Leadership
Alliance
CAMHS
Royal College of Psychiatrists
Alliance
National Autistic Society
Mental Welfare Commission
Adult Support and Protection Convenors Scotland (ASPCS)
Alliance
Royal College of Psychiatrists
EHRC
Law Society of Scotland
Mental Welfare Commission
Mental Welfare Commission
Equality network
Social Science Research Network
INQUEST
Mental Health Tribunal for Scotland
Guys Cross - Care Quality Commission
Forensic Network

Mental Welfare Commission
Royal College of Psychiatrists
ASP Leads
EHRC
Mental Welfare Commission
Mental Haelth Quality and Safety Board
Social Work Scotland - Mental Health Subgroup
Scotland's Mental Health Partnership
Scottish Association for Social Work
Law Society of Scotland
New Zealand Mental health and Wellbeing Commission
Royal College of Psychiatrists
Mental Health Tribunal for Scotland
Irish Mental Health inquiry
Scottish Human Rights Commission
The Promise for Scotland

The Review Team met with Experts

The review team spoke with experts whose knowledge helped them to develop ideas on how the law should be in future. The fact that an expert took part in the review does not imply that they agree with the recommendations. The experts are not responsible for the recommendations.

Derek Feeley	Chair of Independent Review of Adult Social Care	Independent Review of Adult Social Care
Derek Feeley	Chair of Independent Review of Adult Social Care	Independent Review of Adult Social Care
Professor Bill Fulford	Fellow and Director of the Collaborating Centre for Values-based practice, St Catherine’s College, Oxford	University of Oxford
Adrian Ward	Convener of the Law Society's Mental Health and Disability Committee	Law Society of Scotland
Michelle Funk	Unit Head, Policy, Law and Human Rights, Department of Mental Health and Substance Use	World Health Organisation
Professor Bernadette McSherry	Commissioner	Victorian Law Reform Commission
Professor Gerard Quinn	Special Rapporteur on the rights of persons with disabilities	United Nations Human Rights Council
Dr Piers Gooding	Research Fellow	Melbourne Law School
Dr Martin Zinkler	Clinical Director	Klinikum Bremen-Ost

Tina Minkowitz	President and founder	Center for the Human Rights of Users and Survivors of Psychiatry
Professor Steve Pilling	Professor of Clinical Psychology & Clinical Effectiveness	University College London
Professor Sir Graham Thornicroft	Professor of Community Psychiatry	Kings College London
Professor Peter Bartlett	Professor of Mental Health Law	Univesrsity of Nottingham
Dr Roberto Mezzina	Vice President (Program Development)	The World Federation for Mental Health in Europe
Professor Sashi Sasidharan	Professor of Psychiatry	University of Glasgow
Professor Bronwyn Fredericks	Pro-Vice Chacellor (Indigenous Engagement)	University of Queensland
Professor Richard Whittington	Department of Mental Health	Norwegian University of Science and Technology
Robbie Pearson	Chief Executive	Health Care Improvement Scotland
Karen Reid	Chief Executive	NHS Education for Scotland

Katie Boyle	Chair of International Human Rights Law	University of Stirling
Professor Tom Burns	Emeritus Professor of Social Psychiatry	University of Oxford
Dr Jacqui Dyer	President	Mental Health Foundation
Professor Scott Weich	Professor of Mental Health	The University of Sheffield
Helen McGinty	Solicitor	Specialising in mental health and incapacity law.
Professor Brendan Kelly	Professor of Psychiatry	Trinity College Dublin
Individual	Mental Health Officer	Renfrewshire Council
Individual	Mental Health Tribunal Convenor	Advising on named persons and curators ad litem
Individual	Legal services advisor	South Lanarkshire Council
Individual	Mental Health Tribunal Convenor	Advising on (also with Lived experience of) guardianship

Evidence Sessions

During the phase one “Call for Evidence” consultation, the Review Team hosted a series of evidence sessions.

Subject	Workstream/overarching	Sessions
CYP Evidence Sessions	Children and Young People	9
ESC Evidence Sessions	Economic, Social and Cultural Rights	4

Witnesses at ESC sessions	
Professor Alan Miller	National Taskforce for Human Rights Leadership
Dr Andrew Watson	Royal College of Psychiatrists
Dr Jana de Villers	Royal College of Psychiatrists
Wendy McAuslan	VOX
Liz MacWhinney	Lanarkshire Links
Genevieve Smith	Royal College of Occupational Therapists
Lucy Mulvagh	Health and Social Care Alliance
Rob Gowans	Health and Social Care Alliance

Sandy Riddell	Mental Welfare Commission
Julie Paterson	Mental Welfare Commission
Dr Arun Chopra	Mental Welfare Commission

Children and Young People Evidence Sessions	
There were two complementary strands of evidence taking. The first was a series of 9 formal evidence sessions involving 22 expert stakeholders and advisory group members, led by Colin McKay and conducted online. The witnesses are listed below. The second was a more informal set of discussions involving carers/parents and young people, led by Karen Martin. These were, by request, mainly conducted via telephone. A total of 42 individual carers/parents interviews were carried out, plus a group meeting of eight carers/parents from Enable. These all took place between mid-August to end October 2020. During some of the interviews, some of the carers/parents advised that their son or daughter also wanted to provide evidence of their experiences. This meant that four young people, all with experience of, in but now away from, CAMHS, were interviewed about their experiences.	
Informal Interviews	
42 individual carers/parents	
Group meeting with 8 carers/parents	Enable
4 young people with experience of CAMHS	
Witnesses at formal sessions	
Dinah Aitken	Salvesen Mindroom
Carole Murphy	Children and Young People’s Centre for Justice

Professor Derek Auchie	Health and Education Chamber
Carly Edgar	Who Cares Scotland
Pauline Cavanagh	Partners in Advocacy
Paul O’Kane	ENABLE Scotland
Karen Gray	Social Work Scotland
Suzanne Martin	SAMH
Laura Dunlop	Mental Health Tribunal for Scotland
Cara Spence	LGBT Youth Scotland
Dr Kirsty Forsyth	National Autism Implementation Team
Megan Farr	Children and Young Persons Commissioner for Scotland
Dr Arun Chopra	MWC
Dr Kevin Brown	Royal College of Psychiatrists
Dr Duncan Manders	Royal Collage of Psychiatrists
Angela Morgan	Independent review of implementation of additional support for learning
Alistair Hogg	Scottish Children’s Reporters Administration
Claire Stuart	Care Review/The Promise

Dr Katharine Russell	British Psychological Society
Dr Carey Lunan	Royal College of GPs
Hugh McAloon	Scottish Government
Stephen Macleod	Scottish Government

Round Table Meetings

Host	Subject	Present	Individuals	Date
SMHLR	Meeting on Scrutiny & Accountability	NHS Education for Scotland		24/02/2022
		Mental Welfare Commission		
		Healthcare Improvement Scotland		
		Scottish Human Rights Commission		
		Public Guardian & Accountant of Court		
		Public Health Scotland		
		Scottish Public Service Ombudsman		
		Care Inspectorate		
		Audit Scotland		

SIAA	SIAA Round table	SIAA		13/04/2022
SIAA	SIAA Round table			27/06/2022
SIAA	SIAA Round table			27/06/2022
SMHLR	Dual Expert Meeting	a series of meetings with a small group, all of whom have both professional experience and lived experience which is relevant to the Review.		06/05/2022
SMHLR	Data Meeting	Mental Welfare Commission		06/05/2022
		Population Health Analysis Unit, Scottish Government		
		EHCR		

		Public Health Scotland		
		University of Edinburgh, School of Law		
SMHLR	Meeting on Mental Disorder and Fusion	Institute of Psychiatry, Psychology and Neuroscience, Kings College London	George Szmukler	08/06/2022
			Alex Ruck Keene	
		Ireland's Mental Health Commission	Aine Flynn	
		Royal Courts of Justice Belfast	Hilary Wells	
		Queen's University Belfast	Gavin Davidson	
Equality Network	LGBTI - Scottish Mental Health Law Review	Scottish Trans Alliance		14/06/2022
		the Equality Network		
		LGBT Health and Wellbeing		

		The Royal Ed Patients Council		
		the Volunteer Hub in the Royal Ed		
		community members		
		people with lived experience.		
SMHLR	Age Considerations for SMHLR	Scottish Government - Professional Social Work Advisor	Jamie Aarons	29/06/2022
		Scottish Government - Adults with Incapacity Legislation and Practice	Peter Quigley	
		The Institute for Research and Innovation in Social Services (Iriss)	Andreea Bocioaga	
		The Office of the Public Guardian in Scotland	Danielle Rose	
		The Office of the Public Guardian in Scotland	Fiona Brown	

		Scottish Government - Youth Justice and Children's Hearings Unit	Deborah Nolan	
		Scottish Government - Community Justice	David Thomson	
		Scottish Government - Supporting Disabled Children and Young People	Sara Hampson	
SMHLR	Ethnic minority Roundtable event	Radiant and Brighter	Michael Matovu	05/07/2022
		Sikh Sanjog	Trishna Sing	
		BEMIS	Tanveer Parnez	
		Amina	Furrah Riaz	
		Edinburhgh and Lothians Regional Equlaity Council	Parveen Ishaq	
		PKAVS	Jenni Keenan	
		Saheliya	Pervin Ahmad	

EVOC	Meeting with EVOC BAME Group	Feniks		14/07/2022
		Media Education Independent Researcher		
		Mwamba		
		EVOC		
		Sikh Sanjog		
		Greatway Foundtion		
		EaRN		
		The Welcoming		
		CAPS Independent Advocacy		
		Naina Minhas (NKS)		
		Rukhsana (MILAN)		

SMHLR	Advanced Statements	Mental Health Network Greater Glasgow	Gordon McInnes	19/07/2022
		Individual with lived experience		
		Circles Network	Rhiannon Harrison	
		Advocard project		
SMHLR	Section 297 of 2003 Mental Health Act	Napier University - Centre for Mental Health Practice, Policy and Law Research	Inga Heyman	04/08/2022
		Scottish Police Authority	Martyn Evans, Amanda Coulthard	

		Police Scotland	Chief Inspector Ian McKinnon	
		Mental Welfare Commission	Dr Arun Chopra	

Engagement Events

ALLIANCE UNCRPD/ ECHR EVENT	The purpose of this event to raise awareness of Human Rights and the UNCRPD and to aid understanding of how they link to care, treatment and everyday life so that individuals can feel empowered to make sure their rights are upheld. The event was hosted by the Alliance, who also invited all Alliance members to nominate attendees, consisting of practitioners and people with lived experience. Attendees additionally included those on the Review's mailing list.	22/09/2021
Engagement Event - Autism	The purpose of the event to seek the views from those working or living within the Autism community. Invites were sent to autism organisations and group. Invitees were asked to share the invitation within their organisation or to anyone with lived experience who would like to come along to hear what the review is about and have a say in the recommendations. There were 16 guests in attendance at the meeting including people with lived experience, a carer, representatives from NAS across Scotland, EVOC, NAIT Scotland and Autism Awareness Scotland	16/05/2022

Engagement Event - Learning Disability	The purpose of the event to seek the views from those working or living within the Learning Disability community. Invites were sent to organisations and groups. Invitees were asked to share the invitation within their organisation or to anyone with lived experience who would like to come along to hear what the review is about and have a say in the recommendations. There were seven guests in attendance at the meeting. There was a good mix of experience, including people with lived experience in attendance.	17/05/2022
Engagement Event – Ethnic minority communities	The purpose of the event to seek the views from those working or living with ethnic minority communities. Invites were sent to organisations and groups. Invitees were asked to share the invitation within their organisation or to anyone with lived experience who would like to come along to hear what the review is about and have a say in the recommendations. There were two guests in attendance at the meeting, with representatives from CRER and EVOC.	18/05/2022

Engagement Event - Dementia and alzheimers (suggested time)	The purpose of the event to seek the views from those working or living within the dementia and alzheimers community. Invites were sent to organisations and groups. Invitees were asked to share the invitation within their organisation or to anyone with lived experience who would like to come along to hear what the review is about and have a say in the recommendations. There were 4 guests in attendance at the meeting including representatives from Endicam, About Dementia, Alzheimer Scotland.	23/05/2022
Engagement Event - Mental illness and personality disorder (suggested date)	The purpose of the event to seek the views from those working or living within the mental illness and personality disorder community. Invites were sent to organisations and groups. Invitees were asked to share the invitation within their organisation or to anyone with lived experience who would like to come along to hear what the review is about and have a say in the recommendations. There were 3 guests in attendance at the meeting representing Stirling University, Greater Glasgow Mental Health Network and Support in Mind Scotland.	23/05/2022

Engagement Events – Royal College of Psychiatrists Scenarios event

The Royal College of Psychiatrists in Scotland and the Scottish Mental Health Law Review are held an online event on Thursday 17th February 2022 to identify and discuss potential reforms to the Mental Health (Care and Treatment) (Scotland) Act 2003, Adults with Incapacity Act, and Adult Support and Protection Act. This was invitation only event involving psychiatrists, the review team and key stakeholders.

During the event scenarios were discussed which highlight dilemmas and difficulties in the way mental health law operates. The aim was to explore whether the recommendations proposed by the Review will work in practice to resolve some of these issues.

There were 60 guests at the event representing the following:		
3 Individuals with lived experience		NHS Grampian
Advocard		NHS Greater Glasgow and Clyde
Argyll and Bute Hospital		NHS Lanarkshire
Autism and Learning Disabilities Team, Directorate for Mental Health and Social Care, Scottish Government		NHS Lothian
Bipolar Scotland		NHS Tayside
Clackmannanshire and Stirling HSCP		organisation

Dumfries and Galloway Carers Centre		PLUS Perth and Kinross
Dundee Drug & Alcohol Recovery Service (DDARS)		Renfrewshire Council
Edinburgh Carers Council		Royal College of General Practitioners
Forensic Faculty in Scotland		Royal College of Nurses
Forensic Mental Health, GGC		Royal College of Psychiatrists
Mental Health Network Greater Glasgow		Royal Edinburgh Hospital
Mental Health Services, NHS Ayrshire & Arran		Scottish Recovery Network
Mental Welfare Commission		Social Work Scotland
MHTS		Support in Mind Scotland
National Autistic Taskforce		The Law Society of Scotland
New Craigs Hospital Inverness		The State Hospital
NHS Borders		University of Glasgow
NHS Education for Scotland		University of Leeds
NHS Forth Valley		

Engagement Events – Royal College of Psychiatrists Scenarios event

The Child and Adolescent Faculty of the Royal College of Psychiatrists in Scotland and the Scottish Mental Health Law Review held an online event on 8th September 2021 to identify and discuss potential reforms to the Mental Health (Care and Treatment) (Scotland) Act 2003, as it affects children and young people.

This was an invitation only event involving psychiatrists, the review team and key stakeholders.

During the event scenarios were discussed which highlight dilemmas and difficulties in the way mental health law operates for children and young people The aim was to explore possible ways forward.

Organisations represented included:		
Active Health Edinburgh		NHS Lothian
CAMHs		NHS Scotland North
Glasgow Private Clinic		NHS Tayside
Health and social Care - North Lanarkshire		NHS Tayside
High Secure Intellectual Disability Service for Scotland and Northern Ireland		North Lanarkshire Council MHO service
Law Society		Royal College of Psychiatry Children and Young People's Faculty
Mental Health Nursing Forum		The Huntercombe Group

MHTS		University of Edinburgh
NHS Lothian		University of Glasgow
NHS Lothian		

Conferences, seminars and webinars

The Review Team accepted invitations to speak and take questions about the work of the review at the following events and meetings:

Mental Health Partnership Conference	11/12/2019
HSPC Conference	12/12/2019
Legal Service Agency Mental Health Conference	13/02/2020
Mental Health Officers Conference	14/02/2020
Our Mental Health Matters, it’s time to talk - Scottish Gypsy/Travellers	14/02/2020
ASP National Strategic Forum	03/03/2020
SOLAR Conference	12/03/2020
MHJ Policy Lab	04/05/2020

Five Nations Seminar on Adult Support and Protection	08/02/2021
SASO - Autumn Webinar Series	18/11/2021
Mental Health & Justice Project and King's Policy Institute POLICY LAB (hosted by)	23/11/2021
Sikh Women Spreak - Scottish Parliament	07/12/2021
MHO Conference	23/02/2022
Napier University - Centre for Mental Health and Capacity Law Webinar	23/03/2022
State Hospital seminar series	18/05/2022
7th World Congress on Adult Capacity	07/06/2022
Forensic Network webinar	21/06/2022

Responses to consultations

Phase 1: Initial Consultation

Summary of Response to the Consultation

Responses received - 264

Individual - 157 Professionals and organisations - 74

33 responses did not say whether they were from an individual or an organisation.

Adult Support and Protection Committees, Argyll and Bute, Inverclyde, and East Ayrshire		Mental Health Tribunal for Scotland
Advocacy Highland		National Autistic Society Scotland & Scottish Autism (Joint Submission)
Advocacy North East		NHS Ayrshire & Arran
AdvoCard		NHS Borders
Age Scotland		NHS State Hospital Board for Scotland
Angus Health and Social Care Partnership		NHSGGC - AHP Mental health Advisory Committee
Area Psychology Committee		North Ayrshire
Association of Clinical Psychologists - UK		North Ayrshire Adult Protection Committee
Bipolar Scotland		Partners in Advocacy
Bipolar West Lothian		Patients' Advocacy Service

BMA Scotland		People First
British Psychological Society		Police Scotland
British Transport Police		Psychosis Research Group (University of Glasgow: Institute of Health and Wellbeing)
CAPS Independent Advocacy		Renfrewshire Adult Protection Committee
Care Inspectorate		RNC Scotland
City of Edinburgh Council		RNIB Scotland
Coalition for Racial Equality and Rights		Royal College of Occupational Therapists
Dundee Health and Social Care Partnership		Royal College of Psychiatrists in Scotland
East Ayrshire Health & Social Care Partnership		Royal Edinburgh Hospital Patients Council
Edinburgh Peer Collaborative		SAMH (Scottish Association for Mental Health)
Equality and Human Rights Commission		Scottish Association of Social Work
Equality Network		Scottish Borders Adult Protection Delivery Group
Faculty of Advocates		Scottish Borders Health & Social Care Partnership

Falkirk Council Community Care		Scottish Commission for People with Learning Disabilities (SCLD)
Falkirk Health and Social Care Partnership		Scottish Independent Advocacy Alliance
Families in Trauma		Scottish Mental Health Nurse Leads Group
Families Outside		Scottish Public Services Ombudsman
Forensic Mental Health Services Managed Care Network (Forensic Network)		SeeMe
Glasgow City Council/Glasgow City Health & SOcial Care Partnership		Senators of the College of Justice
Heads of Learning Disability Services Scotland (HOLDSS)		Shetland Islands Council - Mental Health Officers
Health and Education Chamber (HEC)		Social work department
Health and Social Care Alliance Scotland (the ALLIANCE)		SOLAR
HEC Scott Review		Stirling Council
Inclusion Scotland		Support in Mind Scotland
Law Society of Scotland		The Royal College of Speech and Language Therapists

Medical Advisory Committee of The State Hospital		The SOLD Network
Mental Health Network Greater Glasgow		West Lothian Health and Social Care Partnership

The Review also asked VOX, an organisation led by members with lived experience of mental health laws and treatment, to arrange meetings with people whose voices are not always heard, to ensure the widest range of views were gathered for the Review. Meetings were held in Glasgow, Inverness and Dundee where VOX engaged with 62 individuals, these sessions were held with VOX members. VOX engaged with 28 other individuals from the following groups (all groups which provide support for people with mental health problems):

Alma

Jeans Bothy

GAMH - Young adults mental health group/arts group for severe mental health problems

Phase 2: Second Consultation

Received 124 responses.
88 were from organisations (44 responded online and 44 by email).
36 were from individuals (28 responded online and 8 by email).

Email responses		Online responses
Advocating together		Aberdeen City Health and Soci
ALLIANCE		AdvoCard
Autism Rights		Age Scotland
British Psychological Society		British Deaf Association Scotland
Carers Trust on behalf of the National Carer Organisations		British Transport Police
Carr Gomm		CAPS Independent Advocacy
Challenging behaviour foundation		Care Inspectorate
Children in Scotland		Children and Young People's Commissioner Scoltand
COSLA		Coalition for Racial Equality and Rights
Edinburgh THRIVE		East Ayshire Health and Social
Edinburgh Carer’s Council Forum		East Dunbartonshire Adult Protection Committee
EHRC		East Dunbartonshire Health and Social Care Partnership

ENABLE - ACE Members		Edinburgh Community Voices (supported by Advocard)
ENABLE Scotland		Families Outside
EVOC		Forensic Mental Health Services
Fife Council ASP Committee		Healthcare Improvement Scotland
General Medical Council		Independent Advocacy Perth & Ki
Glasgow City Council		Medical and Dental Defence Unio
Health and Education Chamber, Scottish Courts and Tribunal Service		Mental Health Rights Scotland
Includem		Mental Welfare Commission
Inclusion Scotland		Moray Council
INQUEST		National Forensic Allied Health Professionals
Lothian Voices		NHS Education for Scotland (NES
Mental Health (Adult Social Work), community Health and Social Care, Lerwick		NHS Greater Glasgow & Clyde Are
Mental Health Worker Forum		Parkinson's UK Scotland
Mental Helath Network Greater Glasgow		Patients' Advocacy Service
Midlothian HSCP		Police Scotland

My Rights My Say		Psychiatric Rights Scotland
National Autism Implementation Team		RCN (Royal College of Nursing)
National Autistic Society		Royal College of General Practtionersi
NHS GGC		Royal College of Psychiatrists
Partners in Advocacy		Salvesen Mindroom Centre
People First		SAMH
SCLD		Scottish Association of Social Work
Scottish Borders Public Protection Committee		Scottish Faculty of Eating Disorders – Royal College of Psychiatrists
Scottish Courts and Tribunals Service		Scottish Independent Advocacy Alliance
Scottish Social Services Council		Scottish Law Agents' Society
SHRC		Scottish Public Services Ombudsman
Social Work Scotland		See Me
SOLAR		Sense Scotland
South Lanarkshire ASP		Social Work Services – Dumfries and Galloway council
The Law Society		Stirling Council
The Royal Society of Edinburgh		Support in Mind Scotland

Voiceability		The Royal College of Physicians of Edinburgh

The Review again asked VOX, an organisation led by members with lived experience of mental health laws and treatment, to arrange meetings with people whose voices are not always heard, to ensure the widest range of views were gathered for the Review.

Organisation	Participants
Bipolar Scotland	10
HUG – Spirit Advocacy	8
Sharpen Her: African Women's Network	10
Oban, New Hope Kitchen	14
Kintyre Link Club	8
Other - Phone call and email	6
Total participants	**56**

Phase 3: Additional Proposals Consultation

We received 74 responses.

54 responded online and 20 via email.

54 were from organisations and 20 were from individuals.

Online	Email
AdvoCard	CAPS Independent Advocacy
British Deaf Association Scotland	Care Inspectorate
Compassion in Dying	Equality and Human Rights Commission
Dunfermline Advocacy	General Medical Council
Edinburgh Health & Social Care Partnership - City of Edinburgh Council	Heads of Forensic Services in NHS Scotland
Enable Scotland	Independent Advocacy Perth & Kinross
Families Outside	Law Society of Scotland
Forensic Mental Health Services Managed Care Network	Mental Health Network Greater Glasgow & Clyde
Forth Valley Advocacy	Mental Health Tribunal for Scotland
MDDUS (Medical and Dental Defence Union Scotland)	People First (Scotland)
Mental Welfare Commission	People First (Scotland) - Supporting Offender with a Learning Disability (SOLD)
Midlothian HSCP	Scottish Association for Mental Health (SAMH)
NHS Greater Glasgow and Clyde	Scottish Commission for people with Learning Disabilities (SCLD)
Patients' Advocacy Service	Scottish Dementia Working Group (SDWG) & National Dementia Carers Action Network (NDCAN)

Perth & Kinross HSCP/Council	Senators of the College of Justice
Police Scotland	Society of Local Authority Lawyers and Administrators in Scotland (SOLAR)
Psychiatric Rights Scotland	The Scottish Courts and Tribunals Service
Royal College of General Practitioners Scotland	Vox Scotland
Royal College of Nursing Scotland	
Royal College of Psychiatrists in Scotland	
Salvesen Mindroom Centre	
Scottish Association of Social Work (SASW)	
Scottish Learning Disabilities Lead Nurse Group	
Scottish Partnership for Palliative Care	
Scottish Public Services Ombudsman	
See Me	
Sense Scotland	
South Ayrshire Health and Social Care Partnership	
South Lanarkshire Council	
Support in Mind Scotland	
The Advocacy Project	
The Royal College of Physicians of Edinburgh.	
The Scottish Children's Reporter Administration (SCRA)	
The Scottish Independent Advocacy Alliance (SIAA)	

VoiceAbility	
Who Cares? Scotland	

Collective Advocacy Consultation

Members of the Review’s Economic, Cultural and Social Rights Group with experience of collective advocacy wrote a short paper on collective advocacy for a targeted consultation exercise over summer 2021. The aim of the consultation was to get feedback on collective advocacy generally and the Executive Team’s ideas for strengthening it. We published the consultation paper and a summary of the responses we received. We got responses from:

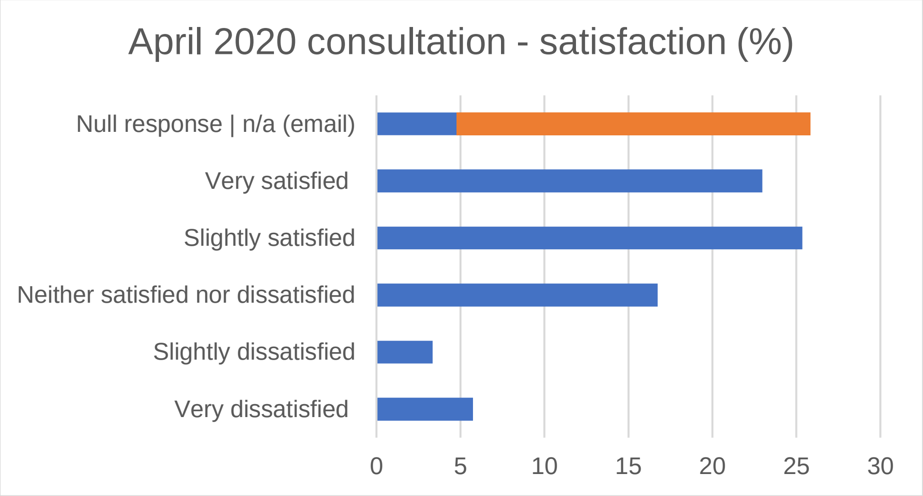
Advocard
ARGH
CAPS Independent Advocacy
Edinburgh Carers Council
Enable ACE
Law and Human Rights Group, People First (Scotland)
Member of the Review’s Lived Experience Reference Group
Mental Health Advocacy Project
Mental Health Network (Greater Glasgow)
Royal Edinburgh Hospital Patients Council
Scottish Human Rights Committee
Spirit Advocacy
VOX (Scotland)

Triangle of Care Consultation

The Communication and Engagement Advisory Group carried out a survey with mental health practitioners in Spring 2021. The aim was to find out what they knew about engaging with carers and the role they should play in this process. We published the survey and a summary of the responses we received. Responses were received anonymously, from 87 professionals across Third Sector, CAMHS, acute settings, community settings, learning disabilities, forensic services, addictions and other. Professions included: nurses, mental health officers, psychiatrists, advocates, GPs, and other health professionals.

Respondent satisfaction

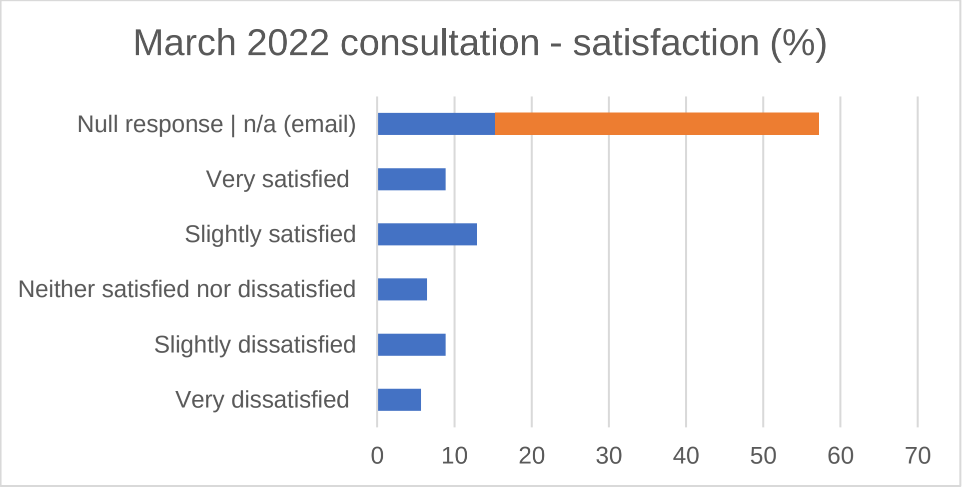
<u>April-May 2020 Initial Consultation (N=209)</u>



The initial consultation, which asked for respondents' views on their experiences of mental health law, went live in April 2020. It was positively received on the whole. 209 individuals and organisations responded. 21% (N=44) of responses were received via email, whereby satisfaction could unfortunately not be recorded. It is therefore not possible to provide feedback on the experiences of those who emailed responses (this applies to all three of the consultations).

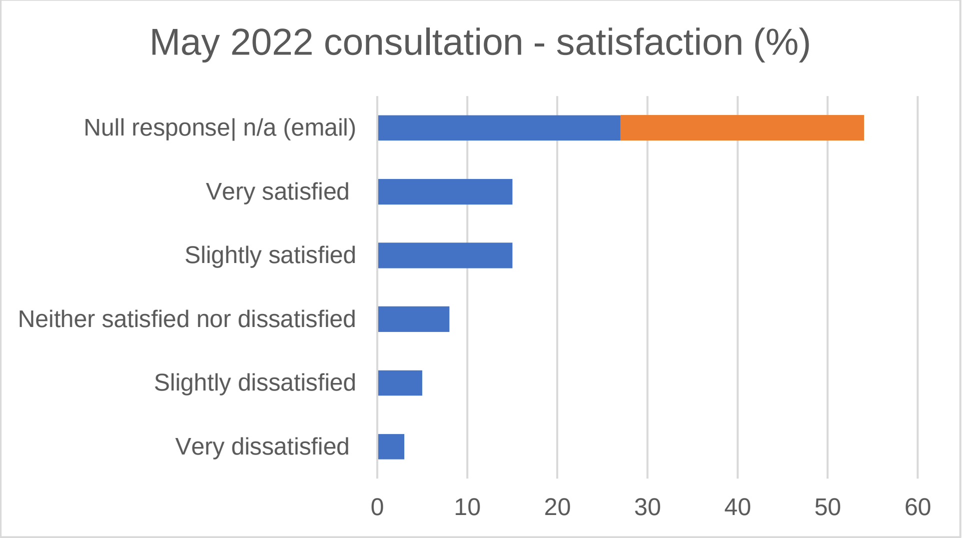
48% (N=100) of total responses stated they were satisfied or very satisfied with the consultation. Comments offered included praise for the breadth of the consultation and opportunity to express points of concern. Only 9% (N=19) offered an unsatisfied rating. Of these, the main comment was around lack of questions offered. 17% (N=36) reported being neither satisfied nor dissatisfied. A small proportion of these did provide additional feedback, highlighting aspects such as the overwhelm of the task, particularly for people with lived experience of mental or intellectual disability. 5% (N=10) provided a null response.

March-May 2022 Second Consultation (N=124)



The second consultation of the review, covering information across 13 chapters, asked for considerations across a wide range of proposals, many arising from the initial consultation. 124 people responded. 42% (N=52) of responses were email responses, where satisfaction was not recorded. Of those who responded online, 22% (N=27) of the total reported satisfaction with the consultation. The layout of the questions, overall clarity, and explanation were offered praise. Of the 15% (N=19) who reported dissatisfaction with the consultation, the majority of comments centred around complaint about accessibility, length and presentation. 15% (N=19) also provided a null response, a portion of which provided additional detail highlighting positives (such as scope of proposals and improved understandings of mental health inequalities); and a negative point (length of consultation).

May-July 2022 Additional Proposals Consultation (N=74)



74 responses were received during the additional proposals consultation. There was a higher degree of satisfaction with this consultation (where possible to discern), compared with the second consultation. It covered a further three sections of proposals for the review, emerging from earlier consultation. 27% (N=20) were non-applicable as email respondents, and the same proportion of total respondents provided a null response. Of those who responded to this part of the consultation, only 8% (N=6) reported dissatisfaction. It was commented that timing, business of mental health services, the summer period, and the volume around the additional proposals consultation may have affected how much people were able to respond. A further 8% (N=6) reported neither satisfaction nor dissatisfaction. Amongst this group, a point expressed was around being too focused on process as opposed to outcomes.

Of the total responses, 30% (N=22) reported being either very satisfied or slightly satisfied. Responses here included satisfaction with the easy read guide and general structure. There was also a positive comment that the important issues were being looked at, with consultees offered the opportunity to bring to light any issues overlooked. Time frame from completion was highlighted as slightly tight for larger organisations.

Annex C: Defining coercion

This is where we started

The consultation document asked for views on our understanding of ‘coercion’, which can be summarised as follows.

’Coercion‘ describes a very broad range of actions. Coercion is generally understood to involve force or the possibility of force. In many situations, some use of coercion can be necessary and proportionate as part of promoting and protecting all of a person’s relevant human rights. The Review is interested in all involuntary support, care and treatment.

There is a need to acknowledge the complexity of coercion so that it is possible for relationships between people and professionals to be open, honest and healing.

Actions can involve different levels of coercion. Coercion may involve a deprivation of liberty and actions against a person’s will and preferences, which can sometimes be justified in relation to human rights. Coercion can involve inducements. Anything done against a person’s free will may involve coercion. Coercion which involves inhuman or degrading treatment or disrespect for the person’s dignity can never be justified.

Lived experience tells us that in some situations, people are too unwell to take decisions, and that decisions may need to be taken with which they do not agree at that time, but the experience of compulsion is too often a distressing and traumatising one, and both the law and systems need to change to address this.

In some cases, earlier intervention might have avoided the need for coercion. Forms of coercion such as compulsory treatment and institutional care can sometimes continue for extended periods only because the support the person needs and deserves has not been put in place.

Culture and attitudes to reducing coercion are important, as are environments and relationships. Institutional cultures can shape attitudes and behaviours towards both voluntary and involuntary patients, with coercive effects which cause harm and no benefit.

There are many specific situations where coercion would be justifiable on the basis that its use in that way and in that situation respects, protects and fulfils that person’s human rights overall, and gives rise to much less harm than would arise if coercion was not used. Coercion, even where it is justified, carries some element of harm, both in the fact that a person’s autonomy has been interfered with, and because it can be distressing and even dangerous. It is important that we consider how best to mitigate these harms.

People who experience coercion are not always aware of harm, but coercion always affects a person’s human rights and may breach those rights. Coercion may be hidden from a person, or a person may be unable to identify or complain that they are experiencing coercion due to an impairment or an experience of disability.

Resistance may be a good indicator of coercion, but not all coercion is resisted. Coercion does not include support, care or treatment which is clearly given with informed consent. Involuntary support, care and treatment often involves coercion but not always. For example, a person with profound learning disability may be living at home with parents. Although informed consent is impossible for this person, there may be no coercion at all in this arrangement. However, we feel that there is a need to recognise coercive practices as such within all support, care and treatment which is in any way coercive. Coercion may be largely under-recognised within services at present. What is “coercive” can sometimes be defined objectively. For example, the use of force is coercive by definition. However, a person may experience coercion subjectively and may feel coerced through an action which is not viewed or intended as coercive by the person who carries out that action.

This is what people told us

We were interested in views on how the Review understands coercion, including views on whether “coercion” or some other word(s) should be used to describe the use of force, the possible use of force, and the experience of coercion. Responses indicated that this matters very much to people with lived experience and to professionals, although sometimes in very different ways. There was a wide range of responses, from strong support to strong disagreement.

Respondents who reflected lived experience tended to support the review's understanding of coercion, and also the use of the term 'coercion'. Most organisations expressed support for the Review's understanding of coercion. Individuals were evenly split. Most organisations did not clearly express a view on whether the word "coercion" should be used in practice. Of the minority of organisations which did clearly express a view on the word, most had a health focus and opposed the use of the word as proposed. Most individuals thought that a word other than "coercion" should be used and suggested a wide range of alternative words.

Agreement

The Royal College of General Practitioners had:

> "…no suggestion for [an] alternative to [the] term "coercion" - it is an uncomfortable word because it is an uncomfortable thing to consider, and so perhaps it is best to keep it to remind us all that coercion is a last resort…. We agree that we need to consider actively, as described in the consultation, more subtle forms of coercion in clinical work, always respecting the autonomy of the patient."

See Me, Scotland's programme to end mental health stigma and discrimination, said:

> "We believe the word "coercion" should be retained to make sure that individuals' experiences of stigma and discrimination, as well as the wider emotional and psychological impacts of coercive treatment, are reflected in the official language used to define their experiences. There should be no creation of linguistic loopholes such that, to borrow terminology from the consultation, an individual can "experience" coercion without actually being deemed to have been subjected to it. The accuracy of lived experience testimony must be respected as far as possible in all situations where coercion has been applied."

AdvoCard reported that they:

> “…see on a daily basis…the impact of secondary trauma on people who are being treated with coercion. This is in spite of very experienced practitioners doing everything they can to mitigate the impact of coercive practice…It is the view of many people that we have advocated for that they are being coerced when forcibly treated.”

We note that most coercive actions do not have malign intent. As Midlothian Health and Social Care Partnership wrote:

> “…not all coercion is bad…it is not a bad thing in itself, but…it needs a legal basis and needs to be justified in terms of benefit to a person’s rights overall.”

Support for the concept

Some professional respondents agreed with the review’s understanding of coercion, but were unsure about the use of the word ‘coercion’.

The Care Inspectorate agreed with the Review’s understanding of coercion as a concept and its effects on individuals in a variety of institutional and community settings. They wrote that:

> “…The term ‘coercion’ can have negative connotations. The Care Inspectorate has no further comment on the term’s suitability but would suggest that the efforts and measures taken to reduce both overt and covert coercion are the essential areas of necessary change in legislation and practice.”

The Royal College of Physicians of Edinburgh wrote that:

> “how the Review understands coercion adequately explains the context…”

but also that:

> “…perhaps a different word incorporating a view that these interventions may be put in place to reduce stress and distress may be considered.”

The Law Society of Scotland proposed a broader concept:

> “We recommend that proposals for reduction of coercion should address any non-consensual intervention of any kind, as well as analogous situations, such as where available choices are unduly limited to choices that suit providers rather than that may suit the individual.”

We assume that any ‘non-consensual intervention of any kind’ would include situations where there is no resistance from a person, but where there has been no attempt to identify the person’s will and preferences and to give effect to these. The Society was also concerned with situations where choices are limited to suit providers instead of the individual. We agree that these additional situations are important, and are relevant to all efforts to reduce coercion. We expect that the Review’s recommended actions on Supported Decision Making, Human Rights Enablement and economic, social and cultural rights would serve to reduce coercion in these situations. Our recommendations on reduction of coercion do not only apply to situations which would be covered by mental health law: they also apply to situations which would currently be covered by incapacity law. We think that there is also a range of situations which are not necessarily coercive even though informed consent has not been given – situations involving ‘non-voluntary’ interventions.

Disagreement

Several professional bodies and several individuals disagreed with both the Review’s understanding of coercion and proposed use of the word ‘coercion’. A common theme in these professional responses was the idea that coercion is always wrong, and that because the use of detention or compulsory care and treatment can be necessary and appropriate, coercion cannot therefore be an appropriate general concept or term. These respondents generally understood the word ‘coercion’ as roughly equivalent to ‘abuse’, so the term ‘coercion’ in relation to mental health services seemed stigmatising, pejorative and inaccurate.

The Royal College of Nursing responded:

> “Although we understand how the review seeks to use this word (as a ‘catch all’ and in a more literal and academic than a popular sense) it remains an unfortunate choice because it is a loaded word which does not account for the governing duties to which nursing are subject (as are other professions). The word suggests an inherently adversarial relationship between the person in receipt of care and treatment and the professionals providing that care and treatment. The relationship is typically anything but adversarial.”

We accept that the professional relationship is not typically adversarial. However, in our view, any approach to increasing benefits from services will be most effective where we consistently recognise the difference in power between professionals and people with lived experience of mental or intellectual disability, and the effects of that difference.

The Forensic Network proposed the term ‘compulsion’, “except when referring to an intent with ill will, and then “coercion” is appropriate.” The Network was:

> “…of the view that coercion is distinct from compulsion, and that the description of coercion by the Review does not reflect this. Coercion implies negative motivation.”

The Review’s understanding of coercion does not assume negative motivation.

The Royal College of Psychiatrists in Scotland, including its Faculty of Eating Disorders, responded as follows:

> "We consider that the term “coercion” is stigmatising and carries connotations of nefarious motivations and malpractice. It should not apply to the use of compulsion to deliver essential, potentially lifesaving care and treatment in the context of conflicting rights and impaired decision-making capacity. It should also be noted that coercion implies that a person has been persuaded. This disregards scenarios where a person is not able to express a view or their actions or views are being overridden in the context of the stipulations and safeguards of mental health legislation.

> …we believe that not all compulsory care, non-consensual treatment or restrictive practice is coercion. Coercion implies malign intent and definitions of it include the use of threats. Coercion also suggests a lesser infringement of rights at times than compulsion as it encompasses the concept that the person subject to it is ultimately persuaded. The terms compulsion, compulsory treatment, and non-consensual treatment are considered more appropriate, as well as restrictive practice.
>
> Terms which equate coercion and harm with mental health services alone and treatments delivered by them further stigmatise and marginalise those who call on, work in, and interface with such services in comparison with physical health care services for example."

Coercion can involve persuasion, but our understanding of coercion includes situations without persuasion, such as the use of restraint. This is discussed below with reference to a model which does not define coercion as being inherently wrong. We acknowledge the College's concern about stigmatisation of those who work in mental health services, but this concern was not reflected by most of the professional organisations which responded to the Review. Organisations representing people with lived experience tended to view the Review's understanding of 'coercion' as one which could reduce stigmatisation and marginalisation of people who call on mental health services.

The Mental Welfare Commission wrote that:

> "…in the literature around psychiatric care, coercion has become a word that has come to mean restrictive care and compulsory treatment. Coercion, in the view of the Commission, is always wrong but the Commission does not view all the practices that the review is bringing together under one umbrella term as coercive. In saying this, we recognise and we hear from individuals that they experience some actions as coercive.
> Restrictive practices require regulation, monitoring, scrutiny and analysis but there are moments in the care of an individual when these can be necessary to prevent harm to the person or to those around them. These are not necessarily coercive

> although they may involve the use of force. Coercion in the Cambridge Dictionary is defined as ‘the use of force to persuade someone to do something that they are unwilling to do’ in operative terms, threat is used/implied to persuade or intimidate someone into taking a course of action that they disagree with. It is a pejorative word that carries negative connotations and its use here distracts from the challenge that is to reduce the use of compulsory treatment and restrictive practices across settings. We prefer to use these terms.”

We do not agree with the Commission’s view that although coercion is defined in relation to the use of force or the threat of force, actions which may involve the use of force are ‘not necessarily coercive’.

With reference to the response from See Me, above, we do not think it is enough just to recognise that individuals “experience some actions as coercive”. That approach carries a risk of minimising or negating individuals’ experiences of coercion. Actions which are well-intended can still be coercive in reality.

We acknowledge that it is much more difficult to work in ways which reduce coercion in environments which are seriously understaffed, and environments which have not had adequate investment, all of which can only make it more difficult for staff to feel valued and to do their work effectively. We address these issues later in this chapter.

Reflection on responses

Some organisations suggested alternate definitions of coercion which would limit the meaning of ‘coercion’ to bad practice and to intentional actions including abuse. Whilst these can all be coercive, limiting the meaning of ‘coercion’ in this way would minimise the lived experience of coercion. For example, we have heard that people can experience harm through effective and appropriate detention and compulsory treatment by experienced and compassionate practitioners. Speaking of ‘coercion’ can be uncomfortable for professionals, but people with lived experience saw our understanding of coercion as accurate and important, not as a distraction.

In our view, it is necessary to use the concept and the word ‘coercion’, as only these can convey the objective and subjective experiences which some people have. It is possible to define ‘coercion’ clearly and in a way which makes sense in practice.

We understand that compulsory care and treatment is a relatively small part of all care and treatment, not the whole, but the use of compulsion continues to increase both in hospitals and in the community. As discussed below, it is not currently possible to know why this is so. However, we do not assume that this increase is due to any professional ‘preference’ for the use of compulsion: we understand that there is a range of increasing pressures on services, and we discuss rising rates below.

We also recognise that some respondents perceive ‘coercion’ as a loaded word which can only have a strongly negative meaning. We are recommending that ‘coercion’ is used as a term and a concept so that the reality of coercion can be acknowledge and addressed. We recognise that it may be difficult to disentangle any symbolic meaning of the term from its literal meaning. However, we feel that this process presents an important opportunity for culture change, not only in the relationship between professionals and people who use mental health services, but also in how society in general perceives mental health services. We do need to move away from a popular image of coercion as a ‘malign act’. But we also need to validate the reality of people’s experiences of coercion, including any secondary trauma which arises from restraint, for example, or from witnessing coercion.

Disability discrimination and the use of coercion

In their responses to the main consultation, People First Scotland stated that they did not believe that coercion on the grounds of being intellectually impaired is justified, and Inclusion Scotland stated that coercion on the grounds of disability can never be justified. The United Nations expects Scotland to take concerted efforts towards abandoning coercive care and treatment, particularly those forms of coercion which are applied only to persons with mental or physical disabilities (United Nations, 2017). However, there are contradictory positions within the UN human rights system, ranging from a position that coercive care is never justified, to a position that coercive care can comply with human rights standards, provided that the coercive intervention is a necessary and proportionate means to achieve certain approved aims and that appropriate legal safeguards are in place. At the same time, there is also much agreement at the United Nations in relation to coercive care and treatment. A range of treaty bodies have raised a range of concerns about coercive care and treatment in the UK including Scotland. The general approach of the United Nations can be summarised:

> “Instead of using legal or ethical arguments to justify the status quo, concerted efforts are needed to abandon it. Failure to take immediate measures towards such a change is no longer acceptable”. (United Nations, 2017. Para 66)

In our view, however, the use of coercion is essential to protect lives of people who would complete suicide if there was no intervention, and in a range of other situations. The European Convention on Human Rights requires public authorities to act to protect lives, including some circumstances where people’s actions endanger their own lives or the lives of others. We therefore have to consider how decisions should be made to compel people to accept care and treatment.

Reports from lived experience organisations showed us that Scots’ experiences of coercive care and treatment have similarities with international experiences, but there are also differences (HUG, 2021; People First Scotland, 2021; REH Patients Council, 2020; VOX Scotland, 2020; see also MWC, 2019 A; MWC, 2020 A). Several reports showed support from people with lived experience of coercion, for the continuation of coercion in mental health services as a means of saving lives and avoiding homelessness or prison, for example. However, it was also clear that coercion can be traumatic and damaging and should be avoided where at all possible. There may a general position of many people with lived experience in Scotland which is not a rejection of all use of coercion in mental health care and treatment. However, if there is such a position on this issue, that position certainly includes a rejection of how coercion is currently used within Scotland.

The March 2022 consultation document gave a position on this, which remains our position:

“If we did away with a legal framework, decisions to use coercion would in many cases still be taken, but without oversight or safeguards…We do not believe we can end coercion at a stroke, but we need to go as far and as fast as we can to reduce the use of coercion within mental health services and the wider care system. We are not proposing targets to reduce the use of coercion. We are proposing that future law should require changes to the mental health system which make it less necessary for coercion to be used…in some situations, people are too unwell to take decisions…decisions may need to be taken with which they do not agree at that time – including that they be detained or required to take medication.”

Further thinking on ‘coercion’

The Review’s main consultation document said that:

> “…we feel that there is a need to acknowledge the complexity of coercion so that it is possible for relationships between people and professionals to be open, honest and healing.”

The wide range of responses to the consultation on this topic, often conflicting and passionate, have convinced us of this need. Organisation including the Scottish Association for Mental Health (SAMH), the Forensic Network and Support in Mind Scotland suggested further work to develop understandings, including lived experience, professional experience and the wider context of environment, culture and society

It is vital that people who use support, care and treatment can become or remain confident that those who provide services understand and accept their experiences of those services. In our view, this is crucially important work. Despite good intent, even when very experienced practitioners do everything they can to mitigate the impact of coercive practices, the use of coercion can still cause trauma for people who are being treated with coercion. This tension at the heart of care and treatment must be addressed openly and should not be reduced to an understanding of compulsion as ‘good’ and coercion as ‘bad’. This work is possible, from a starting point that coercion can be a necessary and proportionate as part of promoting and protecting all of a person’s relevant human rights. This work should begin a process of culture change and will be central to all efforts to reduce harm and to increase healing across all areas of support, care and treatment.

We think that previous work by psychiatrists to define coercion can provide some useful structure for a new approach to coercive practices. The first table in chapter 9 on reduction of coercion includes some terms used in that work. Szmukler and Appelbaum (2008) described an increasing range of ‘treatment pressures’: a hierarchy that ranges from persuasion - at the least coercive end of the spectrum - through interpersonal leverage, inducement, threat, to the use of formal compulsion through mental health legislation. Tom Burns and colleagues developed this approach, using a slightly different understanding of ‘coercion’ (Molodynski et all 2010, Burns et al 2016). In their consultation response, SAMH referred to the need to address what psychiatrist George Szmukler calls the ‘coercive shadow’ (Szmukler, 2015).

We could say that some actions are not coercive, but are also not voluntary: actions are not voluntary when the person could not give informed consent to the action, even with support. This is illustrated in the second table in chapter 9 (not voluntary: no coercion). As discussed in the March 2022 consultation document:

> “Involuntary support, care and treatment often involves coercion but not always. For example, a person with profound learning disability may be living at home with parents. Although informed consent is impossible for this person, there may be no coercion at all in this arrangement.”

In such a situation, Supported Decision Making may make it possible to find a best interpretation of the person’s will and preferences. In this example, the parents’ actions would not be inherently coercive – even if their child is now an adult - as long as they are acting to give effect to the person’s will and preferences, in the context of the person’s rights, and they were not using force or threatening the use of force.

It would be possible for guardianship to be not voluntary and not coercive. For example, the person is an adult, and their parents have financial guardianship powers over the person’s money. The parents can show that they understand the person’s will and preferences, and that they make decisions on spending the person’s money which give effect to person’s will and preferences. The person’s responses show that they accept and do not reject the effects of those decision.

There is scope for any situation to become coercive, but situations such as those described directly above should not be presumed to be coercive.

It will be essential that people’s own expertise on their condition and their life are consistently respected. Signs that this is not happening can include: the absence of real discussion about possible courses of action, where professionals inform the person that ‘we will do this’; professionals’ personal values influencing decisions for other people; and discussions which aim to discredit the person’s own perspective.

As we stated in the Review’s March 2022 consultation document:

> “We think that Scotland could draw from work by NHS England and England’s Department of Health and Social Care on terms and definitions which apply to coercion in mental health and learning disability health services. Scotland could also draw from work in the Netherlands on forms of coercion which may be found in healthcare settings but also in care homes, community care and other settings. Together, this work in England and the Netherlands covers forms of coercion which may currently be used across settings in Scotland which are governed by mental health, adults with incapacity and adult protection legislation.”

A range of organisations suggested a need for:

- Definition of different kinds of coercion, in plain English, with examples and with context showing the effects of different cultural expectations
- Guidance on how to distinguish coercive treatment which is welcomed from that which is not, and on how to seek resolution for a person in either situation
- Clarity on what coercion means in practice, its harm, the alternatives, and how to empower people to recognise and challenge practices
- Clarity on the concept of coercion by institutionalisation
- Clarity on the distinctions between coercion in support, care and treatment; and coercive control in domestic abuse
- Good quality national guidance and multidisciplinary training, for consistency

There is also a need to address the ‘inverse’ of coercion. There are many situations where a person does want support, care or treatment but is denied it, which can do at least as much harm as coercion. Examples may include:

- A person is in crisis and is turned away from services with no access to care
- A family is very close to the point where they can no longer care for a person, and will break down without access to support for the person or family members

We understand that people are very often denied access to support, care or treatment because services do not exist or do not have enough capacity. We expect that Human Rights Enablement would support professionals to address such situations. This approach should consider the balance or risks to human rights which arise from acting with consent, acting without consent, and not acting.

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