SMHLR

SCOTTISH MENTAL HEALTH LAW REVIEW

Consultation

March 2022

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1. Introduction and Background

This consultation paper outlines some of the proposals for change to the law put forward by the Executive Team of the Scottish Mental Health and Incapacity Law Review. They have been developed in partnership with people with lived experience, including unpaid carers, and mental health practitioners through a series of Advisory Groups and Reference Groups.

This consultation relates to all people who have been, or could in the future be, subjected to mental health legislation, their unpaid carers and families and all those who work in mental health, learning disability, autism, dementia, brain injury services and the legal profession.

Aims of Consultation

The aim of this public consultation is to seek views on the Review's proposals for changes to mental health and incapacity legislation before a final report is sent to the Scottish Ministers by the end of September 2022. This report will be published.

The consultation contains a number of questions that invite comment – including concerns and suggestions for improvement – on different aspects of the proposed recommendations.

Responding to this Consultation

We are inviting responses to this consultation by 27 May 2022.

You can respond to this consultation online on our website at: Scottish Mental Health Law Review Consultation 2022. You can save and return to your responses while the consultation is still open.

If you are unable to respond online, you can send your response to:

Scottish Mental Health and Incapacity Law Review
Scottish Government
Mental Health Directorate
St Andrews House
Edinburgh
EH1 3DG

If you have any difficulty with this please email the Review at: secretariat@smhlr.scot

Handling your response

If you respond online, you will be directed to the ‘About You’ page before submitting your response. Please indicate how you wish your response to be handled and, in particular, whether you are content for your response to published. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

If you are posting your response, please also fill in a Respondent Information Form and include it with your response. This will let us know how you want us to handle your response. The Respondent Information form is at the end of this document. A word version can also be downloaded using this link Respondent Information form

To find out how we handle your personal data, please see our privacy policy on our website at: https://www.mentalhealthlawreview.scot/privacy-policy

Next steps in the process

If you have given permission for your response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at: www.smhlr.scot

If you respond online you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with other available evidence to inform recommendations in our final report. Responses will be published where we have been given permission to do so.

We will send a final report to the Scottish Ministers by the end of September 2022. This report will be published.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to the address above or email them to: secretariat@smhlr.scot

Why Your Views Matter

The proposed recommendations being consulted on could lead to a fundamental changes to our mental health and incapacity legislation, bringing it more in line with human rights law and the ambitions set out in the United Nations Convention on Rights of Persons with Disabilities. Your views will help refine or change these recommendations and allow the Review's Executive Team to put together a final set of recommendations for the Scottish Government. It will then be up to Scottish Ministers to decide how many of the recommendations they act on, how they do this, and the timing of any changes to the law.

Background

The Scottish Government asked for an independent review of three key pieces of law. These are the Mental Health (Care & Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007.

The aims of the Review

The principal aim of the Review is to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder, and to remove barriers to those caring for their health and welfare. These rights includes those set out in the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), along with the European Convention on Human Rights (ECHR) and other treaties. The review is considering what is required to achieve the highest attainable standard of mental health. More detail on the review's remit can be found in the terms of reference for the Review. [1]

Impact of Covid -19

Most of the Review's work to date has been carried out during the Covid pandemic. Covid, and the restrictions we have all been living under, have had an immeasurable impact on people's lives. This consultation paper does not consider the effects of Covid and Covid restrictions as they have impacted particularly on mental health and incapacity issues although it is clear that they have exacerbated gaps in our current systems of mental health support and care. As we move to recovery we recognise that there will be enormous pressures on services. In our view this makes a human rights based approach even more central.

Even if we set aside the impacts of Covid, the circumstances in which the Review is being carried out are ones of significant change.

The Scottish Government plans to introduce legislation which incorporates human rights instruments, including ICESCR and UNCRPD, into domestic law. We do not yet know precisely how this will be achieved. However it does mean a different approach to mental health and incapacity law is needed because it means incorporation of UNCRPD in particular is now a reality and no longer an academic exercise. We have the proposals of the National Taskforce for Human Rights, which

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[1] See our Terms of Reference at: https://cms.mentalhealthlawreview.scot/wp-content/uploads/2020/01/Terms-of-Reference-1.pdf

will inform Government thinking. [2] Our provisional proposals draw on their approach and this consultation paper seeks your views on some of those.

At this stage, we cannot say precisely which provisions should be in mental health and capacity law, and which provisions should be in laws which applies to everyone. However, we can set out what duties we think are owed to people with mental health conditions, however that is ultimately given effect in law.

By the time our final report is published we anticipate that legislation to create a National Care Service for Scotland will have been introduced in the Scottish Parliament. Our final report will reflect on this and its impact on the matters the Review is concerned with.

This consultation paper does not reflect all the work the Review has undertaken. In particular, we have commissioned work on the interface between criminal and mental health legislation, and what is needed to change in that field. Targeted consultation will take place on these issues over the coming months before recommendations are made for the final report.

Work is also ongoing on the way compulsory treatment orders in hospital and the community are currently used and how this might be approached differently in the future. Again following targeted consultation, recommendations will be made for the final report. More information on this is provided in chapter 7.

Throughout this consultation paper reference is made to other specific issues, such as named person provisions, where more detailed work is ongoing alongside this consultation.

Not all of the proposals apply to all the pieces of legislation being considered by the Review. In particular, the different perspective of the Adult Support and Protection Act means that some of our recommendations are not relevant to that legislation. We are looking at what specific changes may be relevant to that Act. But we intend that

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[2] National Taskforce for Human Rights: leadership report - gov.scot (www.gov.scot)

the overall approach to the law, its purpose and principles, the new Human Rights Enablement, and proposals around support for decision making should be read with all three pieces of legislation in mind. In the last chapter we ask for views on the convergence of legislation, in light of proposed changes to the law. It is important to note however that that chapter does not focus solely on convergence or fusion, but also seeks views on improved alignment of legislation, and we look forward to hearing views on this issue.

Language

The language used in the legislation at present is being considered by the Review, and chapter 12 asks for your views on aspects of this. For the time being however, it has been decided to use the terms currently in legislation. So we refer to people with a mental disorder and people with a learning disability. We recognise that these terms sit uncomfortably with some but hope that this consultation gives an opportunity to address this.

The Independent Review of Learning Disability and Autism in the Mental Health Act

The Independent Review of Learning Disability and Autism in the Mental Health Act (the Rome Review) published its final report in December 2019. The Scottish Government has not yet responded in detail to this.

The Rome Review concluded that the Mental Health (Care and Treatment) (Scotland) Act 2003 had led to specific negative effects on the human rights of autistic people and people with intellectual disability. Evidence for this was summarised in section 1.4 of its final report.[3] The negative effects were mainly indirect discrimination: the Mental Health Act was being applied to all people with ‘mental disorder’ including people with learning disability through similar processes,

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[3] The Independent Review of Learning Disability and Autism in the Mental Health Act (2019): Final Report.

but there was evidence of more negative effects for autistic people and people with intellectual disability.

The Rome Review made many recommendations, including that:

- Learning disability and autism be removed from the definition of mental disorder in Scotland’s Mental Health Act, once wider changes to law and services had been put in place.
- A new law be created to support access to positive rights, including the right to independent living.
- Scotland work towards law that removes discrimination in detention and compulsory treatment on the basis of disability.

The Rome Review in relation to the Scottish Mental Health Law Review

The Rome Review recognised that it would be for the Scottish Mental Health Law Review to decide which of its recommendations, if any, might apply more generally to anyone affected by mental health law, not only autistic people and people with intellectual disability.

Our proposals are influenced in a number of ways by the Rome Review’s recommendations. In particular:

- Access to positive rights, including to independent living, is a key aspect of our proposed reforms.
- We have sought to develop a non-discriminatory basis for involuntary treatment, although this is a complicated process which may not be achievable in one step.
- We have taken up and developed the Rome recommendations for a human right based assessment as a key tool for ensuring human rights are promoted.

- We want to strengthen the duties on public authorities to provide a range of services to meet the needs of people with mental health conditions of whatever type.

Throughout this consultation paper, references are made to various recommendations from the Rome Review and how they sit with proposals for change in this consultation. In particular, the chapter on children and young people refers to a number of the recommendations the Rome Review made for younger people.

Chapter 12 of this consultation also seeks views on the expression, ‘mental disorder’, and on those who may be included in mental health and incapacity legislation.

In general, we are not attracted to having different legal frameworks for particular diagnostic categories, and are aiming for a law which protects and supports anyone who has a mental health condition of whatever type. At the same time, we recognise the force of the criticism that the Mental Health Act was designed primarily with a focus on mental illness. We want to ensure that new legislation will equally meet the needs of other groups.

We have arranged a number of meetings with people with learning disability and autistic people to hear their responses first hand to the proposed changes.

We are also aware that though the Scottish Government has not responded in detail to the Rome Review, work is underway on a Neurodiversity Bill for the Scottish Parliament and we await more detail on this with interest.

Equality Issues

We have been reaching out to various groups to hear the views of those covered by protected characteristics and their mental health experiences. It is important to us to gather the views from as many different communities as possible so that their voices are heard, and they can advise us on the extent to which our proposals for change in the law meet their needs, and ways in which they can be improved.

We know from meeting with representatives of our LGBTQI communities that they are facing a rise in hate speech and services being reduced or withdrawn. There is a lack of awareness and understanding amongst practitioners which can result in people looking for support within their own community rather than, or in addition to seeking professional help. We will continue our consultation with them to understand how our proposals would impact on them and what else may be needed to reflect their needs.

We have also met with representatives from Asian, Black and Other White communities. We know from the recent Mental Welfare Commission Report on Racial Equality that there is a huge amount of work required in this area to remove the differences in the way mental health legislation is applied across different communities in Scotland.

That report made 3 recommendations to our Review:

- 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 impacts particularly on 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 are taking these recommendations forward and will provide details in our final report. [4]

Final report of the Review

The final report for the Review will be submitted to the Scottish Ministers by the end of September 2022. The report will be published on the Review's website.

Our final report will recommend what the foundations for future law should be, along with recommendations for the overall form of future law. It will not make recommendations on all details of existing law. The detail of future law would be addressed in a future legislative process. We anticipate however that there will be recommendations for change that will not need to wait for future legislation.

The review is not a commission on mental health services. We will not be recommending a particular mental health strategy or programme for reform of services. We will be recommending certain things that need to be part of a strategy or programme for reform in order for human rights to be realised. These are likely to include matters such as core minimum obligations and a commitment to a reduction in coercion, but the full detail will be provided in our final report.

We consider that if an approach to the care, treatment and support of persons with 'mental disorder' is to be fully compatible with developing human rights standards, particularly those in UNCRPD, then state, societal and practice attitudes must shift away from seeing the law as simply authorising and limiting non-consensual interventions towards proactive support.

It is important however, to highlight that without adequate resources and investment in staff, we will not have a human rights approach to mental health services in Scotland and the change we will need to see will not happen. Regardless of the final

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[4] Mental Welfare Commission for Scotland (2021): Racial Inequality and Mental Health in Scotland – A call to action. p.14.

recommendations of the Review, it will be essential to resource, value and invest in staff across the field of mental health and incapacity law and practice.

Summary of issues we are consulting on

This consultation paper does not seek views on everything that the Review is currently considering. Targeted consultation on specific issues will take place over the coming months. Here we look forward to receiving your views on our proposals for change on the following matters:

Chapter 2: What is the purpose of the law ?

This chapter sets out our thinking on the purpose of the law and the principles that should be applied to the law. It covers how we propose the law should be developed to enable people to live fulfilling lives, and to ensure that the human rights of people with mental disabilities are respected, protected and fulfilled.

Chapter 3: Supported Decision making

This chapter looks at the ways we think people should be supported to make their own decisions about their lives, promoting respect for people's will and preferences and enabling them to feel fully engaged in decisions about their lives.

Chapter 4: The role and rights of carers

This chapter looks at some of the issues carers face when supporting someone with mental illness or disability, and how carers can be better supported, and their rights respected, protected and fulfilled.

Chapter 5: Human rights enablement

This chapter sets out a new approach to the way people are provided with help and support, the aim of which is to ensure people receive appropriate care and support at the time that they need it, by assessing a person’s whole situation rather than a focus on acute care and symptomatic relief.

Chapter 6: Autonomous decision making test

This chapter looks at those situations where non-consensual intervention in a person’s life may be necessary, and proposes a new, decision specific framework for such interventions.

Chapter 7: Reduction of coercion

This chapter looks at the ways in which coercive treatment can be reduced, setting Scotland on a path towards a different culture within mental health and incapacity law and practice, in which all the rights of people with mental health conditions are respected, protected and fulfilled.

Chapter 8: Accountability

This chapter considers the need for a strong accountability framework, with clear and accessible routes for people to use if they feel their human rights are being violated, and oversight of systems so we can identify if people are being deprived of their rights, and address this if needs be.

Chapter 9 : Children and young people

This chapter looks at the particular issues faced by children and young people under mental health practice and considers the implications of the UN Convention on the Rights of the Child (UNCRC) for mental health law along with the UNCRPD, both of which require States to bring about real equality for children with mental disabilities.

Chapter 10: Adults with Incapacity proposals

This chapter suggests changes for incapacity law, building on work already carried out in this area, seeking to address the requirements of the UNCRPD in particular.

Chapter 11: Deprivation of liberty

This chapter seeks views on how the challenges around the ECHR requirements concerning deprivation of liberty may be addressed.

Chapter 12: Mental disorder

This chapter seeks views on the how we might remove the use of the term ‘mental disorder’ and associated issues.

Chapter 13: Fusion or Alignment?

This chapter seeks views on whether, in light of the proposals suggested by the Review, fusing legislation is the way ahead or a more gradual alignment of legislation may be preferred.

Terms Used in Consultation

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

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.
Absolute Rights	Cannot be restricted under any circumstances – for example the right to life and the right not to be subjected to inhuman or degrading treatment.
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.’
ASP Act	The Adult Support and Protection (Scotland) Act 2007
Autonomy	The ability to be the author of one’s own life and have one’s will and preferences respected.
CAMHS	Child and Adolescent Mental Health Services

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.
Compulsory Treatment Order (CTO)	The main form of long term compulsory detention and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003. The order is made by the Mental Health Tribunal for Scotland following an application by a Mental Health Officer, alongside two medical recommendations. The order lasts for up to 6 months and can be renewed.

Designated Medical Practitioner (DMP)	Doctors, normally consultant psychiatrists, who have powers under Part 16 of the 2003 Act to authorise medical treatment for mental disorder where a patient is subject to compulsory treatment
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.

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
Involuntary support, care and treatment	Support, care and treatment which is given without consent. This often involves coercion, but not always. Coercion is described in chapter 7. This includes support, care and treatment which is given under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

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.
Named Person	Someone who can look after the interests of anyone made subject of compulsory measures under the 2003 Act. If a person is under 16 this would be a parent or person with parental responsibilities. If a person is 16 or over they have the right to choose whom they wish to be Named Person. The Named Person has similar rights to the patient to appeal to or participate in hearings by the Mental Health Tribunal.

Open Dialogue	Originating from Finland in the 1980s with its background in family therapy for mentally ill children, Open Dialogue in mental health is based on a recovery-oriented model. It seeks to use the support available to persons with mental illness within their social networks (including families) with a view to enabling individual autonomy within a continuous caring arrangement.

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
Qualified Rights	Qualified rights can be restricted in certain circumstances and within limits – for example the right to respect for private and family life and the right to freedom of expression.

Responsible Medical Officer (RMO)	A psychiatrist in charge of the care of a patient subject to compulsion under the 2003 Act. The RMO has a duty to keep the care of the patient under review, and to end compulsion if it is no longer needed.
Risk	The possibility of loss, danger or harm.
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.
Support for the exercise of legal capacity	Referred to in Article 12(3) UNCRPD and ensures that a person's will and preferences are ascertained and given legal force.
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, QC, Solicitor Advocate. Full details of the team are found on the Review website.
The Mental Health Tribunal for Scotland (the Tribunal or MHTS)	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. A Tribunal meeting 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 themselves also have lived experience or provide unpaid care to someone with lived experience. Tribunal meetings are often called hearings. At a hearing the Tribunal members will read and hear about the person called to the Tribunal before making a decision about the person's care and treatment.

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.

2. What is the purpose of the law?

Purpose and principles

We set out proposals on the purpose and principles of mental health and capacity law in our July 2021 interim report. [5] Those proposals are summarised here for consultation.

Purpose

We believe the purpose of the law should be to ensure that all the human rights of people with mental disorder are respected, protected and fulfilled.

We do not believe this can be done solely by general human rights or equality legislation but requires specific provision in law for people whose decision-making ability may be impaired.

We are not solely concerned with the rights of people who receive care and treatment without their consent. The law should secure the full range of rights set out in international human rights treaties for everyone who may currently fall within the category of ‘mental disorder’. [6] Currently, the focus of mental health law is mainly on authorising and regulating the use of care and treatment without consent. It does not seek to ensure that the wider needs of people with mental disorder are met.

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. Capacity law deals with a wider range of issues than mental health law, and this may help in approaching support, protection,

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[5] Scottish Mental Health Law Review (2021) Interim report. https://cms.mentalhealthlawreview.scot/wp-content/uploads/2021/07/Scottish-Mental-Health-Law-Review-Interim-Report-July-2021.pdf

[6] This includes the European Convention on Human Rights, the International Covenant and Economic, Social and Cultural Rights, the UNCRPD and the UN Convention on the Rights of the Child. We generally use the term ‘mental disorder’ in this document as it is the current term in law.

and recovery from a wider perspective. However, capacity law currently has little to say about the economic, social, and cultural rights which we believe need to be part of the legal framework.

Our approach reflects insights drawn from human rights principles and the evidence we have received.

Principles

The interim report also discussed reasons why a new approach to principles is required. Current mental health law is mainly about protecting people from undue interference in their lives. Future legislation needs to be more about helping people with mental disorder to live well and enjoy their lives without stigma or prejudice. The principles of this new framework need to reflect this wider aim.

We believe that this shift can be achieved by basing the principles for reformed mental health law on principles already established in human rights instruments, particularly Article 3 of the UNCRPD.

This reflects our remit to ensure that the law reflects human rights. This will also assist in making sure that future law is consistent with the planned direct incorporation of international human rights into Scots law, including economic, social and cultural rights. Scottish Government is planning to give effect to the recommendations of the National Taskforce for Human Rights Leadership in this way. [7]

We are aiming for a small set of core principles (between 4 and 6) which can be expanded upon in the legislation itself and in guidance. This means that we have to summarise the eight principles in Article 3.

The Review is suggesting **four core principles** which reflect our human rights approach. These are:

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[7] https://www.gov.scot/publications/national-taskforce-human-rights-leadership-report/documents/

- **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 to 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. [8]

  It provides a basis for the claims of economic, social and cultural rights, such as rights to health, housing, employment and social security. 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. This is the freedom to make your own decision and / or be assisted to make your own decision. This is sometimes known as supported decision making and we believe this is very important and should be underpinned in law.

- **Non-discrimination and equality**. Non-discrimination and equality are core 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.

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[8] For further discussion, see the Academic Advisory Panel paper prepared for the National Taskforce by Dr Elaine Webster on ‘The Underpinning Concept of “Human Dignity”. This is available here.

Barriers can be removed through providing access to appropriate support, through reasonable adjustments/accommodation, and creating conducive environments, for example.

- **Inclusion.** This involves the right to be included regardless of a label. 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 anticipate that the legislation and Codes of Practice would set out in more detail how these principles should be given effect. The proposed principles encompass and expand most, if not all of the Millan principles in the 2003 Act and they are also more easily able to accommodate the incorporation of economic, social and cultural rights.

That said, we believe there is a strong case for including some version of the Millan principle of **respect for carers**. We also discuss in chapter 9 our view that we should retain a specific principle concerning the rights of **children**. We welcome views on how best to enshrine these important principles.

Another issue we are considering is whether **reciprocity** should remain as a feature of mental health law. [9] On the one hand, the reason for reciprocity is still compelling - that a person who has had their choices limited by the State should have the right to receive the help they need from the State, particularly (but not solely) to help to recover their autonomy. If we accept this, it can be argued that the principle should be strengthened – recognising that it is currently difficult to enforce. Against this, there are concerns that, if the rights of people subject to compulsion are too different from those being treated with consent, there may be a perverse incentive to use or seek compulsion as a lever to ensure support. It can also be argued that the principle of reciprocity has less relevance if the law contains measures to ensure everyone gets the help they need.

Our proposals seek to strike a balance – ensuring that everyone has a right to appropriate care and support within the context of the core human rights obligations, while also strengthening the power of the Mental Health Tribunal to ensure that people are not subject to compulsion or greater restrictions because of a failure to provide appropriate support. [10]

Enabling people to live fulfilling lives

The state is required to respect, protect and fulfil human rights; in other words, to enable people to live fulfilling lives. This requirement has many practical implications. For example, for Scottish society to become equal for people with mental disorder, universal design and reasonable adjustments would have to be widely used. [11] Universal design means designing services and environments so that they can be used by all people, to the greatest extent possible, without the need for adaptations or specialised design. Reasonable adjustments are needed for a particular person. These adjustments are appropriate, do not impose a disproportionate or undue

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[9] See also chapter 7 on ‘reduction of coercion’ in relation to reciprocity.

[10] See other proposals in this chapter and our proposals on the Mental Health Tribunal (chapter 8).

[11] Article 2 UNCRPD. The Convention uses the term “reasonable accommodation”, which is close in meaning to the term “reasonable adjustment” as used in the UK. See Equality Act 2010 section 20.

burden on the organisation which makes the adjustment, and are needed to ensure that the person can enjoy and make use of their rights and freedoms on an equal basis with other people.

Many of the human rights which enable people to have a fulfilling life are economic, social and cultural rights (ESC rights). ESC rights are *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 *core minimum 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 progressively. [12]

For example, the right to health in ICESCR requires states to immediately ensure: [13]

- Minimum essential levels of each of the rights in the ICESCR, including essential primary health care.
- The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups.
- Equitable distribution of all health facilities, goods and services.
- Appropriate training for health personnel, including education on health and human rights.
- Education and access to information about the main health problems in the community, including methods of preventing and controlling them.

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[12] Cepeda, M., O'Regan, K., and Scheinin, M. (2021) The development and application of the concept of the progressive realisation of human rights: Report to the Scottish National Taskforce for Human Rights Leadership. Bonavero Institute, University of Oxford. (here, page 11)

[13] The UN Committee on Economic, Social and Cultural Rights stated in a General Comment (2000) General Comment No. 14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). E/C.12/2000/4 (here)

- A national public health strategy and plan of action which:
  - is based on epidemiological evidence
  - addresses the health concerns of the whole population
  - is devised, and periodically reviewed, through a participatory and transparent process
  - includes methods, such as right to health indicators and benchmarks, by which progress can be closely monitored
  - gives particular attention to all vulnerable or marginalised groups, both in the process of devising the strategy and plan of action, and in the plan's content.

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.

Scotland's National Taskforce for Human Rights Leadership has recommended that the Scottish Government should move to incorporate ICESCR, UNCRPD and two other UN Conventions directly into Scots law [14]. Scottish Government intends to propose a Bill to the Scottish Parliament to do this. Scotland is already required to ensure that its law complies with ICESCR and other conventions, but the incorporation of these conventions may place stronger, more direct and more enforceable duties on Scottish Government, the courts and public authorities in all areas including mental health law and services. Future mental health law would need to reflect this, and would need to fit with these Conventions as incorporated into Scots law.

Even where a minimum core has been identified by the United Nations, States are generally given the responsibility to set out what realising the obligation means in that State. [15] This means that United Nations Committees tend to scrutinise a State's

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[14] National Taskforce for Human Rights Leadership (2021) Final report.

[15] Cepeda (2021) as above. Page 12.

own methodology for defining the meaning of a minimum core obligation in detail in that State. The United Nations generally does not decide what the particular entitlements are in general for a right, or within a particular State.

Scotland's National Taskforce has recommended that there should 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, which takes into account the content of each right." [16] So, the meaning of each economic, social and cultural right in Scotland would be defined through a participatory process which fully involves all groups in Scottish society, including people with mental disorder.

However, we feel that even with universal design and reasonable adjustment within mainstream services, there are some specific issues affecting people with mental disorder which may need to be addressed through specialist design and specific law. There are some aspects of economic, social and cultural rights which may need specific attention. We will also need to consider what duties should be placed on delivery bodies (local authorities, the NHS, Health and Social Care Partnerships ("Integration Joint Boards") and the new National Care Service), as well as on Scottish Government, courts, Tribunals and the police. We will also need to consider how those duties would inter-relate.

Core minimum obligations, service standards and data

In the mental health context, there have been some tentative steps to define more clearly what people can expect of mental health services, notably in CAMHS, but these are not comprehensive. We understand the current Mental Health Strategy may be reviewed in 2022.

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[16] National Taskforce for Human Rights Leadership (2021) Final report. Recommendation 13.

Our current thinking is as follows:

- **There should be a legal requirement for Scottish Government to establish core minimum obligations to people with mental disorder 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.**

- **Public bodies should have a statutory responsibility to secure those aspects of the core minimum obligations reflected in their statutory powers and duties, and should be accountable to the Scottish Government and Scottish Parliament for doing so.**

- **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.**

- **There should be a systematic process of data monitoring to assess whether these obligations are being met.**

- **The Scottish Mental Health Strategy should be recast to set out a clear framework for the progressive realisation of economic, social and cultural rights for people with mental disorder.**

- **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.**

- **The development of these core minimum obligations and the framework for progressive realisation should be carried out with the full participation of people with mental disorder and their representative organisations**.

Requirements which follow from particular human rights

- Stigma and attitudinal issues

Evidence to the Review from people with lived experience highlights the harms caused by negative attitudes to mental health, including those of staff, wider society and self-stigma experienced by people with mental disorder. We may recommend **a positive duty on Scottish Government to address stigma and discrimination against people with mental disorder**, as a barrier to their full inclusion within society.

- Right to health

We think that sections 25-27 of the 2003 Act 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 core minimum obligations.

The current duties in the Mental Health Act are widely framed to:

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

However, there is little evidence that these duties are directly influencing what local authorities provide, and there is no mechanism to assess whether or not the duties are being adequately met. They are also restricted to local authorities.

We are **not** proposing to create a threshold which leads to some people having their rights fulfilled, with other people not having their rights fulfilled.

This proposal would not cover all of the obligations implied by the right to health, which should be fully covered. Other obligations include **prevention of mental health problems, and addressing the social determinants of good and poor mental health**. These are, of course, also relevant for other health conditions. We are not proposing that duties are addressed in the reframed sections 25 to 27 of the Mental Health Act, but that they are addressed in the wider proposals (above) for fulfilling the right to health through a reframed mental health strategy.

We may also wish to ensure that Government actively addresses the **physical health needs of people with mental disorder**, given the huge health inequalities experienced by this group, and concerns about ‘diagnostic overshadowing’.

- Adequate income

Evidence to the Review highlights a number of issues around **poverty and access to employment**. These issues may be common to a range of disadvantaged groups, but we believe 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.

The new Scottish benefit system has a right to advocacy, and we wish to discuss with advocacy organisations if this could be more effectively linked to the mental health advocacy framework.

- Housing and independent living

The rights to **adequate housing and independent living** are particularly important. 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.

We are considering a **strengthening and broadening of the duties in section 25 of the 2003 Act**, which mentions ‘residential accommodation’, and ensuring that these duties inform both the policy framework and the actions of delivery bodies.

- Inclusion in society

Evidence to the Review also highlights issues of **isolation and loneliness**. At the moment, it is doubtful that any statutory agency feels under any obligation to address these. We feel 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

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 may recommend 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 disorder whenever they may need it, not just when they may be subject to detention/compulsion. It may be important to set out in more detail, perhaps in the Code of Practice, how information should be produced – with people with lived experience – to meet the requirements of people with lived experience, and how those duties should be discharged when someone *is* subject to compulsion.

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.

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

- Significant lived experience input at all levels of service delivery, and in the development of law, policy and practice. This includes people with mental disorder and unpaid carers. This needs to be done properly and will need supports in place for this to be equitable. Scrutiny bodies have a duty to increase user focus in the Public Services Reform (Scotland) Act 2010, although this may not have been transformative.[17] There may need to be stronger duties on bodies providing services, and to build on previous developments in collective advocacy. [18] Scotland needs to follow the requirements of the UNCRPD in this area, as interpreted by the UN Committee on the Rights of Persons with Disabilities, [19] along with guidelines from the lived experience movement on best practice. Patient director posts are one example of good practice [20], but best practice should be defined by and with people with lived experience of mental disorder or unpaid care. There may be a need to work to a transformation where people with lived experience feel that they have ownership of scrutiny bodies, through equal roles in inspection and in governance.
- Human rights budgeting: law reform may be required to ensure that budget decisions reflect human rights standards, and that the process of formulating, approving, executing, and auditing budgets reflects human rights principles. [21] [22] We may also need to ensure that the budget allocated to mental health relative to physical health reflects the incidence of mental ill-health Scotland.
- Community *and* inpatient services**:** both forms of services must be adequately resourced, not one at the expense of the other.

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[17] Public Services Reform (Scotland) Act 2010. Sections 112 and 113 (User focus)

[18] See the section on collective advocacy in chapter 7.

[19] UN Committee on the Rights of Persons with Disabilities (2018) General Comment 7 https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/7

[20] Gilbert, D. (2021) Patient directors—the next step in the patient revolution. The BMJ Opinion. https://blogs.bmj.com/bmj/2021/06/25/patient-directors-the-next-step-in-the-patient-revolution/

[21] National Taskforce for Human Rights Leadership (2021) Final report here, page 55.

[22] Human Rights Budgeting | Scottish Human Rights Commission

- 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 collaboration: in addition to professional training, there will be a need for awareness raising across and beyond health and social care services. Carer awareness exists in Scotland. Lived experience awareness training may need to be developed.
- Redefining culture: We think that culture in services for people with mental disorder 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 welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would be particularly interested to know:

- What are your views on the purpose and principles that we are proposing?
- What do you think about the approach that we are proposing for Scottish Government to meet core minimum obligations for economic, social and cultural rights in this area?
- What are your views on our suggestions for reforming sections 25 to 27 of the 2003 Act?
- Do you have suggestions on how law could be reformed to address stigma, discrimination, and issues with attitudes towards mental disability?
- Do you have suggestions on how the law could lead to prevention, and how the law could address the social determinants of mental health?
- What are your views on our proposals on adequate income, housing and independent living, inclusion in society, and accessible information?
- Are there other economic, social or cultural rights which you feel are particularly relevant to mental health?
- Do you have views on the system-wide changes which we think are needed?
- What do you think law reform can do to achieve culture change in mental disability services?

3. Supported decision making

Supported decision making is 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. It includes support for the person to put those decisions into effect and can include support to challenge barriers that disable the person. This is essential if people are to participate on an equal footing with others, in decisions about their lives.

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. We say more about the vital role of unpaid carers in the next chapter.

Supported decision making starts from the premise that everyone has a right to make decisions for themselves as far as they are able. The decision maker should be at the centre of the process, with respect given for their autonomy.

There have been a number of attempts in 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. Nevertheless we have heard from many, that individuals' views must compete with other principles, practices and cultures that might be more favourable to non-consensual intervention and that inadequate service provision has an impact as well. The current framework in Scotland focuses in the main on protecting individuals with mental disorder with 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.

The Scottish Government undertook work in this area a number of years ago, with the help of an expert group. A report detailing that work is on the Review website, [23] and this chapter draws on some recommendations contained therein.

The UNCRPD [24] sets out the duty of States to ensure access to support for the exercise of legal capacity for all persons who need it. This is to ensure that the rights, will and preferences of persons with disabilities are enjoyed on an equal basis with others.

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.

The Executive Team of the Review 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 6 of this paper. It is informed by consideration of a range of views including the voices of lived experience, which are far from unanimous on this issue.

However, this position needs to be seen alongside all the areas where the Review does agree with the Committee such as the need to reduce the use of coercion and the requirement to provide a wide range of options for support for the exercise of legal capacity, often described as supported decision making, to ensure that the person's voice is always heard.

The use of supported decision-making 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 supported decision making does include the ability for others to

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[23] www.smhlr.scot

[24] Art 12(3) CRPD

make a non-discriminatory best interpretation of the person's will and preferences. This interpretation is something which is different to a “best interests” decision and should be based on information gathered from those known to the individual and taking into account the person's values and beliefs and past expressions of will and preferences. Consideration also needs to be given to how the supporter’s views on decisions taken can and / or should be taken into account. 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 it has to be noted that 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 but 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

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. [25] It sets out some informal and formal means by which support may be provided.

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[25] UN Committee on the Rights of Persons with Disabilities (2014) General comment No. 1. Article 12: Equal recognition before the law. CRPD/C/GC/1

These include:

- By 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 have set out the purpose of supported decision making but 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. But 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.

Why do people need support to make decisions and to put them into effect?

When we refer to ‘decision making’ this extends too to being able to action the decision that has been made.

People who have used health and social care services are often disempowered by the system and don’t always have many meaningful opportunities to express their preferences, wishes and desires. Some people due to their mental disorder never learn effective decision making skills e.g. some people with a learning disability. And some people may have reduced or limited capacity due to dementia, or lost skills they previously had due to mental illness.

In addition to decision making skills, there needs to be proper recognition of the loss of agency experienced by people who have often faced discrimination, oppression, and marginalisation. Different people will need differing levels of support to help them understand options, consider choices, think about consequences, exercise agency, make decisions and finally give effect to those decisions.

When is supported decision making needed?

Supported decision making can obviously occur on an informal basis at any time, but we suggest that it is part of the human rights enablement (HRE) process – as set out in chapter 5 - that during that process consideration is given to the type of support, if any, that might be required to enable a person to participate fully in decisions about their life, always bearing in mind that in asking for someone else to make decisions for them, a person can be exercising their rights just as much as anyone else.

Range of support to be offered

Over the past months working on the Review, it is increasingly clear that a range of options for supported decision making are required, encompassing some familiar and some less familiar approaches to create a range ways to support decision making to allow persons with mental disorder the same opportunities as others.

This range of support should be broadly based on the recommendations by the UN Committee in its General Comment 1. We have also looked at the tools recommended within anticipatory care planning (ACP) and expanded on these. ACP is used by the NHS to enable people with a long term condition to plan for expected changes in their health. It seems rarely used in mental health settings beyond the specific use of advance statements.

1. Advance statements

Advance statements can be made by anybody but can only be about how a person wants to be treated for mental disorder if in the future, because of a mental disorder, they lose capacity and they are being treated under the 2003 Act. [26] A person can make an advance statement about future psychiatric treatment, including refusing treatment, and a doctor or tribunal should respect the advance statement if they can. Advance statements are notified to the Mental Welfare Commission, but are not held by the Commission. But if a doctor considers a person is at risk, or would most benefit from other treatment they may overrule the advance statement. They do however have to justify and record reasons for doing so, and inform the person, their named person and the Mental Welfare Commission. [27]

Some of the issues raised concerning advance statements include

- Despite initiatives by the Mental Welfare Commission and others, and some success in particular settings, they remain relatively little used.
- The law requires that people have “capacity” in order to make a valid advance statement. It also means that advance statements will not be valid if they are made during crisis or other situations in which the person is not considered to have the ability to make decisions.
- The advance statement only really talks about treatment, not wider issues affecting a person, or which could affect them in the future.
- There is a lack of knowledge amongst the population about advance statements.
- People have little faith in advance statements because they feel they are often ignored by professionals.
- A lot of the time professionals might not know an advance statement exists (although there is now a register held by the MWC).

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[26] S.275, Mental Health (Care and Treatment) (Scotland) Act 2003

[27] Mental Welfare Commission for Scotland (2017) Advance Statement Guidance: My Views, My Treatment. Page 6.

We think it should be easier to make an advance statement, and it should be more integrated with other forms of advance planning. We discuss below a possible model – a statement of rights, will and preferences.

2. Advance directives

Advance directives are different in that they don't just relate to treatment for mental disorder. They can be about any kind of medical care or treatment and how a person would want to be treated in the future in the event that they are unable to make such a decision for themselves. They can be made by anybody as long as they have capacity to make decisions for themselves at the time the directive is made. Sometimes advance directives are known as living wills. They work on the basis that if a person is currently capable of making decisions about their care and treatment, then they should be capable of making decisions about their care and treatment for the future.

England and Wales have legislated in the Mental Capacity Act 2005 [28] for Advance Decisions to Refuse Treatment (ADRTs). An ADRT is generally binding on doctors, with some limited exceptions, including where there are reasonable grounds for believing that circumstances exist which the adult did not anticipate on making the advance directive.

The Scottish Law Commission report on Incapable Adults [29] recommended similar provision in Scotland, but this was not legislated for in the AWI Act.

There is some uncertainty about what legal effect advance directives have in Scotland, but the principles of the AWI Act and 2003 Act (in some cases) mean that a doctor should consider an advance directive as evidence of a person's wishes and feelings.

The justification for not legislating for advance directives in the AWI Act was partly that it was felt better to allow case law to develop. In fact, there have been very few

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[28] ss.24-26, Mental Capacity Act 2005

[29] Scottish Law Commission (1995) Report on Incapable Adults. Scot Law Com No 151

cases, and the law is still uncertain. We believe it would be better to make explicit legislative provision for such directives. The Law Society of Scotland is currently reviewing this area of law, and we await its report with interest, before considering what recommendations we make.

3. Statement of rights, will and preferences

The Rome Review recommended that a statement of rights, will and preferences should replace the advance statement in the Mental Health Act, for people with learning disability or autistic people. We believe that this could be extended to apply to all persons who may be subject to mental health or incapacity legislation in the future. The statement could be made about all or anything that affects the person's mental disorder and as the Rome Review suggested would not only be about crisis situations or medical treatment but about the support, care and treatment the person felt they need across all areas of their life. This would inform future care planning using the human rights enablement approach we suggest at chapter 5.

A statement of rights, will and preferences should be subject to regular reviews, and only be overridden in very specific, narrow circumstances. These might include interventions which are necessary to prevent significant suffering or a serious deterioration in a person's condition, and where there is no reasonable alternative.

Further work is being carried out on these suggestions and targeted consultation will take place over the coming months. This targeted consultation will consider a new name for advance statements, the breath of topics they should cover and when they should be taken into account. Final recommendations will be made following this work, but this consultation gives the opportunity for people to give their initial thoughts on possible changes.

4. Powers of attorney

Powers of attorney are recognised as a valued means of advance planning and supported decision making but are not without criticism. Recommendations about the powers of attorney regime are found in chapter 10.

5. Decision making supporter

As part of the reform of guardianship, we have been looking at the creation of a decision making supporter. Further information on this is in chapter 10, alongside other suggestions for changes to Adults with Incapacity legislation.

6. Independent Advocacy

The right to independent advocacy 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, often having to focus on support for legal process such as a tribunal hearing, rather than provide a more holistic and accessible service, which may help to prevent a crisis necessitating compulsion from arising.

Advocacy is a valuable tool for support for decision making. The Rome Review recommended that independent advocacy be offered on an opt out basis to autistic people and people with learning disability. We suggest this approach be extended across mental health and incapacity law. This should include the recommendation that independent advocates should be able to support people through the whole process of decision making. We are undertaking further work in this area but views are sought at this stage on this approach.

In chapter 8, on accountability, this consultation considers how collective advocacy may be developed more effectively to give people a stronger voice in mental health and incapacity law.

7. Specialist support in legal and administrative proceedings

The Rome Review recommended that suspects and accused persons with autism or learning disabilities should have a right of access in law to an intermediary. An intermediary is a term used in English law. The role was created by the Youth Justice and Criminal Evidence Act 1999 [30] to help in criminal cases which involved

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[30] 1999 c. 23 Part II

vulnerable witnesses. The use of intermediaries has since spread to be included in Family Court proceedings in England due to the needs and vulnerabilities of many people involved in these proceedings. The role has also been used with success in Northern Ireland. [31]

In Scotland we have the Appropriate Adult scheme, whereby the role of an Appropriate Adult is to assist a vulnerable person, whether victim, witness or suspect/accused to understand what is going on and to support communication between the vulnerable person and the police. The Appropriate Adult's role does not continue during any court or tribunal hearing.

Access to support and representation in legal and administrative hearings is vital for all persons, and we are well aware of the gaps within the current system not just for autistic people and people with learning disability, but for all who may have mental disorder. It is particularly important for those individuals who may be diverted to a mental health disposal. This should not happen simply because a person was not given sufficient support to understand their situation.

And we know of many cases with the Adults with Incapacity legislation where the adult is not represented or able to exercise their right to appeal.

Whilst in principle we recommend that a scheme such as that suggested by the Rome Review should be available to anyone with mental disorder who is a witness, or charged with or prosecuted for an offence and who needs support with their communication, we are also considering, in conjunction with work mentioned below on named persons, looking at reframing curators so that they move from a 'best interests' approach to one which focuses more on the will and preference of the adult. The role of safeguarders will also be considered in this work.

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[31] https://www.justice-ni.gov.uk/ri

8. Named person

The role of named persons is one that has generated a lot of response to the Review. The general consensus is that the system is not working as it should, and the changes brought in under the Mental Health (Scotland) Act 2015, with the creation of the listed initiator role have resulted in fewer named persons being appointed and very little uptake of the listed initiator role.

The named person role was created by the 2003 Act. The Act attempted to define the roles of various people who may be involved with a patient. It distinguishes between the primary carer, who may have information about the patient’s care needs and the named person, who is entitled to receive information about proposed compulsory measures and take action if they think this is necessary to protect the patient’s interests.

The Act does not define the role of the named person but generally, it is to represent and safeguard the interests of the patient. The named person may be able to help the patient claim their rights by helping set out the patient’s past and present wishes and feelings and by helping the patient to be involved in, and understand, decisions about their care and treatment. However, the named person does not take the place of the patient in the way that, for example a welfare guardian could. The named person represents the interests of the patient but does not necessarily represent the patient and need not necessarily agree with the patient’s views on what should happen. This can cause some confusion as to the role of a named person.

The named person is entitled to representation at a Tribunal hearing and as a party to the Tribunal, as well as being entitled to all papers relating to tribunal proceedings. They can also initiate appeals. Any person discharging a function under the 2003 Act should consider the views of the named person before reaching a decision regarding the patient’s care and treatment.

8(a) Changes to the role of named person in 2015 Mental Health Act

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, a named person has to be notified of their role and accept it. There is no 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 a named person should be abolished. A new role of listed initiator was however created.

A listed initiator can be any relevant welfare guardian or attorney, or a patient’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 initiator 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.

8 (b) Current situation with named persons

Since the changes made by the 2015 Act to the way named persons are appointed, there has been a significant drop in the number of named persons appearing at hearings. There have been only a handful of individuals taking up the role of listed initiator.

The Review’s first consultation asking how well the 2003 Act was working drew a lot of criticism about named persons and listed initiators. In particular the MWC commented that having a named person is one way to have family and / or carer support for an individual but the changes made by the 2015 Act have made this more complicated and it is not helpful that it only comes into play when an individual is being considered for compulsory measures.

The Equality and Human Rights Commission recommended that the Review needs to consider whether the Act with the appointment of named persons, listed initiators and curators ad litem, sufficiently protects people who lack capacity, from discrimination arising from disability.

The named person can be a good safeguard for the patient, but often the named person is unsure of their role

The McManus Review also recommended the following:

> “Anyone with an interest, including carers, relatives and friends, should be able to apply to the tribunal to be appointed as named person. The appointment could be time limited or for an indeterminate time, if the service user was likely to remain unable to appoint a named person for the foreseeable future.
>
> If a service user for whom compulsory measures are being contemplated is unable to appoint, and has not appointed, a named person and no-one has applied to act as named person on his or her behalf, the mental health officer should notify the tribunal, which might appoint a curator ad litem or safeguarder to protect the person’s interests.” [32]

As mentioned above, the Review is carrying out a discrete piece of work looking at the role of the named person, how this could interact with the role of for example a welfare attorney or welfare guardian, and the position of safeguarders and curators in both Tribunal hearings and hearings for AWI cases. Targeted consultation will take place over the coming weeks. However general views on the issues raised would be welcome at this stage, including any comments on the role of safeguarders and curators more generally.

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[32] Limited Review of Mental Health (Care and Treatment)(Scotland) Act 2003, B3067752, p 24

9. Aids to communication, non-instructed advocates

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.

In addition, the Rome Review recommended that non-instructed independent advocates are allocated to all persons who are not able to instruct an independent advocate due to the limits of their communication abilities and we suggest that this should be extended across mental health and incapacity law generally.

Undue influence

This concept goes to the heart of the authenticity and voluntariness of a person's ability to make decisions. The Review Team recognises the challenge of identifying undue influence. 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 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.

One may consider influence "undue" when it mainly, or entirely, benefits the person providing the support and not the person being supported. A Code of Practice should have clear guidance on identifying undue influence.

The Review Team is considering what safeguards are necessary to ensure influence is not undue and does not impact adversely on a person's ability to exercise their legal capacity and other rights on an equal basis with others. We seek your views on how we might adopt effective, but workable, safeguards.

Controlling influences

Undue influence is an example of a controlling influence. There are various other controlling influences which may present barriers to a person's decision-making ability. Examples are:

1. Undue influence being exerted by another person, or persons.
2. Conflict of interest on the part of the person or body supporting a person's decision-making.
3. Language, or literacy, challenges.
4. Cultural barriers.
5. Environmental factors.
6. Socio-economic factors.

The supported decision making framework should be used to ensure, wherever it is possible, that the impact of such factors is mitigated.

What needs to happen practically to facilitate successful implementation of SDM?

As mentioned above there have already been a number of attempts to support autonomy in Scotland, but we suggest that a comprehensive, integrated approach is needed. This should be based on an accepted understanding of supported decision making, of rights and of principles. The work needs to be taken forward with practitioners and people with lived experiences and there needs to be commitment at Ministerial level to drive forward the right of people with mental disorder to make their own decisions.

We consider that a set of principles for support for decision making must be established as priority, and it may be that the work on developing a National Care Service provides an opportunity to have a whole systems approach. Work is needed to identify barriers and what needs to happen to enable effective SDM practice from policy to structures, management, policies and practice. Policy developments need to incorporate appropriate approaches to accessing supported decision making in the delivery of services and in different settings.

Whilst we have found an enthusiasm and willingness to take forward supported decision making, this needs to be met with the appropriate resources and understanding of what is involved.

Suggested approaches have included the establishment of a Centre of Excellence for SDM, to provide expertise, work with the Scottish Government to develop policy and practice changes, roll out training and build capacity for this work.

We are also aware that supporting decision making need not be a formal role, and is often carried out by family, friends and professionals in a range of ways. Within that there are international examples of specific schemes where SDM supporters are recruited, trained and supported. A Centre of Excellence could consider whether to develop and evaluate such schemes.

One particular proposal on which we welcome comments is creating a duty on public bodies to ensure that anyone who requires it has access to support for decision making, in the same manner as there is currently a duty (even if not fully implemented) to secure independent advocacy. The details of how that support should be provided would be shaped by guidance from the Centre of Excellence, and potentially monitored by the Centre.

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter.

We would also particularly be interested to know:

- What are your thoughts on our recommendations for a wide ranging supported decision making scheme?
- What do you consider would be the barriers to this?
- How do you think the SDM scheme should be taken forward?
- How do we mitigate against undue influence or pressure in SDM generally?
- Should there be legal duties on public bodies to secure SDM for people who need it? If so, given that advocacy is a form of SDM, what should be the relationship between that and the existing duties in respect of advocacy?
- What are your thoughts on the creation of a Centre of Excellence for Supported decision making?

4. The role and rights of carers

The role of unpaid carers of all ages

As we said in the last chapter, engagement and participation are not merely ideals for interactions between people with lived experience, unpaid carers and those who work within the mental health services. They are essential approaches that honour human rights and represent genuine partnerships to deliver the best outcomes at individual, service, and organisation level. The World Health Organization has recognised that the empowerment of people with lived experience and unpaid carers 'leads to tangible biological, psychological and societal benefits [33].

Despite this, the Review has been told that unpaid carers providing support to people with mental disorder are often excluded from any involvement in the care and treatment of their relative. This is despite the fact that the right for carers to actively participate in decisions about [34]care, with consent, is stated within the Carers (Scotland) Act 2016.

And on a purely practical level, this could be seen as a short-sighted approach as many hold vital information that the individual may not be able to give. Involving unpaid carers in recovery focussed services can lead to promotion of recovery and is also vital to ensuring the safety and dignity of the person they care for. This can then help achieve a person-centred approach to care for them. [35]

Unpaid carer experiences in mental health

In the Review's last consultation in spring 2020, we asked people to share their experiences of mental health law in Scotland. An analysis of the responses was

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[33] World Health Organization Regional Office for Europe. User empowerment in mental health: A statement by the WHO regional office for Europe. Copenhagen: World Health Organisation; 2010.

[34] ss.28-30, Carers (Scotland) Act 2016.

[35] Going Beyond Harm, joint report from Carers Trust Scotland and Healthcare Improvement Scotland, Scottish Patient Safety Programme – Mental Health, 2016

published in July 2020 [36] and a common thread in the responses from unpaid carers was the difficulties they had trying to communicate and engage with mental health practitioners. People with lived experience were also distressed at the lack of involvement and / or communication with their unpaid carers even when they had given their consent to share information.

Many unpaid carers felt ‘left-out’, ‘ignored’, and ‘under-valued’. Many reported that they were not kept informed about their family member’s progress and were not given any support for themselves. The Review has been carrying out work with its Communication and Engagement advisory group and more recently its Lived Experience reference group to look at some of these issues and come up with suggestions for change.

Engaging with unpaid carers

In Scotland there are two main resources open to mental health practitioners to better understand and work with unpaid carers.

Equal Partners in Care [37] is an online training course, designed with input from unpaid carers to raise awareness with practitioners of the needs and concerns of all unpaid carers.

The Triangle of Care [38] is a therapeutic alliance between service user, unpaid carer, and practitioner. It is based on six standards. Mental health 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.

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[36] See the Review’s *Summary of the Responses to the Consultation* (2020) report at: https://mentalhealthlawreview.scot/workstreams/summary-of-the-responses-to-the-consultation/

[37] More information about Equal Partners in Care is available here: Equal Partners in Care | Turas | Learn (nhs.scot)

[38] See *Triangle of Care: Carers Included: A Guide to Best Practice in Mental Health Care in Scotland,* Carers Trust Scotland, 2019.

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 regarding 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 carers support services is available.

A survey of mental health practitioners was carried out by the Review in 2021. This survey was looking specifically at practitioners’ awareness of unpaid carers. [39]

The full survey can be read on the Review website but in summary the responses raised concerns of a lack of awareness and training amongst mental health practitioners about the rights and needs of unpaid carers. The survey also suggested that unpaid carers and practitioners had very different perspectives regarding staff’s ability to identify and involve unpaid carers in care and decision-making.

Young carers

Over one third of young carers (across the UK) provide care for someone with a serious mental health problem who is their parent or holds a parental role in their life; yet this vulnerable group often remains hidden. [40] This could be for a variety of reasons; however research has also shown that it can be due to young carers feeling let down by inconsistent and disappointing experiences with practitioners. [41]

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[39] Scottish Mental Health Law Review (2021) Triangle of Care – A Professional Perspective. Summary of Responses

[40] Roberts et al., 2008, Smyth et al., 2011, Gray et al., 2008

[41] Young Carers of Parents with Mental Illness, student social worker, University of Salford, 2014

The Review approached several young carer services in the early phase of consultation. Only a small number of young carers responded, but some information came from services supporting them. The overall impression was similar to the research mentioned above. Young carers find that they can be routinely overlooked, can find it difficult to attend appointments (daytime appointments clash with school / university / college), and that services lack knowledge of their role.

Proposed recommendations

Considerable work has taken place in the past few years regarding the rights of carers but the concerns brought to the Review's attention suggest that not all of this work has translated into differences in people's lives, particularly when it comes to caring for people with mental disorder. So, after consideration of all the issues raised, the following proposals were suggested by the Lived Experience Reference Group in May 2021:

- Framework to be developed which encompasses best practice in identifying and working with carers of all ages and in improving communication in general.
- Carer Awareness Training to be mandatory for all mental health staff
- This training to be continuous to keep mental health staff up to date with carer rights
- Awareness raising of Carers (Scotland) Act 2016 and rights within this, especially around right to involvement in discharge planning and processes.

We welcome any comments, suggestions or thoughts you have on what we have said in this chapter. We would also be interested to know:

- What are your views on mandatory Carer Awareness training for all mental health staff?
- What are your views on information sharing with unpaid carers of all ages?
- If an unpaid carer, what are your views on sharing information with mental health practitioners?
- What is needed to ensure mental health services identify and engage with young carers?
- What are your views on including unpaid carers in discharge planning and processes, as stated in the Carers (Scotland) Act 2016?
- What needs to happen to ensure unpaid carers of all ages are respected and valued?

Please answer the questions you feel are more relevant to you, or feel free to answer all of them. Please tell us anything else you think may be relevant to the role of unpaid carers when supporting someone with mental disorder and working with services.

5. Human rights enablement – a new approach to assessment

Introduction

Mental health law in Scotland focuses on providing safeguards against unnecessary non-consensual interventions as well as safeguards where such interventions become necessary; it does not proactively ensure that a person's wider needs are respected. It also does not guarantee that the voices of people with mental disorder are heard on an equal basis with other people. It provides no absolute guarantee that the person's will and preferences will normally be paramount or that there will be access to appropriate support. Support may be necessary to overcome difficulties with making decisions, with communicating will and preferences in respect of that decision, or with taking the necessary action to give effect to the person's will and preferences.

The consistent message that the Review Team has been receiving, from persons with lived experience and their carers, is that their overriding wish is to feel respected, cared for and to receive the appropriate support and protection at the right time.

The language used to describe such desires does not always refer to "human rights" but, if these wishes are to be respected, it is essential that there is a legal framework which enables proper respect for human rights.

Proposed recommendation

To achieve this, we propose the inclusion in law of a framework which enables respect for human rights; to ensure a focus on respect for the will and preferences of people with mental disorder, whilst at the same time ensuring appropriate support and protection. The framework applies irrespective of diagnosis and would be applied in situations currently covered by mental health, adults with incapacity and adult support legislation.

Human rights enablement

In order to determine the most appropriate strategy of overall care and support, an accurate and comprehensive evaluation of the person's situation, needs and values is necessary, coupled with a plan for addressing any matters identified. We are calling this evaluation 'human rights enablement' (HRE). We believe 'enablement' encompasses both the assessment of actions needed, and the plan for action.

HRE is not a one-off or discrete event but rather an underpinning process of consideration as to how decisions or actions would be likely to affect the human rights of an individual, or of a group of people. It should provide a framework which enables professionals to make decisions that are demonstrably necessary and proportionate, identifying needs that must be fulfilled as well as any restrictions on the person.

The HRE framework, which we outline below, is part of a suite, together with supported decision making (see chapter 3) and a new proposal for an autonomous decision making test (see chapter 6). We recommend that you consider supported decision making, human rights enablement and autonomous decision making as a suite, rather than as discrete elements. Collectively they are focused on our purpose of ensuring the human rights of people with mental disorder are respected, protected and fulfilled.

Important components of HRE include:

1. Maximising a person's ability to make an autonomous decision (see chapter 3) and in doing so, 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.
    - 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. Protection of the rights of others - in some instances, decisions will be necessary to protect the human rights of other people, be this the public generally or another person individually e.g. a carer or co-tenant. This recognises that rights must be enjoyed by everyone on an equal basis.
3. Relevant human rights would be clearly identified and would be considered individually – because of this it is not possible to prescribe an enablement process of universal application but below we offer an outline of what the HRE process may look like in practice.

Please see chapter 9 for how human rights enablement applies to children and young persons.

Enabling human rights in practice

The requirement to undertake an HRE applies to public bodies in situations currently covered by mental health, adults with incapacity and adult support legislation.

We recognise there is already a complex framework of assessment processes in health and social care, including Community Care Assessments, Self-Directed Support, assessments in an application for a Compulsory Treatment Order, the Care Programme Approach and so on. We also appreciate the huge burdens on services, particularly now, and the administrative load that is imposed by any assessment process. Our intention is not to add ‘yet another assessment’ but to build on what exists now, to ensure there is meaningful consideration of an individual’s human rights when decision-making, to ensure a holistic view of the person’s needs.

Human rights are of course important for the courts and the Mental Health Tribunal, but they are also relevant in many public authority and professional decisions, even if not specifically referred to.

We also recognise that there are various examples of existing guidance on assessments which include consideration of a human rights based approach, although these may be less comprehensive that we propose. [42]

In summary, current clinical or other assessments should be widened to include an evaluation of human rights and completion of an HRE.

Evaluation overview

Things to consider as part of an HRE evaluation are:

1. What are the person's will and preferences in respect of the given issue? It may be that there is already a written statement of will and preferences. If this is the first contact with the service, there will need to be co-production of an HRE.
2. What rights, if any, are in need of protection, including the rights of others or another?
3. Have all relevant human rights been considered, including all relevant economic, social and cultural rights, not just those limited to care and treatment? A record should be made of this consideration. This record should be easily accessible for ease of later review.
4. In addition, HRE should weigh 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.

Creation of an HRE

HRE is not an additional, discrete, assessment; it is an enabling framework, which we envisage as a development of existing assessment structures. It should be a co-production between the person and the practitioner. Where an assessment is

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[42] For example, paras 4.10-4.12 of Social Care (Self-directed Support) (Scotland) Act 2013: statutory guidance - gov.scot (www.gov.scot)

currently required this should be extended to include, explicitly, an evaluation of the person’s human rights, insofar as they are relevant to the decisions to be taken.

As an HRE covers the breadth of a person’s needs e.g. economic and social as well as clinical it will normally require input from a number of persons (e.g. the person, their family and / or carers, independent advocates, various practitioners).

As HRE is supplementary to any current assessment of needs, **the person with responsibility for initiating the HRE is the person who undertakes the care/treatment/service needs assessment,** with any additional practitioners then reviewing and revising the HRE, as may be required. Your views are sought on this approach.

You will see from this, that we do not envisage repeated and fresh HREs with every referral to a new service provider but rather that the initial HRE evolves as different practitioners become involved and consider the person’s needs from their specialist perspective. An evaluation of the human rights implications becomes the responsibility of everyone involved in decisions about care and treatment with HRE being incorporated in their assessment processes.

We seek your views on this.

We seek your views also on whether there should be an identified professional responsible for ensuring that there is proper coordination, and that a coherent HRE plan is developed. If so, what are your views on who this might be, or the contact with and knowledge of the person that such a lead person should have?

Action corresponding to the situation

The requirement to undertake an evaluation of HRE is not intended to be unnecessarily burdensome; the extent of use of the HRE framework will depend on the individual's needs at a given time.

For example:

1. Some people's needs will be simple; the level of HRE should be commensurate with this.
2. A full HRE may feel overwhelming for someone already in distress. An abridged HRE may be preferable at this point, with a more detailed review once the presenting situation is controlled.
3. Some people will simply want the intervention they see as warranted and would see an HRE as unnecessary and intrusive bureaucracy. For example, a person with a chest infection, with no underlying issues, may approach their GP for advice, perhaps needing some medication, without the need for an HRE – but an HRE may be indicated for a person who attends with repeated chest infections as this may identify, for example, lack of suitable accommodation.

We recognise that there will be some cases in which it may be difficult to decide if an HRE is required, or not. For example, a person approaching their GP with moderate anxiety may not seem to require an HRE but an HRE may be beneficial in identifying the cause of anxiety which may be something which could be addressed, or which required onward referral.

Consequently, we do not intend to be prescriptive about when an HRE is definitively required leaving this to professional judgement. We welcome any thoughts you may have on this.

Right to refuse or decline an HRE

A person has a right to refuse or decline an HRE. This should normally be respected but this must be a voluntary decision of the person, having been given appropriate information of the purpose and value of the HRE and unencumbered for example by the impact of their illness or other persons (see chapter 6 on autonomous decision making). If refusal is not an autonomous decision, an HRE may need to be completed in any event if harm may otherwise result.

For clarity, a decision by the person to decline an HRE is distinct from any decision they may wish to make about the proposed care or treatment.

An HRE should be completed if the person does not have the ability to make an autonomous decision on accepting, refusing or declining the evaluation. See chapter 6 on autonomous decision making.

A refusal of an HRE 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 a review of the HRE would otherwise be due, a check should be made that the decision to decline remains.

Crisis Intervention

The Review Team acknowledge that the smooth process outlined above is not necessarily possible when the first contact with a person is at a point of crisis. As much of the process as can practicably and reasonably be completed should be done, perhaps with input from trusted relatives, friends or advocates if these are known. It is accepted, however, that there are occasions, for example involving the immediate preservation of life, when a full HRE is not possible. A record should be made of the lack of, or limited, HRE review undertaken and why a full consideration was not possible. As soon as is reasonable and practicable after the crisis is averted an HRE review, as outlined above, should be completed and recorded.

Actioning the outcome of an HRE

Outcomes of the HRE and necessary further action, if any, will vary dependent on the individual’s circumstances. Action to enable fulfilment of the person’s rights should be agreed with the person, as far as is possible. This may be by way of a Care Programme Approach or similar person-centred method which develops a coordinated plan of management. A person is entitled to decline action to address any gaps which the HRE may have identified. If refusal is not an autonomous decision, action may need to be taken in any event if harm may otherwise result.

It may be necessary to address any restrictions on a person’s rights before treatment commences, to be satisfied that the treatment remains appropriate once rights are fully enabled; but necessary treatment must not be withheld whilst the enablement of rights is in progress. A review of the treatment options may be necessary once any identified restrictions are remedied.

Ongoing HRE

As has been said, HRE is not a discrete or one-off process. It should offer a structure for continuous review by way of regular engagement, but there should also be formal updating. There should be a number of events which should trigger a review of the HRE, or relevant aspects of it:

1. A request from the person or an interested party e.g. their unpaid carer.
2. Application for compulsory care and treatment.
3. Application to authorise restrictive measures outwith 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.
4. A newly identified vulnerability.
5. A new episode of care.
6. A referral to a new / different service.
7. A formal review of the treatment plan. A review of the person’s human rights should be an integral part of the discussion with the person when reviewing their current treatment pathway and particularly so if any changes are likely to be proposed.
8. 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 should generate a review of the HRE.

If none of these events has arisen, a formal review should occur no later than one year from the date of the last review.

Remedy and Appeal

There needs to be a route of appeal on the outcome of the HRE, as well as a route to remedy, for example, failure to deliver rights to which a person is entitled, where it is reasonable that these could be met.

We are proposing 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. These reviews should include formal consideration of the benefit of mediation. The final stage would be an application by the individual or their representative to a judicial body for a legal review. The judicial body might be a court or tribunal.

We also propose that one or more bodies should have the right to ask the court (or Tribunal) to review whether it is reasonable that the rights of any group or individual are not being met. They might do this when an individual would not realistically be able to pursue such action themselves, or where there is evidence of a more systematic failure, affecting a wider group of people.

We envisage that the Mental Welfare Commission would have the power to do this, and possibly also the Scottish Human Rights Commission, or a recognised collective advocacy organisation. We seek your views.

Conflicting rights

There may be occasions when to respect one right brings conflict with another right to which that person, or another relevant person (e.g. an unpaid carer), is entitled. It is permissible to limit a person’s rights but only if this does not discriminate on the basis of the mental disorder and will demonstrably lead to more respect, protection, and fulfilment of the person’s rights, or other people’s rights. Any limitation on rights must only be to the extent required to achieve these protections.

Conflict of interest

We recognise that an unpaid carer, for example, has their own rights which are equally as valid and need respecting, but there may be occasions when a person involved in the HRE - e.g. a carer, family member or clinician - has a conflict of interest. Conflicts of interest need to be identified and managed to prevent harm to the person. That said, conflicts of interest are nothing new, they are generally recognised and handled professionally. We do not advocate any changes but will recommend inclusion within the guidance of the appropriate way in which to manage such conflicts; including with reference to confidentiality which we are advised can be particularly problematic.

Recording the HRE

To facilitate the continuing nature of HRE, the HRE, including a record of the person’s will and preferences, should be readily accessible. For example, this may be in the front of a paper file, in a specific field in a digital file, or held by the person themselves, or a combination of these options.

We recognise that there are limitations with each of these options.

It is important that anyone involved in the care, treatment and support of a person with mental disorder should have access to relevant information in the HRE (assuming the person has consented to this). Current inadequacies in the digital healthcare record network make this impossible. Recommendations in respect of health care IT networks is outwith the remit of this review but the Review Team wish to acknowledge our recommendations are limited by those IT inadequacies. Despite the current IT challenges, we consider that until such difficulties are resolved there should be a statutory requirement to ensure that, with consent, the record is placed in all relevant health and social care files and a duty on those who have made or been involved with the assessment to inform others.

We are not proposing a template pro-forma, as we wish the record to reflect the individual’s circumstances; however, there needs to be an identifiable HRE, so we are proposing a Form, clearly marked as HRE, on which there are guided sections for completion and which is then stored accessibly in the patient record.

HRE would be backed by a statutory Code of Practice setting out the underlying principles, and detailed guidance on how to operate the HRE approach in different contexts.

Training

A lot of what we outline above will already happen, albeit informally, perhaps piecemeal and without an official record. We recognise that to develop a coordinated, formal HRE structure will require a strategy of training and awareness-raising to realise the progressive change needed.

- What are your thoughts on the proposed HRE framework?
- How do you see the framework as proposed working in practice?
- What barriers do you see to its operation in practice?
- What are your thoughts on who should initiate an HRE?
- What are your views on the triggers for an HRE? Is there anything not included which should form a trigger?
- What are your views on the right to request a review and the right of remedy and appeal as proposed?
- Would the body for remedy and appeal differ if the request for a review was in respect of a group of persons rather than an individual?

Please offer any relevant views. You do not need to limit yourself to addressing these questions.

6. Autonomous decision making test

Introduction

The previous chapters covered the broad framework for supported decision making and respect for the whole range of human rights which we propose becomes the tenet of our mental health law. Notwithstanding this, the Review Team accept that there will be occasions when non-consensual intervention is required, to prevent harm, to act for someone's wellbeing where they are unable to personally request this, and even to give effect to will and preferences which were expressed at some earlier point but are still relevant.

Capacity and SIDMA

Currently, justifying such intervention is predicated on a test of capacity under the Adults with Incapacity (Scotland) Act 2000, or significantly impaired decision making ability (SIDMA) under the Mental Health (Care and Treatment) (Scotland) Act 2003.

There are divergent views on the value of both the current capacity and SIDMA tests. Some people see these as giving a level of objectivity and focus but will tend to comment that more clarity is required in how the tests should be applied, to enable consistency of application.

Contrary to this, there are a significant number of people who are more critical of the current tests; for example, that they:

- are subjective
- 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

- are applied inconsistently
- are misunderstood
- are applied too early in practice, to facilitate treatment and resource allocation decisions rather than considering other options.

Those who see little value in the current tests feel they are not always fit for purpose, with capacity assessments being inappropriately made, resulting in unnecessary restrictions of the person, or made so that appropriate support for a person can be secured or, alternatively, involving a person being denied vital support because they are considered to have capacity. Those who favour the tests emphasise their objective value, if applied properly.

The Review Team wish to seek wider opinion.

We seek your views on the following questions.

1. Are you in favour of the current capacity and SIDMA tests remaining – unchanged?
2. Are you in favour of the current tests remaining, distinctly – but with one or both reframed, if possible, to address the current problems articulated above? If you would prefer a reframed definition, please feel free to comment on what you would wish to see adjusted.
3. Are you in favour of the current tests remaining but reframed as a single test? If so, would this include additional matters, or be a reworking to conjoin the current tests?
4. Do you see little value in the current tests, preferring to see one or both of them replaced?
5. You may prefer an option not mentioned. Please feel free to comment.

Proposed Alternative Test

Subject to strict safeguards, an inability to make an autonomous decision may warrant others taking action on behalf of that person, to ensure that their authentic views can be given effect, insofar as they are known, or until such time as these views can be ascertained

Capacity and SIDMA tests are currently used to justify intervention in the absence of the person's ability to consent. If the current tests are abandoned, what would form the threshold for non-consensual intervention? The Review Team are proposing a test of autonomous decision making ability (ADM).

The Review Team believe, where it is possible, a person must make an autonomous decision, and if necessary be supported to make that decision. All people, irrespective of diagnosis, should have the opportunity to make an autonomous decision.

In chapter 3 we discussed the impact of controlling influences. An autonomous decision is one which is free from controlling influences, i.e. factors which may adversely impact on autonomous decision making. A person's ability to make an autonomous decision can be adversely affected by such controlling influences, rendering the person unable to express an authentic view, or for others to know the person's authentic view.

In chapter 3 we gave examples of controlling influences which may present a barrier, or barriers, to a person's autonomous decision making. To these, we now include:

- The impact of a person's illness or condition
- Crisis

The SDM framework should also be used when such factors are present, to support a person, as far as is possible, to reach an autonomous decision. It is accepted however that, even with every support, such controlling factors may limit the person's

ability to make an autonomous decision. They are factors which, according to European human rights law, may in limited circumstances provide justification for detention, involuntary treatment or other decisions without consent.
This is contrasted to the potential barriers mentioned in chapter 3. Those factors are not recognised in human rights law as possible justifications for non-consensual interventions. However, it is recognised that they may exacerbate, or adversely impact on, the person's illness to such an extent that a person is unable to make an autonomous decision.

In summary, the Review Team accept that there does need to be a threshold at which non-consensual intervention is justified. Subject to views on incapacity and SIDMA these tests, potentially reframed, may continue to form the threshold for non-consensual intervention but we wish too to explore a threshold in the absence of these tests.

We are proposing a new autonomous decision making test – which provisionally is seen as replacing the capacity and SIDMA tests. The test of autonomous decision making is not predicated on a diagnosis.

Autonomous decision making (ADM) test – the concept

1. The ADM test should take place within the supportive and enabling frameworks outlined in previous chapters.
2. The ADM test may be applied in any contexts, wherever it appears the person is unable to make an autonomous decision.
3. The test is not based on any specific diagnosis but on whether the person can arrive at an autonomous decision. It may therefore apply potentially to any person.
4. Diagnosis may be important in determining the nature of support and interventions that are required, to enable effective enjoyment of the person's rights.
5. The ADM test is decision specific.

6. 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.
7. Where a person is judged 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. 'Harm' would be defined in legislation with further explanatory narrative in guidance.
8. 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.
9. A decision to intervene without giving full effect to the person's will and preferences is permitted only if this will demonstrably lead to more respect, protection, and fulfilment of the person's rights overall, or to prevent harm to another person or other persons. Intervention must only be to the extent required to achieve these protections.
10. A decision 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.
11. 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 authenticity, or voluntariness, of their decision-making.
12. Any departure from a person's will and preferences must be for as short a period as possible.
13. Any restriction on a person's autonomous decision making must be lawful and proportionate, and non-discriminatory.

Please see chapter 9 for how the test applies to children and young persons.

Autonomous decision-making (ADM) test in practice

Non urgent situation

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 others, the SDM and HRE frameworks as outlined in chapters 3 and 5 should be used to establish what the person's autonomous wishes are, what their needs are, and how these can be best met.

However, where it is felt that the person may not be able to consent to a proposed intervention then some authority is required to validate the intervention. The ADM test will be applied. The steps are outlined below but detail would be provided in guidance.

1. Firstly, there is a need to ensure that there is a framework of support for the person. The ADM test should not be applied until every support has been provided to maximise the person's ability to make an autonomous decision.

If, despite every support, the person is unable to make an autonomous decision on the proposed intervention:-

2. It is important to know why this is – for example, as a result of impact from one, or more, of the controlling influences mentioned above. The record would include the rationale for concluding that the person is not able to make an autonomous decision.
3. Before proceeding, the evaluation of human rights would be reviewed (see chapter 5). If this is not the first contact the person has had with relevant services, there should be a human rights enablement record easily accessible within their file. That said, this may need updating as the record may have originated from contact with another provider and so have taken no cognisance of the treatment or intervention you are now proposing. If this is

the first contact an HRE should be completed, in accordance with chapter 5, before proceeding with the proposed intervention, if the situation permits this.

4. It may now be possible to consider the expressed authentic will of the person. Any expressed advance wishes must be considered, for example those made in an advance statement.
5. If there are no advance wishes, or they are unrelated to the situation now faced, then a best interpretation of what the person’s preferences may be, or may have been, must be sought (see chapter 3). If a best interpretation of the person’s likely wishes can be established, this should be respected.
6. Dependent on the proposed intervention, it may now be possible to justify progressing with a non-consensual intervention. But, before this, there must be consideration of any formal legal authority which may be required; for example, completion of a Section 47 ‘Authority to Treat’ certificate or authorisation by Tribunal.

Urgent situations

The Review Team recognise, however, that in some situations where action is required with immediacy, for example where there is a serious and imminent risk of harm and action is necessary to protect the rights of the person or of others, it may not be possible to complete the ADM test process before initiating the immediate protections.

1. Even in crisis, significant efforts should be made to provide every support for decision making.
2. Consideration must be given to any expressed advance wishes, for example those made in an advance statement or plan.
3. If there are no advance wishes, or they are unrelated to the situation now faced, then every effort must be made to seek a best interpretation of the person’s likely will and preferences. It is recognised that to proceed contrary to the person’s will and preferences may exacerbate the crisis.

4. To the extent possible, before proceeding, an evaluation of human rights implications should be completed.

A decision to intervene without the person's express consent is permitted only if this will demonstrably lead to more respect, protection and fulfilment of the person's rights overall, or to prevent harm to another person or other persons.

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. The authority to treat may require an ADM test, and the person may be able to make an autonomous decision to refuse treatment.

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?

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 stated above.

We seek your thoughts on the skills and experience required by an individual in order that they may competently carry out an ADM test.

Conflicts of will and preferences

There may be occasions when past will and preferences conflict with currently expressed will and preferences. The person responsible for the ADM test, following review of the HRE and any decision to intervene, should determine the best resolution of this conflict, which should be the option which best protects the person’s human rights overall. More information would be offered in guidance.

Recording the ADM test

The nature of the record may vary dependent on the particular intervention but the 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 (see chapter 5 ‘Recording the HRE’).

Review and renewal of the ADM test

The authority granted for non-consensual intervention is only to the extent needed and only for as long as needed to achieve the protection required. The completion of the ADM test, and any renewal of this, should include a review date, which should be commensurate with the likely duration of the loss of the person’s ability to autonomously decision-make on the given matter. In any case, authority may be granted for no longer than one year at a time but could be renewed annually, for as many occasions as may be needed to achieve the protections required. Authority must be revoked sooner if the person regains autonomous decision-making ability.

A review for potential renewal of the authority should be within one month of expiry of the original authority. The renewal process should reflect the original ADM test as outlined above.

Appeal of the ADM test findings

There should be an appeal route for concerns about an ADM test outcome.

Where the ADM outcome indicates requirement for a judicial intervention, for example the application for a compulsory treatment order, or for a decision-making representative (see chapter 10 on guardianship), the judicial consideration of the ADM test would be part of that process.

However, there will be occasions when non-consensual treatment follows an ADM test that is not judicially authorised, for example, treatment currently covered by a section 47 certificate under the Adults with Incapacity Act. We seek your views on a discrete ADM test appeal procedure. Things you may wish to consider are:

- What qualities should the appeal have? - for example, it needs to be accessible and speedy.
- Who can trigger an appeal? – the person themselves or any other party with an interest?
- Should it have escalation – for example, commence with an internal review before secondary or external review?
- Who should conduct an external review?
- Should there be easy access to an independent second opinion? How might this be obtained?
- Should there be any limit on the frequency with which one can dispute an ADM outcome?
- Should there be access to a judicial process?

- We seek your views on the current capacity and SIDMA tests.
  You may wish to use the numbered options in that section above to indicate your preferred position but feel free to offer other suggestions and to expand on your preference.
- We seek your views on the concept of the test of autonomous decision making, distinct from a capacity or SIDMA test.
  We have deliberately not asked specific questions; we wish to leave this open for you to offer any comments on its workability for different categories of persons and to make any suggestions for improvement.
- What are your views on the skills and experience required for someone to competently undertake a test of a person’s ability to make an autonomous decision?
- What are your views on the ADM appeal process?

Please read the chapters on enablement of human rights, supported decision making and this chapter on the autonomous decision making test as part of a suite of key information.

7. Reduction of coercion

The Review is interested in all involuntary support, care and treatment. This may include, for example: interventions which may currently be authorised in the community, hospitals or care homes by the 2003 Act, the AWI Act, other legislation or the common law; *de facto* detention (detention without proper legal processes); and blanket restrictions. We are interested in common aspects of how mental health services operate, such as locked wards, and the broad range of actions covered by "Seni's law" in England on the use of force against patients in mental health units, and how care homes operate, for example. [43]

All of this involves coercion to some extent. Coercion is generally understood to involve force or the possibility of force. [44] Detention and compulsory treatment under the 2003 Act, for example, is inherently coercive. However, coercion is not only about detention, restraint and seclusion in their various forms. It also includes other restrictive practices such as surveillance without informed consent, interference with private communication, and restrictions on social relationships. Coercion is also about how you are made to feel when you feel that you have no choice but to be subjected to or go along with something you are not happy with.

We recognise that some professionals will be uncomfortable with the use of the word "coercion" to describe aspects of current practice. This chapter explains what we mean by the word, and we invite views on this. Of course, we think that the vast majority of professionals do not want to use coercion, if it can possibly be avoided. We are addressing the use of coercion as a *systemic* issue.

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[43] Mental Health Units (Use of Force) Act 2018

[44] See for example: Barbui, C. et al (2021). Efficacy of interventions to reduce coercive treatment in mental health services: umbrella review of randomised evidence. The British Journal of Psychiatry, 218(4), 185-195; and Szmukler G. (2015) Compulsion and "coercion" in mental health care. World Psychiatry 14:259–261. The Committee on the Rights of Persons with Disabilities in its General Comment No 1 interpreting Article 12 CRPD and Guidelines on Article 14 CRPD refers to 'forced treatment' rather than 'coercion'.

The impact of the UNCRPD

The UN Convention on the Rights of Persons with Disabilities requires States to ensure equal treatment of people with mental disorder in all areas of life, including support, care, medical treatment and decision-making. The UN Committee on the Rights of Persons with Disabilities has issued a General Comment on Article 1*2* of the Convention [45] on the exercise of legal capacity, and has issued Guidelines on Article 14 of the Convention on liberty and security. [46] Since these documents were published, there has been extensive debate across the world about whether the Committee's conclusions go further than the Convention requires, and about tensions between that Convention, the European Convention on Human Rights, and other international human rights treaties.

We have considered the Committee's recommendations and have spoken to a number of international human rights experts about what the Convention requires. We understand that Scotland, as part of the UK, has committed to reform its law towards compliance with the UNCRPD – the Convention – and to *take account* of direction from the United Nations Committee on the Rights of Persons with Disabilities on how to do this.

In the long term, it might be possible to remove coercion which constitutes *unequal treatment* of persons with disabilities. This would require the United Nations *as a whole* to clarify its position on what it now means by "disability discrimination" and unequal treatment in this context. At this time, the Review's position on reducing coercion reflects our understanding that, 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. This reflects current practice across the world, despite some models which may be considered closer to the Committee's interpretation.

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[45] UN Committee on the Rights of Persons with Disabilities (2014) General comment No.1. Article 12: Equal recognition before the law http://daccess-ods.un.org/access.nsf/Get?Open&DS=CRPD/C/GC/1&Lang=E

[46] Committee on the Rights of Persons with Disabilities (2015) Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc

We believe that major change is needed to law, policy and practice to meet the aspirations of the Convention. We do not believe that it is possible now, or perhaps in the future, to abolish mental health or incapacity law, and the United Nations has not called for all such law to be abolished. [47] Not everything we want can be achieved straight away, but it is vital that we set Scotland on a path towards a fundamentally different culture, in which all the rights of people with mental disorder are respected, protected and fulfilled on the basis of equality and non-discrimination.

The experience of coercion

We are listening to and reflecting on the views of those who use services in Scotland, as the UNCRPD requires. While views differ, we have mainly heard 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 – including that they be detained or required to take medication.

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. And in some cases, earlier intervention might have avoided the need for compulsion. We are also extremely concerned about situations where compulsion and institutional care are continued for extended periods – not because the person cannot be supported in the community, but because the support the person needs and deserves has not been put in place.

People with lived experience have also told us of the importance of culture and attitudes to reducing compulsion and coercion. Services which are in a comfortable environment, which demonstrate compassion, care, empathy and humanity are likely to require far less coercion than services where people feel bored, patronised or side-lined, with no private space, and where relationships are discouraged. Peer support, shared decision making and community connections will all have a positive

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[47] General Comment 1 from the UN Committee on the Rights of Persons with Disabilities called for law reform to ensure that the legal capacity of persons with disabilities is fully respected on an equal basis with other persons. We understand that this is not a call to abolish all mental health and capacity law. http://daccess-ods.un.org/access.nsf/Get?Open&DS=CRPD/C/GC/1&Lang=E

effect on relationships, and better relationships are central to changing how people feel about the care and treatment they receive.

Defining coercion

It may be important to define 'coercion': to enable monitoring and reduction of coercion, and because a particular level of coercion may require a particular kind of authorisation such as going to a tribunal. More generally, a definition may be needed so that rights can be balanced proportionately when decisions are made about whether it is appropriate to intervene without consent. This is a complex and emotive area and the Review is considering how this complexity can best be reflected in law. We are interested in suggestions on how to authentically describe lived experience and professional experience of coercion in mental health and social care services.

Our current understanding of coercion is as follows:

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. Of course, many interventions may have effects that are not necessarily wanted, so this is not unique to psychiatry; but it is important that we consider how best to mitigate these harms.

“Coercion” describes a very broad range of actions. For example, in consultation and through the review’s advisory groups, we have heard that institutional cultures can shape attitudes and behaviours towards both voluntary and involuntary patients, with coercive effects which cause harm and no benefit. Coercion such as that is clearly not appropriate. Both for these contexts, and for contexts where coercion is appropriate, 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.

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 also involve inducements, and anything else against the person's free will. Coercion which involves inhuman or degrading treatment or disrespect for the person's dignity can never be justified.

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 partly be defined objectively, but a person may subjectively experience coercion through an action that is not viewed or intended as coercive by the person who carries out that action.

Current law and coercion

Both the 2003 Act and the AWI Act 'front-load' the judicial oversight of compulsion – they pre-authorise a range of potentially coercive interventions.

There is little judicial scrutiny at the time coercive interventions are made. The legislation can sometimes mask situations where coercion actually happens. Even if a patient is admitted on a 'voluntary' basis, their acceptance of treatment may be effectively coerced by the threat of compulsion – 'if you try to leave, or if you don't take your medication, we'll detain you and make you take it'.

It is sometimes assumed that the 2003 Act is used where forcible treatment is required, while the AWI Act is about support for people who can't take decisions. In fact, medication can be forcibly or covertly administered under the AWI Act, and there are significant concerns about issues such as the administration of antipsychotic medication in care homes. The COVID pandemic has increased these concerns.

Medical treatments for detained patients are subject to the Designated Medical Practitioner (DMP) system for second opinions in Part 16 of the 2003 Act, but there are no specific legislative safeguards for restraint and seclusion.

The Mental Welfare Commission monitors the use of detention under the 2003 Act and the granting of welfare guardianship under the AWI Act. It is not currently able to monitor systematically particular coercive interventions, or to interrogate why they are being used.

Reducing coercion through law reform

We believe that it is important to have law which regulates decisions that involve coercion, to protect the person. Greater support and enablement of rights should reduce the need for coercive interventions but may not remove the need for it. If we did away with a legal framework, decisions to use coercion would in many cases still be taken, but without oversight or safeguards.

Greater levels of coercion require stronger safeguards. It is possible that high levels of coercion are currently used in situations which have relatively weak safeguards in law in Scotland. Scotland may need to do much more to record, monitor and address coercion across settings.

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.

This requires a ‘full spectrum’ approach across law, policy and practice, including all five concrete actions identified by the UN Special Rapporteur, Dr Dainius Pūras [48] :

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.

We note international research which states that:

> “…efforts to prevent and reduce coercion appear to be effective. However, no jurisdiction appears to have combined the full suite of laws, policies and practices which are available, and which taken together might further the goal of eliminating coercion.” [49]

We believe Scotland can and should be a leader in this comprehensive approach.

We note international evidence that different models of hospital and community services can dramatically reduce the need for coercion. With a few exceptions, such as the Scottish Patient Safety Programme, we have found limited evidence of similar innovation in Scottish mental health services in recent years, and we believe that much more work is needed.

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[48] UN Human Rights Council (2017) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/HRC/35/21

[49] P. Gooding, B. McSherry, C. Roper (2020) Preventing and reducing ‘coercion’ in mental health services: an international scoping review of English-language studies, *Acta Psychiatrica Scandinavica,* 142(1) 27-39

Our initial view is that Scotland’s approach to reducing coercion in services should include 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

None of these elements on their own could provide the sole answer to distress and disabling mental disorder, and these draft recommendations would not be a replacement for a national mental health strategy.

Sense of belonging, connection and trust in society

Communities should be enabled to develop their own forms of peer support and community support; for example, for diverse ethnic communities, the deaf community, prisoners, the homeless or other communities.

Community wellbeing hubs are needed to serve every community, both for people with a mental illness and to support the wellbeing of the general population. To define what these hubs should be, we need coproduction in research into what community services would help improve mental health and wellbeing and also ultimately reduce coercion. We need innovation, and there are lots of examples which we should look at. [50]

The Review has heard about new models of open, flexible and accessible crisis services in different countries. In Scotland, a range of supports may be needed to avoid crisis; for example; intensive home treatment, assertive outreach, crisis houses, open dialogue and early intervention in psychosis. More generally, it may be that community mental health teams need to be part of the community, not

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[50] Relevant examples of community-based services from other countries include community mental health centres in Trieste in Italy (here and here); prevention and recovery care units in Victoria in Australia (here, here and here); and the Ethnicity & Mental Health Improvement Project in London (here).

institutionalised as a series of offices in health centres. These are our initial observations. It will be important that 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

The following may all be needed:

- A systematic improvement programme led by Scottish Government and involving services, people with lived experience and regulatory bodies, over several years, to reduce restrictive and coercive practice across the mental health system.

- Implementing support, services and approaches which have been successful in reducing coercion in other countries. This will require scope to experiment and a culture of willingness to learn from others and spread good practice. However, approaches should not remain localised to one area of Scotland. Ultimately, there should be consistency in approaches, resourcing and recording across Scotland with good practice adopted nationally rather than operating only in pilot areas.

- Implementing ward-level interventions which reduce coercion including restraint, such as Safewards.

- Academic research on approaches to reducing coercion which is led by people with lived experience.

Stronger safeguards when compulsion is authorised

Part 16 of the 2003 Act deals with safeguards for medical treatment. We are considering whether we should recommend strengthening these safeguards, including the current responsibilities of the Mental Welfare Commission and ‘Designated Medical Practitioner’, and ways in which the patient or their supporters might challenge particular interventions.

There is a ruling of the European Court of Human Rights [51] 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. There may also be a need to consider *how* the use of different forms of coercion is authorised.

We also wish to consider extending the ‘excessive security’ appeal provisions [52] which currently operate in high and medium secure care to provide an appeal right in other situations where a person is subject to greater restrictions than are justified in their individual case.

We intend to review the time limits which operate on compulsory measures to assess whether they could be reduced.

The Review is considering what further safeguards could be included for restraint, seclusion and other non-medical interventions in a range of settings.

- **Monitoring and scrutiny**

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. [53] We think that the scrutiny system may need to have a sufficiently wide scope to consider evidence/data and identify underlying causes of coercive treatment. We also think that measures to address those underlying causes may need to be systemic measures, not just measures for individual institutions.

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[51] X. v. Finland, no. 34806/04, 2 July 2012, European Court of Human Rights

[52] Mental Health (Care and Treatment) (Scotland) Act 2003 sections 264-273

[53] See chapter 8 on accountability

We are considering whether there is a need to provide powers to the Mental Health Tribunal to ensure that supports are in place which might mean compulsion is not necessary or can be ended more quickly. [54]

We think there may be a need for stronger requirements for services to record, reflect on and reduce coercive practices, along with national monitoring of coercive practices which drives learning and improvement. This Review may be able to identify groups that are likely to be particularly affected by coercion. However, it would be for a new monitoring and scrutiny system to do the work of actually measuring the experiences of groups who may be particularly affected by restrictive practices.

More work will be needed to define various forms of coercion. 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.

Improving the recording and monitoring of coercion in Scotland across settings would be a complex and long-term task. It would be important that a new system was not unduly bureaucratic and did not have perverse consequences.

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[54] See chapter 8, subsection on recorded matters.

Work in progress

Rising rates of detention

The Review's remit includes considering why there has been an increase in compulsory detention and treatment and the reasons for variation in compulsory orders across Scotland. The use of detention has increased over time in Scotland, with the most dramatic increases in the incidence of orders for emergency detention and short-term detention. [55] The Review has asked the Mental Welfare Commission (MWC) to analyse its dataset and report on the increasing use of community-based Compulsory Treatment Orders in Scotland. In addition to the *number* of people on orders, the *length* of those orders is important. MWC has found that some short-term detentions were being allowed to lapse, instead of being ended as soon as possible. [56] The length of community-based Compulsory Treatment Orders is discussed below.

We are aware that criteria can have a major effect on how often involuntary treatment and detention are used in mental health services. Research for the Wessely Review of England's mental health law could not give definitive reasons for an increase in detentions, partly because better data are needed, but that research did identify some factors which were more likely to have contributed to the increase. [57] 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. [58] Ireland has around half the rate of involuntary psychiatric admission of England, and different legislation may be one reason for this. [59] Norway introduced a capacity-based criterion to its Mental

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[55] Mental Welfare Commission for Scotland (2021) Mental Health Act monitoring report 2020-21. Page 14.

[56] Mental Welfare Commission for Scotland (2021) How long do short term detentions last and how do they end?

[57] Rains, L. S., Weich, S., Maddock, C., Smith, S., Keown, P., Crepaz-Keay, D., ... & Lloyd-Evans, B. (2020). Understanding increasing rates of psychiatric hospital detentions in England: development and preliminary testing of an explanatory model. BJPsych Open, 6(5).

[58] Smith, S., Gate, R., Ariyo, K., Saunders, R., Taylor, C., Bhui, K., ... & Pilling, S. (2020). Reasons behind the rising rate of involuntary admissions under the Mental Health Act (1983): Service use and cost impact. International journal of law and psychiatry, 68, 101506.

[59] Conlan-Trant, R., & Kelly, B. D. (2021). England's rate of involuntary psychiatric admission is double that of the Republic of Ireland: Why? A consideration of some possible causes. Medicine,

Health Act in 2017. This led to a significant and unexpected increase in the use of community-based treatment orders. [60]

Community-based Compulsory Treatment Orders

In many countries, there is debate about whether orders should be used for mental health treatment in the community. In 2001, the Millan Review recommended community-based Compulsory Treatment Orders for Scotland's mental health law. 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'. Community-based Compulsory Treatment Orders contain greater safeguards than the previous model, which was leave of absence at the discretion of the person's psychiatrist.

Despite the extensive use of these orders in Scotland, there appears to have been relatively little controversy over their use. These orders are each scrutinised by the Mental Health Tribunal, which can only approve an order if it is found to be necessary. The Mental Welfare Commission reported on the use of these orders in 2011: [61]

> "There was much to praise in the way people subject to CCTOs were being treated. Generally, we commend NHS, local authority, voluntary and independent services for the care and support they offer. This is reflected in…the views of the people we met during our visits."

Science and the Law, 00258024211029071.; Gilhooley, J., & Kelly, B. D. (2018). Return of the asylum. The British Journal of Psychiatry, 212(2), 69-70.

[60] Høyer, G., Nyttingnes, O., Rugkåsa, J., Sharashova, E., Simonsen, T. B., Høye, A., & Riley, H. (2022). Impact of introducing capacity-based mental health legislation on the use of community treatment orders in Norway: case registry study. BJPsych Open, 8(1).

[61] Mental Welfare Commission for Scotland (2011) Lives less restricted: A report into the use of compulsory community treatment in Scotland.

The Commission reported on longer-term use of these orders in 2015: [62]

> “About half the people we saw felt the order was of some benefit to them, though very few were clear under what circumstances the order would be revoked. Half had issues with the order, related either to medication or the requirement to accept care and support. We generally felt that practitioners carefully weighed up the benefits of the order, the risks of not being on an order and considered patients’ views in extending the orders. However, a number of people felt they were not listened to and there are challenges in trying to ensure they have meaningful participation in the review of their care and treatment and, where possible, an ‘exit strategy’ from compulsory treatment…Care plans were in most cases appropriately addressing the person’s needs and had a focus on recovery.”

Community-based CTOs may be too narrow in approach, in that they do not address the wider needs of the person such as social inclusion. This Review is proposing a range of approaches to address people’s wider needs, and those proposals apply to people who are subject to community-based orders.

Millan gave a very approximate estimate that around 129 people might be made subject to community-based CTOs. In early January 2021, 1677 people were subject to a community-based CTO in Scotland. [63] This is thirteen times higher than Millan’s prediction.

Millan reported three concerns which were expressed during consultation but concluded that these orders were both justified in principle and had potential for practical benefit.

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[62] Mental Welfare Commission for Scotland (2015) Visits to people on longer-term community-based compulsory treatment orders.

[63] The Mental Welfare Commission’s MHA monitoring report for 2020-21 reports that of 3751 individuals who were subject to any Compulsory Treatment Order in Scotland on 2nd January 2021, 44.7% were subject to a community-based CTO. This equates to 1677 people.

The concerns were:

- A concern about imposing treatment in community settings, and particularly in a person's own home. As Millan intended, treatment is not forcibly administered in someone's own home. However, community-based CTOs 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.
- Community treatment orders might become an additional control imposed on people who would otherwise have been dealt with on an informal basis. A very large proportion of CTOs are now community-based CTOs, and the very substantial increase in community-based CTOs has not been associated with a decrease in hospital-based CTOs. [64] This suggests that community-based CTOs 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.
- 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. MWC has found relatively little planning for discharge from these orders. [65] [66] One MWC study found that the average durations of community-based CTOs were longer than for hospital-based CTOs. [67] Scottish community-based CTOs may also last much longer on average than English Community Treatment Orders. [68]

Research with MWC data found that, after beginning a community-based CTO, the average of number "hospital bed days" per patient fell very substantially for most age

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[64] Mental Welfare Commission for Scotland (2020) Response to Phase 1 Consultation of the Scottish Mental Health Law Review. Paragraphs 92 and 94.

[65] Mental Welfare Commission for Scotland (2011) Lives less restricted

[66] Mental Welfare Commission for Scotland (2015) Visits to people on longer term community-based compulsory treatment orders

[67] Welsh, H., & Morrison, G. (2017). Learning disability and the Scottish mental health act. Advances in Mental Health and Intellectual Disabilities.

[68] Using a different methodology from the Welsh and Morrison MWC study above, England's NHS Digital reported data for 2015 on the average duration of Community Treatment Orders, by age range and by gender. These average durations ranged from 77 days (0.2 years) for females aged 18 to 24, to 149 days (0.4 years) both for females aged 17 or under, and males aged 65-74. Based on data from April to November 2015 due to the introduction of a new data set. Table 1 here

ranges. [69] The researchers did not simply explain the reduction in hospital use as being a result of the compulsory treatment mandated by the CTO, as the CTO might bind the individual into a more assertive or effective form of holistic community service. International research has reported mixed results on benefits of community-based compulsory treatment orders.

Benefits of community-based CTOs may come at a cost. Interviews with people who had early experience of community-based CTOs showed that [70] :

> "Although [the introduction of community-based CTOs] was regarded by some service users as a positive innovation, the limits imposed on autonomy, choice and control were universally unpopular. Those with early experience of community CTOs reported feeling stigmatised by compulsion, regardless of setting and regretted the missed opportunity for wider treatment alternatives and more recovery-orientated approaches."

A major additional concern has emerged: there is evidence of racism in the use of these orders. Recent work by the Mental Welfare Commission for Scotland showed how orders have been used with different ethnic communities in Scotland [71]. 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. In England, people of black African or Caribbean heritage are 10 times more likely to be subjected to Community Treatment Orders than those of white heritage. [72] The Review will continue to explore this issue to try to understand what this data means for Scotland.

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[69] Taylor, M., Macpherson, M., Macleod, C., & Lyons, D. (2016). Community treatment orders and reduced time in hospital: a nationwide study, 2007–2012. BJPsych Bulletin, 40(3), 124-126.

[70] Ridley, J., & Hunter, S. (2013). Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health & social care in the community, 21(5), 509-518.

[71] Mental Welfare Commission for Scotland (2021) Racial Inequality and Mental Health in Scotland: A call to action.

[72] A figure of 8 times more likely was cited in the Wessely Review final report (2017-18 data; here). By the time of the UK Government White Paper on mental health law reform in January 2021 (here), this figure had risen to 10 times more likely.

The Review will continue to consider community-based Compulsory Treatment Orders during the final consultation, including international research in this area.

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would be particularly interested to know:

- Your views on how the Review understands coercion
- What you think about the Review's proposed approach to reducing coercion, including reducing the use of involuntary treatment
- Whether you think that "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
- Your views on whether law reform could drive changes which could reduce the use of coercion. Changes might include: changes to physical environments; changes to resourcing and better valuing of staff; addressing attitudes and culture; and acceptance, participation and activities on wards, for example.
- Whether you think that safeguards for medical treatment in Part 16 of the Mental Health Act should be strengthened, including the current responsibilities of the Mental Welfare Commission and 'Designated Medical Practitioner', and ways in which the patient or their supporters might challenge particular interventions.
- Your views on whether the Mental Welfare Commission should have stronger powers to oversee the use of coercive interventions and to identify areas for action.
- Any suggestions that you have for the Review's ongoing work on understanding rising rates of detention and on community-based Compulsory Treatment Orders

8. Accountability

Introduction

In 2008, the then UN Special Rapporteur on the right to health, Paul Hunt, described accountability as one of the most important features of human rights. And one of the least understood.[73]

A strong accountability framework is an important element of a human rights approach. By this we mean, first that people know what their rights are. Then, they need to know what they can do and where they can go if they feel their human rights are being violated. There need to be clear and accessible ways for people to challenge this and seek a remedy or solution. People need to be empowered and supported to use these routes to remedy to claim their rights. Ultimately, people will become the best protectors of their own human rights.[74] But, even if fully aware of our rights, we may need help to protect them. In addition, it should not fall on the shoulders of an individual to tackle known systemic issues that breach their rights. Systemic issues are issues that affect more than one person. This suggests these issues are built into the system around the person rather than as a result of their individual circumstances. So, it is not enough to provide effective and accessible routes to remedy for individuals. We must also have sufficient oversight of our systems to be able to identify if people are being deprived of their rights, and address that if they are.

We need to be sure that there are appropriate bodies 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 we are doing in realising and protecting people’s rights. This will also allow us to know and be honest about

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[73] Hunt, Paul (2008) *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*. Human Rights Council, p17.

[74] Sunkel, Charlene and Shekhar Saxena (2019) “Rights-based mental health care”. *The Lancet Psychiatry*. 6:1, 9-10, Elsevier Ltd. p10.

how well (or not) we are doing. It will also help us identify and address systemic issues.

Clear, effective accountability systems – or 'frameworks' - are needed to protect everyone's human rights. A lot of work is already going on across the Scottish Government which may change our existing accountability frameworks. Strengthening accountability was key to the National Taskforce for Human Rights Leadership's recommendations.[75] The Scottish Government has accepted the recommendations of the Taskforce, including incorporation of human rights treaties into Scots Law. This should provide an overarching framework for the protection of everyone's human rights. The inquiry into mental health services in NHS Tayside called for a national review of assurance and scrutiny of mental health services across Scotland. [76] Scotland's health and social care sector is currently focused on the Scottish Government's commitment to create a National Care Service. This was recommended by the review of adult social care in Scotland.[77] The Programme for Government 2021-22 promises a Patient Safety Commissioner and a new Learning Disability, Autism and Neurodiversity law and Commissioner.[78] The review of forensic mental health services identified the need for greater accountability and oversight of these services.[79] The Scottish Government has set up a collaborative working group to decide what to do about that.

All the programmes of work may create new routes to remedy for people who may currently fall under our mental health and capacity law. Our focus is identifying the requirements (including the removal of barriers) to ensure accountability mechanisms are available, effective and equitable for people who are covered by our current mental health and incapacity laws. Including our full range of human rights,

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[75] See the National Taskforce for Human Rights Leadership (2021): Final Report.

[76] Inquiry into Mental Health Services in NHS Tayside (2020): Final report: *Trust and Respect*, recommendation 12.

[77] Independent Review into Adult Social Care (2021): Final Report, recommendation 16.

[78] Scottish Government (2021): *A Fairer, Greener Scotland: Programme for Government 2021-22*, p32 and p49.

[79] Independent Review into the Delivery of Forensic Mental Health Services (2021): Final Report: *What we think should happen*: Final Report (2021) p16-20

means our accountability framework also needs to be more comprehensive and user-centred.

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) tells us what an accountability framework covering disabled people needs to include. 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. And, the right information must be collected to make sure we develop policies that support the realisation of people's rights.[80]

A recap

The main focus of the accountability framework in the Mental Health Act is to make sure that people covered by the Act are not abused, ill-treated or neglected. This includes making sure that any detention and compulsory treatment is legal. It includes the powers and responsibilities of the Mental Welfare Commission for Scotland and the role of the Mental Health Tribunal for Scotland (the Tribunal). However, we set out in chapter 2 how current mental health and incapacity laws should not just focus on safeguards for when our civil and political rights are violated.

To recap, we are clear that mental health and incapacity laws should not just regulate what can be 'done to' people covered by these laws. It should also remove barriers that stop them from realising all of their rights. This includes their economic, social and cultural rights. These rights include the right to health and the right to independent living. This means that 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.

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[80] UN Convention on the Rights of Person with Disabilities, Articles 4.3, 13, 16 and 29.

Some new accountability measures have already been proposed in earlier chapters. For example, in chapter 2 we propose what additions we think are needed to our accountability framework if it is to protect, promote and fulfil all the human rights of people covered by our existing mental health and capacity laws.

These included:

- Developing a set of core minimum obligations.
- Ensuring duties for health and social care reflect human rights standards.
- A strategy for how we will progressively realise economic, social and cultural rights for people with mental health conditions.
- How we think the few duties in our existing legislation that do link to the promotion and fulfilment of some economic, social and cultural rights should be extended. (These duties are in sections 25-27 of the 2003 Act).

Then, in chapter 5 we consider potential accountability mechanisms for our proposals on Human Rights Enablement (HRE). These include ways a person would be able to get different aspects of this process reviewed by the courts or the Tribunal. In chapter 6, we ask for your thoughts on the review and appeal processes needed to address any concerns about the outcome of an Autonomous Decision Making (ADM) test.

Chapter 10 considers our proposals in respect of the current Adults with Incapacity Act. We are suggesting a new decision-making model to replace guardianship, intervention orders, access to funds and management of residents’ finances. We also seek your views on the supervisory processes which should accompany the reframed decision-making model, as well as how we might strengthen Part 5 safeguards and those for powers of attorney.

In this chapter, we set out some more recommendations and ideas for strengthening the accountability framework for mental health and incapacity laws. We have grouped these around three themes:

- Remedies and access to justice.
- Advocacy, advice and support.
- The scrutiny and regulatory landscape.

For each, we set down the position we have reached and our suggestions for change. At the end we ask some specific questions, but we welcome any feedback you have on the ideas and issues in this chapter.

Remedies and access to justice

People must have access to justice through a range of remedies when their rights are violated. For these to meet human rights standards they need to be accessible, affordable, timely, and effective. It is important that people do not always have to go to court to seek redress. But there does need to be access to an ultimate legal remedy. The National Taskforce for Human Rights Leadership recommended a new statutory framework to ensure that access to our judicial remedies better meet these human rights standards. It should also make sure that all our rights, including our economic, social, cultural and environmental rights, are enforceable rights.[81] This means they can be enforced by a court or tribunal.

As we are recommending some new legal remedies here, it becomes even more important that steps are taken to ensure people covered by our mental health and capacity laws can get access to expert legal advice and support.

A report by the Mental Welfare Commission in 2019 identified specific barriers that people with mental ill health experience when seeking legal representation. People said the biggest barrier was their mental health condition itself. It could leave them

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[81] See the National Taskforce for Human Rights Leadership (2021): Final report (2021)

unmotivated, delusional, paranoid or distressed. This impacts on people's ability to organise, understand or participate in legal processes. Other barriers included worrying that solicitors did not understand the needs of people with mental health problems. People also said it was hard to find solicitors with enough understanding of mental health legislation. This was especially true in remote and rural areas.[82]

Investigating deaths

Section 37 of the Mental Health (Scotland) Act 2015[83] requires the Scottish Government to review the arrangements for investigating the deaths of people who are under compulsory care and treatment in hospital at the time of their death. The remit of the review was later extended to include similar deaths in the community. It reported in 2019. It found that not all deaths were investigated. Investigations were not carried out in a consistent way. They were not guaranteed to be independent. Carers and families highlighted the wide and unacceptable variation in time taken to carry them out.[84]

These investigations link to the protection of 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. These deaths should 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 summarises the human rights based requirements based on judgements from the European Court of Human

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[82] See the Mental Welfare Commission (2019): The views of people with experience of mental ill health on the barriers that they face in getting legal representation.

[83] 2015 asp9 s37

[84] See Scottish Government (2018): *Review of the arrangements for investigating the deaths of patients being treated for a mental disorder*.

Rights. It provides a checklist for conducting effective investigations into these deaths.[85]

The Scottish Government review decided that the Mental Welfare Commission should develop a system for investigating these deaths. The Mental Welfare Commission has recently consulted on their proposals for this.[86] We want to be sure that any new arrangements meet the human rights based requirements for such investigations. We also note that the consultation did not explicitly suggest any aspect of the arrangements would need to be incorporated into law. This could leave gaps in accountability. It may also leave those responsible for these investigations without the necessary powers to gather or share the information that they need.

The investigation of deaths of people in legal custody is treated differently in law. A Fatal Accident Inquiry must take place into the death of anyone while in custody. The HM Inspector of Prisons for Scotland, the Chief Executive of Families Outside and the Chair of the Scottish Human Rights Commission concluded a related review in 2021. They reviewed the response to deaths in prison custody. Their final report recommended a new independent body to conduct timely reviews of every death in custody.[87]

We will continue to consider the work underway around deaths in custody and detention as we consult and finalise the recommendations for our final report.

The Mental Welfare Commission is also currently piloting a system for reviewing homicides by people who have had recent contact with NHS mental health or learning disability services. We will consider further whether recommendations are required around investigations of mental health related homicides for our final report.

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[85] See the Equality and Human Rights Commission (2015): *Human Rights Framework for Adults in Detention*.

[86] See the Mental Welfare Commission (2021): *Investigating deaths occurring during compulsory care and treatment under mental health legislation in Scotland: A consultation on the Mental Welfare Commission for Scotland's proposals*.

[87] Independent Review of the Response to Deaths in Prison Custody (2021): Final Report (2021), key recommendation, p.6.

Recorded matters

The Mental Health Tribunal for Scotland (the Tribunal) is a judicial body which takes decisions regarding compulsory treatment under the 2003 Act. This includes authorising Compulsory Treatment Orders and considering appeals against compulsion. It can generally only decide whether compulsory measures are justified in individual cases. However it does have some limited powers to make ‘recorded matters’ (under section 64(4)(a)(ii) of the 2003 Act). This allows it to specify services it thinks should be provided for people on a Compulsory Treatment Order. Anything they specify is then called a ‘recorded matter’.

This power was intended to support the principle of reciprocity in the Mental Health Act. This principle was about making sure that people compelled to accept treatment got the services that they needed in return. For example, the Tribunal can face situations where a person continues to be detained because there is no alternative support in the community. The Tribunal could then make the identification of alternative support in the community a ‘recorded matter’. This can encourage NHS and local authorities to find the resources needed to allow someone’s detention to end. However a Mental Welfare Commission report in 2020 highlighted the limitations of this power.

In 2020, the Mental Welfare Commission published a themed report on people with learning disability in hospital. It found a high number of people whose discharge from hospital was delayed. The reasons for this included lack of funding, accommodation, or appropriate care provider. They found a small number of cases where the Tribunal had made a ‘recorded matter’ for the local authority to identify the services needed to support the person’s discharge. They found it hard to judge how effective this was. They gave one example of ‘recorded matter’ being made in 2014. The ‘recorded matter’ was to identify accommodation and support for someone within six months. This had still not been done when this report was published six years later. [88]

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[88] See Mental Welfare Commission for Scotland (2016) *Visiting and Monitoring Report. No through road: People with learning disabilities in hospital*.

We think that the Mental Health Tribunal's power to grant 'recorded matters' should be strengthened.

We think 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.

We are keen to hear whether there should be any limits placed on what services the Tribunal can require. We know there are constraints on resources which may mean that services cannot always deliver everything they would like to. However, the process of establishing core minimum obligations discussed in chapter 2 and the human rights enablement process proposed in chapter 5 would assist the Tribunal in deciding when it would be reasonable to require services to be provided to meet the human rights of the patient.

We do not intend this power to be used to require professionals to deliver care which they do not believe can be clinically justified. However, such a clinical decision could itself only be justified if the patient has been involved in the decision-making process using the principles of supported decision making.

Excessive security appeals

People held in high and medium secure hospitals have the right to appeal against the level of security they are being held in.[89] These appeals are heard by the Mental Health Tribunal for Scotland. The review into forensic mental health services recommended that low secure patients should also have that right. They could be moved into conditions of lesser security, including the community.[90]

We think all patients subject to compulsion should have a right to appeal against being subjected to unjustified restrictions. Unlike the appeals for excessive security,

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[89] Sections 264-273 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

[90] Independent Review into the Delivery of Forensic Mental Health Services (2021): Final Report: *What we think should happen*, recommendation 13.

this proposal is not just about a person's right to move to a less restrictive care or treatment setting. It is also about people having the right to challenge the level of restrictions while staying in the same place. For example, it could allow someone to challenge 'blanket' restrictions on a ward. This is when the same set of restrictions are applied to everyone on the 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.

Complaints

Earlier reviews of mental health services have found that complaint processes do not work well for people wishing to raise issues about their care and treatment. The review of mental health services in NHS Tayside said the complaint system did not appear to designed around the needs of complainants.[91] 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 with their care and treatment.[92]

We have also heard that people receiving or seeking mental health care and treatment can experience specific barriers within the complaint system. People fear repercussions. They do not have the psychological safety needed to freely complain because they continue to rely on the services for their ongoing care and treatment. People fear not being believed or being labelled a 'trouble-maker'. They have had concerns dismissed as part of, or used as further evidence of, their illness. These barriers can be such that people do not even view as the complaint system as a viable option for them. They simply do not complain.

At the point of considering the need to complain, people can be distressed or in crisis. They often do not have the time, knowledge, or resilience to contemplate what was described as an 'onerous' process. We also heard that the process of going

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[91] Inquiry into Mental Health Services in NHS Tayside (2020): Final Report: *Trust and Respect*, paragraph 3.56.

[92] Independent Review into the Delivery of Forensic Mental Health Services (2021): Final Report: *What we think should happen*, Section 6.1.4.

through the complaint system can lead to a person’s mental health getting worse. One person said her experience had replicated and mirrored what people with trauma endure. She felt she was not listened to, she was not heard, she was not seen and she was not believed.

People told us mental health complaints are complex and time-consuming. We received little compelling evidence why this is, or needs to be, the case. There was a sense that if people were appropriately involved in decisions about their care and treatment or had their concerns truly heard as they arose many complaints could be avoided. Some people who want to complain need more support to share their experience in a way that works for them. While mediation is included as an option within the process, this is not often used. Mediation might be quicker, more accessible and more effective for some people. Some people just want to make a suggestion or ask a question, rather than complain. We heard examples of people using the complaint system as a last resort just to get clear, open answers about their treatment.

People felt that not enough was done to learn from complaints. There is no requirement to check the extent to which complaint decisions result in any positive change for the complainant. NHS Boards do publish annual reports on their complaints. People felt there was room for these to be more meaningful. For example they could identify trends and patterns of issues or what learning had been fed back into the system.

There was little evidence that human rights are routinely considered as part of complaints handling processes. One person stressed the need for complaint handling bodies to understand the rights held by complainants. The National Taskforce for Human Rights Leadership wanted the human rights role and capacity among scrutiny bodies to be strengthened. [93] Those bodies who already have a greater focus on rights like the Mental Welfare Commission and the Scottish Human Rights Commission do not look into individual complaints.

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[93] National Taskforce for Human Rights Leadership (2021): Final Report, Policy Objective 19.

Scrutiny bodies, like complaint handling bodies, will play a critical role making human rights based approaches across services a reality. Scrutiny bodies need to be supported to build their capacity to play this part. Similarly, those people who support people to make complaints must be helped to build their knowledge of human rights. The National Human Rights Leadership Advisory Group has already recommended that new duties for scrutiny bodies are needed to ensure human rights obligations are given effect by all public authorities. [94]

We must have a complaint system that is fit for purpose. The current complaints handling process seems to assume an equity of access for people with long term mental health, or intellectual or sensory impairments which in reality does not exist. We need a system 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 think the ways a person can raise a concern or complain about their care and treatment should be reformed. The ideas that have come from the evidence we have received so far suggest:

- The ways for someone to be able to challenge their care and treatment need to be more equitable, accessible, co-ordinated and effective.
- They need to be designed around the needs of the complainant. Complainants and their families, and complaint handling bodies should be equal partners in the development of these.
- The formality and purpose of the complaint process needs to be challenged. The idea of ‘remedy panel’ rather than a complaint handling process captures the solution-focused and collaborative aspects people told us they would like to see.
- 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

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[94] As above.

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.

There may also be learning available from changes other public bodies have made to their complaints systems as a result of the pandemic. For example, Police Scotland recorded a significant increase in the proportion of complaints resolved through their Frontline Resolution process in the first two months after the first COVID-19 lockdown in 2020. Using this process meant that, 'more of the complaints received in the first two months of the lockdown period were resolved through explanation, apology and assurance than in the prior two months'.[95] Lessons to learn from this might include changing the complaints system to provide much more accessible processes, quicker responses, acknowledgement and, where appropriate, apology.

Collective complaints

There is no clear place within the existing accountability framework for people to take collective complaints to. Even if scrutiny bodies suspect there may be systemic failures behind the individual complaints they look at, they are limited in what they can do. This leaves it up to different individuals to each seek their own redress.

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[95] See Scottish Police Authority (2020): *Meeting 30 June 2020 Paper: Independent Advisory Group on Police Use of Temporary Powers related to the Coronavirus Crisis*, p.11.

The National Taskforce on Human Rights Leadership wanted organisations with ‘sufficient interest’ to explicitly be able to bring systemic cases of public interest to courts.[96] They felt this was especially important in the context of economic, cultural and social rights where issues often affect many people. In chapter 5 in relation to our proposals on the human rights enablement (HRE) process, we have suggested more bodies should be able to ask courts to review whether the rights of any group or individual are not being met. Our initial suggestion is that the Mental Welfare Commission and the Scottish Human Rights Commission should be able to do this. We also asked collective advocacy groups if they would welcome being able to bring cases to court. Some groups were enthusiastic, others pointed out potential risks or supported an alternative escalation pathway.

At this point, we suggest that:

- 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 also know that individual advocacy organisations often also provided collective advocacy. They gather data and intelligence on issues they support people with as part of their commissioning and funding processes. As such they are also well placed to notice patterns in human rights breaches for example in particular services or geographical areas e.g. people being ‘detained’ in the community without a formal or legal detention order. This means they are also well placed to be able to take

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[96] National Taskforce for Human Rights Leadership (2021): Final Report, Policy Objective 23.

court action for human rights breaches. We welcome any views you have then on extending these proposals to individual advocacy groups.

Independent advocacy

In Section 259 of the 2003 Act, people with a mental disorder have a right to independent advocacy. Local authorities and the NHS have to make sure this is available. They need to report to the Mental Welfare Commission on this. Despite this, people tell us there is not enough advocacy available. Where it is available it is often limited to advocacy on detention processes e.g. for tribunals. This is another indication that the current system favours our civil and political rights over our economic, social and cultural rights. Everyone who needs advocacy needs to be able to get it.

Chapter 2 already seeks views on some of our ideas for independent advocacy. These proposals reflect the important role it has in supporting decision-making. One of the proposals is that independent advocacy should be offered to everyone covered by our mental health and incapacity law on an ‘opt-out basis’. It also considers the need for a new duty on NHS Boards and local authorities to make sure *whatever support* a person needs for decision making is available.

The current provision for independent advocacy is mainly funded for adults. We make a number of proposals to strengthen the provision of advocacy for children and young people in chapter 9. This includes the proposal that 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. And, a duty for Scottish Ministers to support collective advocacy for children.

We will continue to consider these issues alongside the need for any further proposals for individual advocacy during the consultation. Below we set down our proposals for collective advocacy.

Collective advocacy

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 run by and for their members. And they are independent.

UNCRPD's Committee General Comment No. 7 emphasises the importance of groups like this. It says governments need to strengthen the capacity of these groups to allow them to participate in all phases of policy making. It says resources should be prioritised for those groups that focus on advocacy for disability rights.[97]

Provision of collective advocacy is inconsistent across Scotland. The current right to advocacy under the Mental Health Act does not specify collective advocacy. This means it is sometimes overlooked in favour of funding individual provision. We did a targeted consultation among collective advocacy groups and other representative groups last year to help us form some proposals for change. The consultation paper and the summary of responses has been published on the Review's website.[98]

The responses confirmed the important role collective advocacy can play in realising and promoting people's human rights. Collective advocacy groups raise awareness of rights with their members as well as with organisations. It needs to be available in community and hospital settings. They provide a safe and supportive place for people to voice their concerns. They do not take on individual issues, but look across issues they are told about for themes. This means they can identify gaps and issues in services which could indicate wider systemic issues. They want to be fully involved in all levels of decision-making as set down in UNCRPD's General Comment 7. They would need to be better supported and resourced to do this.

We consider that collective advocacy is one of the key ways to ensure people are involved in decisions that affect them. It increases the capacity for people to affect

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[97] See United Nations Committee on the Rights of Persons with Disabilities General Comment No. 7 (2018).

[98] See Scottish Mental Health Review (2022): *Collective Advocacy Report: Consultation Paper and Summary of Responses*.

change in areas that they define as important. Evidence shows that groups that face discrimination and marginalisation experience particularly poor outcomes when using mental health services. It is therefore particularly important that collective advocacy is available for all marginalised populations. This includes racially minoritised people, people across our LGBTQ+ communities, children and young people. Both the mental health system and people who are marginalised in the system would benefit from specialist collective advocacy groups.

We propose strengthening collective advocacy in the following ways:

- A duty on the Scottish Government to secure and support effective collective advocacy organisations. This should be at a local and a national level. The need for an obligation to ensure that collective advocacy for children and young people is supported is discussed more in chapter 9.
- There should be a duty for NHS Board/local authorities to provide and resource this. However, collective advocacy groups cannot be ‘mandated’ into existence, they must continue to emerge from the needs, wants and views of their potential members.
- 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.
- 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. We do not propose any reciprocal duty on groups to take these opportunities. They remain accountable to 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.

There should be national, regional and local groups, as well as issue specific advocacy groups, that can feed into all levels of policy development. UNCRPD's General Comment 7 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.[99]

Feedback from collective advocacy groups highlighted that the disabled people's movement is not a homogenous one. There was concern that one overarching coalition covering all disabilities may simply result in the mental health voice being marginalised or misunderstood within it. However the value of coalition work which could retain specialist mental health expertise and focus was recognised and supported. There could be benefit in a national organisation to support the development and promotion of collective advocacy. This body could provide direct support to local groups around infrastructure, clarity of purpose, recruitment and training for members and could directly employ staff. Equally, there is a role for a body which is placed to collect and amplify the issues arising from mental health groups across Scotland.

Scrutiny and the regulatory landscape

We need to know how our mental health services are doing. We need to have oversight of the system. And we need scrutiny bodies who hold duty-holders to account. These are vital parts of an effective accountability framework. (Scrutiny bodies include different types or organisations. They can be regulators, inspectors complaint handling bodies, commissioners). As we outlined above, there is other work already going on which may make changes to our existing framework.

The inquiry into mental health services in NHS Tayside services said that there is only 'limited scrutiny and oversight of our mental health services' at a national level. It said there was no system of assurance. It highlighted that some oversight bodies cannot enforce the recommendations they make. It recommended a national review

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[99] United Nations Committee on the Rights of Persons with Disabilities General Comment No. 7 (2018), paragraph 57.

of the assurance and scrutiny of mental health services.[100] The Scottish Government has responsibility for delivering this recommendation. It is being supported by the Mental Health Services Quality and Safety Board to do this. They are in the process of developing proposals about what they are going to do.

The development of a National Care Service will also impact on the existing health and social care scrutiny mechanisms. However decisions are still being made about which services will be included and what accountability framework it will have.

Here we set down our initial views on what is needed in terms of scrutiny to promote, protect and fulfil the rights of people under mental health and incapacity law. We expect to be recommending further changes to the wider scrutiny landscape. We will be considering this more during the consultation and as we finalise our recommendations in the summer.

The scrutiny landscape

There is no one body with oversight and accountability for our mental health and incapacity legislation. The health and social care scrutiny landscape is made up of a number of bodies who together have responsibility for overseeing our mental health services. This is a form of 'networked governance'. This is when there are many stakeholders and no one actor has all the knowledge or influence.[101] It includes the Mental Welfare Commission, Health Improvement Scotland, the Care Inspectorate, the Scottish Public Services Ombudsman, Audit Scotland, NHS Education for Scotland and the Public Guardian in Scotland

People have told us that it can be useful to have more than one set of eyes across a system, with different perspectives. It becomes an issue however if the system becomes too confusing or fragmented. If this happens it can be difficult to identify

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[100] Inquiry into Mental Health Services in NHS Tayside (2020): Final Report: *Trust and Respect*, paragraph 3.64, Recommendation 12.

[101] Healy, Judith. (2011). *Improving health care, safety and quality: reluctant regulators*. London: Routledge. p.60.

who is responsible for what. There is then a risk of duplication of oversight in areas or conversely of aspects falling through unidentified gaps.

We have heard that it can be difficult for the public to work out what agency or body is responsible for what when looking to raise a concern. For example, it can be hard to work out how the different roles and processes across the 2003 Act, the ASP Act and the AWI Act relate to each other. There are then different levels of accountability between the different laws.

We think it is striking that there is no comprehensive regime of inspection of mental health services. The Mental Welfare Commission visits hospitals, but is not an inspectorate. The Care Inspectorate focuses on social care. Healthcare Improvement Scotland does not normally inspect services (apart from private hospitals) and has a focus on improvement.

Gaps in the current system include:

- No one organisation has an overview of the system as a whole and how well it is working for people.
- 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', the user voice in scrutiny appears weak.

Attempts have been made to address some of these concerns across health services more generally. The Sharing Intelligence for Health & Care Group was set up in 2014. Co-ordinated by Health Improvement Scotland it is a group of seven of our national scrutiny bodies. Each body has a different scrutiny role within our mental health and care services. The group's aim is to share and make good use of existing data and intelligence to improve the quality of care.

Successful 'networked governance' relies on the different players speaking with each other to allow them to arrive at shared ways of thinking about principles and processes.[102] The Sharing Intelligence for Health & Care Group is an example of where this happens. Its role could be developed or extended. Its current focus is the NHS not the wider system. It also does not specifically focus on mental health.

Alternatively, we could introduce a system of inspection and regulation of our mental health services. This is the path other countries have chosen. So we could look to introduce duties and responsibilities into our accountability framework similar to those of Care Quality Commission in England or the Mental Health Commission in Ireland. These could sit with the Mental Welfare Commission or another body.

It has been argued that a responsive regulatory landscape feels appropriate for a sector like health. This is on the basis that people who work within it generally do so with the intention to do good rather than harm.[103] A responsive regulator seeks to work respectfully and collaboratively with professionals within the services. Its initial focus is achieving compliance through persuasion and capacity building. But services need to know that there are consequences if they do not comply with these conciliatory methods.[104]

As said above, the inquiry into mental health services in NHS Tayside concluded that there was no system of assurance for mental health services It pointed out that while Health Improvement Scotland and the Mental Welfare Commission make recommendations, they do not have effective powers of follow-up or enforcement. It therefore specifically included a review of the powers of Healthcare Improvement

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[102] Healy, Judith (2011). *Improving health care, safety and quality: reluctant regulators*. London: Routledge. p. 60.

[103] Healy Judith (2017). "Patients as regulatory actors in their own health care". In *Regulatory Theory: Foundations and Applications*, edited by Peter Drahos. 591-609. Acton: ANU Press. p. 605.

[104] Braithwaite, John (2017). "Types of responsiveness". In *Regulatory Theory: Foundations and Applications*, edited by Peter Drahos, 117-132. Acton: ANU Press. p. 118-9.

Scotland and the Mental Welfare Commission as part of the overall review of assurance and scrutiny it recommended. For example, it found Health Improvement Scotland identified similar issues in inspections in NHS Tayside in 2014, 2017 and 2018.[105] Similarly, when the forensic mental health services review published its final report in 2021, it highlighted that some of issues it found had already been identified by the Mental Welfare Commission in 2017.[106]

A human rights approach to mental health recognises the need and value of people with lived experience's involvement in the monitoring and evaluation of services. UNCRPD's General Comment 7 calls for this level of participation.[107] As we said in chapter 2, we need to look at ways in which people with lived experience feel that they have ownership of scrutiny bodies, through equal roles in inspection and in governance. Collective advocacy groups felt it was important they were involved in governance and oversight activities. This includes the monitoring and evaluation of services. One group felt this was especially important for assessment and treatment units, long stay hospitals and care homes. They explained, 'we see time and time again the failings of these services but nothing has changed to make us any safer'. Another group suggested that they could be one of a number of organisations that could be called on to investigate specific issues.

This is about empowering people to be involved in decisions which affect their lives. The voice of families and unpaid carers of people also needs to be included. However, there is an additional benefit of involving people who use services in the regulation and scrutiny processes of those services. It decreases the risk of 'regulatory capture'. 'Regulatory capture' is when the people meant to be providing scrutiny start to identify more with the services than the people using them. People

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[105] Inquiry into Mental Health Services in NHS Tayside (2020): Final Report: *Trust and Respect*, paragraph 3.64 and recommendation 12.

[106] Independent Review into the Delivery of Forensic Mental Health Services (2021): Final Report: *What we think should happen*, Section 6.1.5, 6.2.2,

[107] See United Nations Committee on the Rights of Persons with Disabilities General Comment No. 7 (2018).

using services often have different ideas about what makes for a good quality service. The value lies in these different perspectives.[108]

So our initial proposal is that:

- 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.

This is only a very provisional recommendation. We recently met with a range of scrutiny bodies to explore ideas and we will develop these over the next months as we consult more widely.

We are also considering the need for additional proposals to do with data collection. The UN has asked the UK to increase the availability of high-quality, timely, and reliable, disaggregated data in relation to UNCRPD.[109] 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. For example, in chapter 4, we provided an example of how disaggregated data allowed the Mental Welfare Commission to expose evidence of racism in the use of Compulsory Treatment Orders. In chapter 2, we have already identified the need for additional monitoring processes to oversee the use of restrictive practices. And that these must help us to understand and address the extent to which specific groups may be particularly affected.

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[108] Care Quality Commission (2020). *Rapid literature review on effective regulation: implications for the Care Quality Commission.* p.13.

[109] See the United Nations Committee on the Rights of Persons with Disabilities (2017): *Concluding Observations on the initial report of the United Kingdom of Great Britain and Northern Ireland*, paragraph 65.

We are considering too, the extent to which this Review should be ensuring sufficient scrutiny of the social determinants of mental health. These are external factors that can impact on our mental health, like employment, education, housing and social connection. But they are not mental health services. However, in chapter 2 we are proposing a re-framing, extension and increased oversight of sections 25–27 of the 2003 Act. The human rights framework coming out of the National Taskforce for Human Rights Leadership recommendations may also address the barriers to accessing these wider factors, as they are also linked to the realisation of everyone's economic, social and cultural rights.

The Mental Welfare Commission

The Mental Welfare Commission has a duty to promote the principles of the 2003 Act. It visits people in hospitals, prisons and, to a lesser extent, the community; monitors the use of the Act; provides advice to other bodies, professionals and the public; 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 or to services, but does not regulate services and has very few powers to order changes to happen. In 2021/22 it received £4.5 million. This covered its core corporate costs and funding for specific projects. This is a very small part of the overall mental health budget.

Representatives of families and carers have told us they feel the Mental Welfare Commission is limited in the way it can help individuals who feel voiceless in the system. The Mental Welfare Commission's survey of its stakeholders in 2020 said that people wanted them to able to offer more practical support and help to patients and their carers. Professionals were significantly more positive about the Commission's advice line's ability to solve problems. They value the opportunity to get a 'sense check' or reflect on a particular situation. Some people who responded wanted greater powers to follow-up and monitor recommendations they have made. However some professionals felt this could change how professionals and the

Mental Welfare Commission worked together. They felt the strength of the Commission lay in its approachability.[110]

We believe the Mental Welfare Commission's role should be extended if it is to more effectively reflect the wider human rights framework. This will require an increase in the organisation's size and budget. We have discussed this with our practitioner and lived-experience advisory groups and the Mental Welfare Commission. These are initial proposals:

- Making its core remit to safeguard and promote the human rights of people covered by mental health and incapacity law.
- Strengthening the requirement to include people with lived experience in their work and governance, and to engage with organisations representing people with lived experience.
- Increasing its work in community settings.
- 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.
- Powers to initiate legal proceedings to protect the human rights of any person or group covered by mental health and capacity law.
- Statutory responsibility to monitor incapacity and adult support and protection legislation.
- Stronger powers to oversee the operation of advance statements and other forms of supported decision making to ensure these are given due weight in individual cases.

Additionally, in chapter 7 we considered the need for stronger requirements for national monitoring of the use of coercive practices. This included proposals for stronger powers for the Mental Welfare Commission to oversee the use of coercive interventions and identify areas for action.

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[110] See the Mental Welfare Commission (2020): *Stakeholder Research Report*.

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter and on any other aspect of accountability you wish to let us know about.

We would also particularly be interested in the following:

- What do you think about our proposals to give the Mental Health Tribunal increased powers to order that specific care and / or support be provided for a person?
- What do you think about the ways we want to extend current excessive security appeals to anyone who feels they are being subjected to unjustified levels of restriction?
- What do you think about our ideas for reforming the ways a person can raise a concern or complain about their care and treatment? Do you have any other ideas to make this process more effective and equitable?
- What are your thoughts on collective advocacy groups raising court actions? What about our idea of creating a way for them to escalate unresolved human rights issues to an identified scrutiny body? Is there an existing organisation you feel should take on that role? Should these proposals also cover individual advocacy organisations?
- What are you views on why and how we think collective advocacy should be strengthened?
- Do you have any suggestions to make the scrutiny landscape for mental health services more effective?
- What do you think about the ways in which we think the role of the Mental Welfare Commission should be extended? Do you have other ideas?

9. Children and young people

The United Nations Convention on the Rights of the Child (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 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.

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 has 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 also 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 2003 Act, simply because other services which might be more appropriate do not exist. Too often, families and carers do not feel supported or empowered. There is also evidence that, as with other transitions within mental health systems, that from childhood into adolescence and then adulthood is often poorly managed.

Several Reviews, including this one, 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. [111]

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 [112] of the UNCRC and the UNCRPD, which require states to bring about real equality for children with mental disorder:

- 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.

Principles

There should continue to be a specific principle reflecting the needs and rights of children in the principles of future mental health law.

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[111] Independent Care Review (2020) the rules https://www.carereview.scot/wp-content/uploads/2020/02/The-Rules_pages.pdf

[112] A paradigm is a set of theories which explain the way that a particular subject is understood at a particular time.

The 2003 Act has a set of principles at the beginning. One 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’ [113].

This consultation document sets out a possible set of four new principles for mental health law. [114] These principles are: respect for dignity; respect for autonomy; non-discrimination and equality; and inclusion. These should all apply to children, but we think we need to keep a specific principle which should apply to children.

The current child welfare principle appears 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 are asking for views on whether the current 2003 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.

We are also thinking about whether there is more we can do to ensure that the principles have real force, rather than being seen as a general guide which may not always be given effect.

Rights to support

There should be a statutory duty on Scottish Ministers and health and care agencies to provide for children with mental disorder the minimum core obligations necessary to secure the rights set out in international treaties. This should include the right to the highest attainable standard of mental health. The duty should be attributable and enforceable.

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[113] Section 2(4), Mental Health (Care and Treatment) (Scotland) Act 2003

[114] See chapter 2

We believe that the right to support for mental health needs to be strengthened. The Human Rights Taskforce 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.[115]

We are considering a similar recommendation in respect of adults,[116] but there will be some particular supports which are more relevant to children, including education. We are developing our recommendations in relation to Economic, Social and Cultural Rights, and will consider any further specific issues affecting children as we do so.

As far as we can tell, although the existing duties in the 2003 Act for local authorities to provide services (sections 25 to 26) apply to children as well as adults, they are not used in that way, at least in any sense that can be measured.

The 2003 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. There is some evidence that this has contributed to the development of specialist in-patient services for children, but we wish (a) to strengthen the accountability for it, and the ability of young people, their families, or bodies like the Mental Welfare Commission to challenge a failure to deliver, and (b) to extend the duty beyond in-patient services.

Section 277 of the 2003 Act seeks to ensure that children who are detained continue to access education. There are some good examples of this for long term detention,

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[115] Recommendation 13, National Taskforce for Human Rights Leadership Report

[116] See chapter 2

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.

Crisis services

There should be 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

The safeguards for emergency detention in respect of children and young people should be strengthened, including:

- **A requirement that the detention be approved by a mental health officer**
- **A review of the detention within 24 hours.**

Our joint event with the Royal College of Psychiatrists, which also involved lawyers, social workers, nurses, psychologists and other stakeholders, highlighted a particular concern around crisis interventions, when children are felt to be at serious risk of self-harm. It was felt that mental health services were being asked to fill in for gaps elsewhere in the system. This meant some people would receive 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. This may hold promise as a way of de-escalating crisis situations.

A particular aspect of the principle that children may require more protection than adults relates to deprivation of liberty. Experts have argued that a child has a right to be brought before a 'competent authority' within 24 hours of detention. [117] This has implications for emergency and short term detention, neither of which currently provide this. The Mental Welfare Commission is concerned that Mental Health Officers (MHOs) may often not be involved in emergency detentions. There has been 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. [118] Emergency detention without MHO consent has increased during the pandemic, reducing still further the safeguards. 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.

Age-appropriate services

Section 23 of the 2003 Act (discussed above) is generally understood to mean that children should be in specialist services rather than adult wards, although it is not an absolute requirement. The Mental Welfare Commission monitors and reports on the extent to which children are admitted to adult or non-specialist wards. We anticipate that the minimum standards which need to be developed would reflect the need for age-appropriate services.

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[117] Article 37(d) 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 state that protection against arbitrary and unlawful deprivation of liberty is applicable to all deprivations of liberty, including for mental illness. For children, protections include: immediate access to a lawyer, or to adequate free and independent legal assistance; and to be brought before a competent authority to examine the legality of the (continued) deprivation of liberty within 24 hours. This is a higher standard than that required for adults. Tobin and Hobbs argue that access to a lawyer is required well within twenty-four hours of a child being deprived of his or her liberty unless the state can demonstrate that there are reasonable grounds to justify its failure to ensure such access. Tobin, J. and Hobbs, H. (2019) Art.37 Protection against Torture, Capital Punishment, and Arbitrary Deprivation of Liberty. In: The UN Convention on the Rights of the Child: A Commentary. Editor: Tobin, J. Oxford University Press.

[118] Mental Welfare Commission for Scotland (2020) Characteristics of young people detained under the Mental Health Act in Scotland 2015-19

16 and 17 year olds

Children should be entitled to access CAMH Services where needed at least up to their 18th birthday.

The child welfare duty in section 2 of the 2003 Act applies to anyone 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. There may also be a need for a developmental approach for young adults. The brain continues to grow, and cognitive abilities continue to mature, until as late as 25 to 30 years of age. [119]

Relatives and families

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.

Children who are able to do so should have the right to choose their ‘named person’, in the same way as adults can.

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.

We had a lot of evidence of families feeling shut out of decision making – but also some evidence from young people of services talking to families rather than them.

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[119] O’Rourke, S., Whalley, H., Janes, S., MacSweeney, N., Skrenes, A., Crowson, S., MacLean, L. and Schwannauer, M. (2020) The development of cognitive and emotional maturity in adolescents and its relevance in judicial contexts. Literature review for the Scottish Sentencing Council.

Under Article 5 of the UNCRC, families have a right to support their children, and this may need more formal recognition.

We acknowledge that there are tricky issues about how to frame this for children aged 16 or 17, who are adults in terms of parental rights and the Adults with Incapacity Act, but children under the UNCRC.

We also recognise 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. 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”).

Capacity and supported decision making

Unlike adults, it is not argued by human rights bodies that the will and preferences of children, including children with disabilities, should always be given full effect: the best interests of children should always be a primary consideration in decisions for children, 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. This may amount to a kind of supported decision making, but that concept is not commonly used in respect of children. There are examples from the Additional Support Needs Tribunal and elsewhere of ways to enhance the voice of children in legal processes, and how to maximise capacity and involvement. We should consider what specific lessons there may be for the mental health system.

There is a complex issue about how capacity is understood in children, and the extent to which any limitation in decision making ability reflects the lack of maturity of the child or is a consequence of a mental disorder. In the former case, the use of the 2003 Act would not be appropriate but untangling the two factors is not always easy. It isn't clear at the moment whether this causes real practical problems. The evidence from the Royal College of Psychiatrists to this Review was that the significantly impaired decision-making test (SIDMA) worked reasonably well with children and young people.[120]

We are seeking your views on how our thoughts on Supported Decision-Making, Human Rights Enablement and the Autonomous Decision-Making Test, mentioned in chapters 3, 5 and 6, may apply to children and young people.

In Scots law, where a child or young person under the age of 16 [121] is unable to take decisions about treatment for mental or physical health conditions, their parent (or those with parental responsibilities) may consent to or refuse such treatment on their behalf. This could authorise treatment against a child's wishes without the use of the 2003 Act. This may be an issue for guidance rather than legislation, but it is important that safeguards for children are not bypassed.

Where a child has the maturity to make a treatment decision 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.[122] The existing 2003 Act Code of Practice [123] 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.

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[120] This is the test of whether the person has 'significantly impaired decision making ability', which occurs when a mental disorder affects the person's ability to believe, understand and retain information, and to make and communicate decisions. SIDMA is caused by mental disorder and is not the same as limited or poor communication, or disagreements with professional opinion (here).

[121] s 1(1) Age of Legal Capacity (Scotland) Act 1991

[122] s 2(4) Age of Legal Capacity (Scotland) Act 1991

[123] Scottish Executive (2005) Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice. Volume 1. para 33.

Children and young people who come into contact with health and social care services often have many different needs which must be addressed. We therefore consider that the human rights enablement assessment, taking into account also the child's or young person's rights in the CRC, should also be applied.

Supported decision making and our suggested Autonomous decision making test seek to overcome challenges in decision-making and reflect the individual's authentic views in all situations, whether or not non-consensual measures are used. These can be equally applied in the case of children and young people. [124]

However, we need to consider further how they might relate to the different frameworks which exist for the assessment of the needs of children.

Advocacy

The duties in the 2003 Act to secure advocacy should be strengthened to ensure that any child with a mental disorder is made aware of their right to independent advocacy and is able to obtain this when needed.

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, which is discussed below.

There should be a new duty on Scottish Ministers to support collective advocacy for children with mental disorder.

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[124] See also Article 29 UNCRPD on Participation in Political and Public Life and Article 33 on National Implementation and Monitoring, and General Comment number 7 (here).

There is evidence from the Mental Welfare Commission 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 2003 Act. We need to do further work to consider how the duty can best be strengthened.

Advocacy is being introduced to Children's Hearings, and for people with disabilities claiming devolved benefits. There may be an opportunity to join up these various provisions.

Chapter 9 has 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.

Collective advocacy for children with mental disorder is even less prominent than for adults. Children and young people with mental disorder have a right to be engaged in the planning and development of services to support them, not to be represented only by adults.

Accountability

The various bodies responsible for oversight of children's services should work with bodies representing children to develop a more coherent and consistent framework to ensure proper scrutiny and accountability of the right of all children to the highest attainable standard of mental health.

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, learning 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 appear to be limited and sporadic.

The strong criticism by the Children and Young People's Commissioner Scotland (CYCPS) of the oversight by Education Scotland of the use of restraint in educational settings suggests a gap in safeguards. [125]

We believe there needs 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 MWC, the Care Inspectorate, Education Scotland, Healthcare Improvement Scotland (HIS) and the CYCPS. The Sharing Intelligence Network chaired by HIS in respect of health and social care services may offer a partial model.

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.

Autism, learning disability and neurodiversity

We have not reached a concluded view on the use of diagnostic criteria within mental health law, and whether these should include learning disability or neurodiversity.

We generally endorse 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:

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[125] Children and Young People's Commission Scotland (2018) No Safe Place: Restraint and Seclusion in Scotland's Schools

- **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**

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. [126]

We received a lot of evidence that children with autism and other neurodiverse conditions (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. They also represent a huge share of the disputes referred to the Additional Support for Learning Tribunal.

Ensuring access to economic, social and cultural rights will be particularly important for neurodiverse children, alongside a stronger right to services that are appropriate for their needs, rather than being slotted into services designed for a different condition.

Safeguards for treatment

Part 16 of the 2003 Act should be strengthened to include specific safeguards where children are subject to restrictive interventions including physical restraint and seclusion or isolation

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[126] See chapter 12 on mental disorder

There has been considerable concern and an investigation by the Children and Young People's Commissioner Scotland into restraint in educational settings. [127] We also received evidence as to the distress that restraint can cause to other patients as well as the patient who is subject to restraint.

There have been a range of calls internationally by human rights bodies for a ban on restraint, or at least much stronger safeguards.

This consultation document discusses recommendations which would aim to substantially reduce coercive practices in the mental health system. [128] These would also apply to children, but the particular needs of children need to be recognised in this context. For example, the threshold for what constitutes 'inhuman or degrading treatment' may be lower for children than adults.

For the moment, our proposed recommendation focuses on hospital detention, but we believe there should be consistent standards and safeguards across residential, mental health and care settings. We will consider how this can best be secured.

Perinatal mental illness

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.

Section 24 of the 2003 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 [129] was that services needed to be significantly expanded and improved. There is now a Perinatal Mental Health

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[127] Children and Young People's Commissioner Scotland (2018) No safe place: restraint and seclusion in Scotland's schools

[128] See chapter 7 on reduction of coercion

[129] Mental Welfare Commission (2016) Perinatal themed visit report: Keeping mothers and babies in mind

Network in Scotland which has produced a needs assessment report [130] setting out how services need to be developed. This is encouraging progress, but we believe this needs a stronger duty and accountability framework, recognising the complex interaction of duties towards mothers and children.

Relationships between parents and children

On respect for home and the family (Article 23 UNCRPD), it is not clear that the 2003 Act ensures respect, protection and fulfilment of the rights of children with mental disabilities, or of children whose parents have mental disabilities. Section 278 of the 2003 Act imposes a duty on the NHS, local authorities and others to take steps to mitigate the impact of detention of a child or a parent on their relationship. Research by the Mental Welfare Commission on the operation of these duties when parents are detained left the Commission with “many unanswered questions”. [131]

The duty applies where: a child - under 18 – is subject to ‘any measures’ authorised by the Mental Health Act; or a measure authorised by the Criminal Procedure (Scotland) Act 1995 due to mental disorder; 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. [132] The duty also applies in the opposite circumstances, where the parent is subject to measures under either the 2003 Act or Criminal Procedure Act. [133] In any of these circumstances, the 2003 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. [134] The child’s

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[130] Perinatal Mental Health Network Scotland (2019) Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services

[131] Mental Welfare Commission for Scotland (2013) When parents are detained

[132] Section 278(1)(a), Mental Health (Care and Treatment) (Scotland) Act 2003

[133] Section 278(1)(b), Mental Health (Care and Treatment) (Scotland) Act 2003

[134] Mental Health (Care and Treatment) (Scotland) Act 2003 (2018) W. Green. 2nd Edition. Section 278-02.

mental health officer (MHO) has an important role in ensuring that this happens [135] but children do not always have MHOs. [136]

The whole area of decision-making on separating children and parents in the context of mental health detention may need careful consideration, towards developing an approach in law and in practice which carefully and openly weighs up competing human rights. Such an approach could act to ensure, for example, that parents and children are never separated by hospital detention as a consequence of inadequate resources in the community.

Exploring integration of child law and mental health law

Scottish Government and its partners are working 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. This work should consider the development of a unified legal framework for compulsory measures, and for judicial oversight of compulsory measures, which affect children with mental health conditions or disabilities.

A full realisation of UNCRC and UNCRPD may involve a move away from mental health law which regulates compulsory medical care for a small number of children, towards a legal framework which secures the full range of rights for children with mental disabilities.

This requires us to look at the 2003 Act alongside other provisions affecting children with mental disabilities.

The evidence we have received suggests that many more children with mental disabilities may be subject to formal measures under other legislation, including the Children’s Hearing system and Additional Support for Learning, than the 2003 Act.

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[135] Stavert, J. and Patrick, H. (2016) Mental Health, Incapacity and the Law in Scotland. Section 41.34

[136] Mental Welfare Commission for Scotland (2020) Annual statistical monitoring: Young people monitoring report 2018-19, page 6

In some cases, the legal route you go down depends more on the professionals who happen to take action than your 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.

We have said that the reform exercise following the Care Review needs to join up with our work, and that there is an opportunity to develop 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.

This may be affected by the Government's consultation on the National Care Service, which suggests the inclusion of child and family services into this new framework. That would further blur the distinction between medical and social care for children and young people, making a law based largely on a medical approach to mental health appear even more anomalous.

That said, there are 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 can bring for the small number of children with severe mental illness.

Perhaps most significantly, it would separate mental health law for children 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 we recommend a fusion of mental health and capacity law, it may be necessary to make separate provision for children anyway – as has been found in Northern Ireland. [137]

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. We believe this needs serious consideration, although it is wider in scope than our review, and we do not have the capacity to consider it ourselves, without input from other stakeholders.

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[137] Lynch, G., Taggart, C., & Campbell, P. (2017). Mental Capacity Act (Northern Ireland) 2016. *BJPsych bulletin*, *41*(6), 353-357.

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would also be interested to know:

- Do you think the current 2003 Act principle for children is still needed? Should it be replaced by a wider principle of respecting all the rights of the child under the UNCRC in any intervention – or something else?
- What do you think about having 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 such as the UNCRC?
- What are your views on reforming crisis services for children and young people experiencing acute mental distress, and about safeguards for emergency detention?
- What you think about law reform to ensure access to CAMH services up to at least the person's 18th birthday, and to ensure age appropriate services more generally?
- What are your views on our ideas about relatives and families?
- What are your thoughts on how supported decision making, human rights enablement and the autonomous decision making test in chapters 3, 5 and 6 might apply to children and young people?
- What do you think about our proposals on advocacy, and on accountability?
- What are your views on autism, learning disability and neurodiversity, and the possible law reforms for children and young people?
- What do you think about our proposals on safeguards for treatment, and on services and safeguards to protect the relationships between children and parents?
- At this time, Scotland's mental health law applies to compulsory mental health treatment at all ages. Do you have views on the idea of moving mental health law for children to connect it with other law for children, to apply across health, education and social care?

10. Adults with Incapacity proposals

Introduction

Between January and April 2018, the Scottish Government carried out a consultation on the Adults with Incapacity (Scotland) Act 2000 (AWI)[138]. 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 Minister, in her announcement of a review of Scottish mental health law (SMHLR), included too a remit for the Review Team to consider the position with adult capacity law[139].

The Review is grateful for the views offered by a range of AWI practitioners. Taking account of these, this chapter highlights the position of the Review, thus far, on relevant AWI matters. It includes early recommendations the Review is considering and questions on which further consideration is needed.

Guardianship

Position statement

The issues with the current system of application for guardianship are well rehearsed so are not repeated in detail here. The Review acknowledges the difficulties, as narrated in the AWI consultation.[140] In summary, the current guardianship application process is bound by delays, on all fronts; the process can be cumbersome; it lacks the flexibility needed to meet the needs of those subject to

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[138] Scottish Government (2018): Adults with Incapacity Reform Consultation: https://consult.gov.scot/health-and-social-care/adults-with-incapacity-reform/

[139] Scottish Mental Health Law Review Terms of Reference

[140] As above, Scottish Government (2018): Adults with Incapacity Reform Consultation.

guardianship; it is costly; and it cannot be delivered quickly. The person subject to guardianship can be lost in the process.

The Review accepts 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 the person's will and preferences. This requires a range of measures, both voluntary and non-voluntary, integrated with the supported decision-making approach discussed in chapter 3.

Proposals

1. The Review proposes that guardianship, including the term, ceases, with the person supported under a new decision-making framework. More detail on this is offered below.
2. There needs to be provision within the decision-making model for an emergency application. The application model is shown at Appendix A at the end of this chapter.
3. The current orders for specific intervention, access to funds and management of residents' finances are subsumed with the reframed decision-making model.
4. Appropriate supervision for the newly appointed Representatives will be reviewed. There is more on this below.
5. A Code of Practice will underpin the operation of the reframed process.

Decision-making framework

The Review considered 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 given legitimacy.

We wish to see new ways in which family members and trusted individuals can have a greater role in decision-making, and have concluded that this can best be done by reforming the decision-making framework.

It is proposed there are three ‘tiers’ of supporting agent.

- Decision-making supporter
- Person appointed under a power of attorney and
- Decision-making representative

There is more about this framework below. In all cases, support can be in respect of finance and / or property and / or welfare decisions.

The Review considered a model which included the role of a co-decision-maker but this has been omitted from the current proposals as a co-decision maker role was considered fraught with potential challenges. We offer more information on this below and seek your views.

Decision-Making Supporter

The supporter offers 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 Supporter facilitates the person to make their decision, maximises the person’s ability to be able to make their own decision – for example, by:

- ensuring that information needed to make the decision has been provided
- offering explanation, or ensuring this has been provided
- ensuring information and explanation is in an appropriate format
- agreeing the time frame within which the decision needs to be made, negotiating this, if necessary and possible
- establishing the person’s will and preferences in relation to the decision
- supporting the person to communicate the decision, or, with the permission of the person, communicating the decision on the person’s behalf

- supporting the person to take such other action as may be required to give effect to their decision, or, with the person's permission, taking such action to give effect to the person's decision
- monitoring and following up on the decision to ensure it is implemented.

The person would self-nominate whom they wished as their supporter, by way of a simple application pro-forma. This would be registered, likely as part of the Office of the Public Guardian (OPG) registration system, to offer legitimacy to the supporter.

There can be more than one supporter appointed. The application would include the authority to be given to the supporters (e.g. joint, joint and individual or a mix).

The Public Guardian/Local Authority and Mental Welfare Commission should have investigatory powers where there are concerns about the actions of a supporter.

In the event the person is not able to make an autonomous decision, even with support, the supporter can offer a best interpretation of the person's likely decision but has no formal / official powers of representation. In this respect, you may wish to think of it as a reduced form of Power of Attorney (PoA). In offering this lesser form of supporter, we should not lose the value of a PoA.

Co-decision maker

As mentioned, the Review considered a formal role of co-decision maker. A co-decision maker would provide all of the facilitatory functions of a decision-making supporter, described above, but, in addition, would be able to offer their own views and advice on decisions. The decisions would be joint decisions, of the person and the appointed co-decision maker, based on the will and preferences of the person. The co-decision maker would help the person express a decision and ensure that the decisions are implemented. For example, in situations where a formal agreement is required, such as legal contracts or tenancy agreements, both parties would sign the document.

Ultimately, we concluded that the role of co-decision maker was insufficiently distinct from that of decision-making supporter and decision-making representative, as well as the role of an attorney under a PoA, all of which would lead to confusion and to ‘slippage’ of powers i.e. that an individual with co-decision making authority would slip into a representative role without them having been duly appointed to that role. Additionally, there was anxiety as to what would happen if, or when, the co-decision maker and person had a difference of opinion on the decision to be made, or where the decision was on a matter for which there was a clear conflict of interest.

Respecting these views, the role of co-decision maker has been omitted, but we seek your views.

Decision-Making Representative

We believe that a situation where an individual is appointed without the consent of the adult to take decisions should require judicial oversight.

We therefore propose that, when a person's ability to make a decision or decisions is not autonomous (see chapter 6) an application can be made to the court or tribunal (yet to be decided) for a decision-making Representative. The decision-making representative must act within the framework of SDM and respecting the ADMT (outlined in chapters 3 and 6 respectively) and, where it is applicable, ensure human rights are enabled, in line with the HRE framework (outlined in chapter 5).

The role of the decision-making Representative is to take decisions based on the will and preferences of the adult, or the best interpretation of these. Alongside engagement with, and using their knowledge of, the adult, they should use loved ones, carers, other family members and close friends in order to establish the person’s likely will and preferences. The decision must be the one that the Representative believes is right for the person, not necessarily the decision they themselves believe is right.

Applications could be made in respect of any person, aged 16 and over, who requires such a Representative.

A Representative would only be appointed if

- a decision-making supporter now requires formal powers of representation,
- an attorney has not been nominated
- the necessary powers are outwith those granted by the power of attorney, or
- when the attorney can no longer fulfil the role, which can arise for a variety of reasons.

The Representative may be someone other than the nominated supporter or attorney but, in determining the most appropriate Representative, regard must be had to the evident importance of the supporter or attorney to the individual.

There can be more than one Representative appointed. The application would include the authority to be given to the Representatives (e.g. joint, joint and individual or a mix)

A Decision-making Representative may have health and welfare and / or property and / or financial powers. These may be combined in a single court order; the court order would narrate the relevant powers granted, but powers should be contained in identifiable and separate lists.

Support and Supervision

Similar to guardianship, we see the Public Guardian /Local Authority and Mental Welfare Commission as the relevant organisations to oversee Representatives.

We feel their primary role should be one of support, but we recognise the need for safeguards so propose, as now, a role of supervision. We recognise however that, because of the growth of guardianship, the level of welfare supervision particularly has greatly reduced. We seek your views on an effective supervisory system, against the backdrop of the reframed model of Decision-making representative.

Should the roles be refocused? For example, should MWC more actively monitor Local Authorities where they are appointed as the decision-making representative, given the potential for conflict of interest?

What about alignment of roles? The current supervisory system separates welfare and financial supervision, which it is recognised is artificial. What are your views on a more streamlined system?

What about clarity of supervision? The current landscape for reporting of concerns is confusing, people do not know who to report to, and what they may report, or when. What are your views on how we could have a clearer structure for reporting of concerns – in respect of any AWI matter, not just about a decision-making representative?

Application Process

The Review has heard much criticism about the current application process for guardianship being overly cumbersome and time consuming. It is accepted that the process is certainly contributing to lengthy delays in orders being granted.

Appendix A illustrates the new model. The application for a judicially appointed representative is by ‘pro-forma application’. We seek your views on how we can make the application proportionate and how can we speed this up, whilst also maintaining the safeguards. Please note, we will be taking into account responses made to the 2018 AWI consultation and work of the AWI review team over more recent years, so there is no need to repeat responses you have already given but we would be keen to hear updated views as you have had time to consider things in the interim and in light of the proposed decision-making framework.

Emergency Provision

The Review has heard criticism of the current guardianship model in its lack of ability to apply in a case of urgency. In Appendix A we are proposing that a judicial decision can be made on the papers as lodged where there is evidence of urgency.

We seek your views on this new provision. Things that we would welcome opinion on are: how you envisage the emergency provision will work; should there be a limit on what may be considered “emergency” and what ‘papers’ should one have to submit for an emergency application.

We acknowledge a problem with the current system is that you need the same papers for an interim order as you do for the final determination. Is there an abridged process that may speed up the application process whilst also maintaining the safeguards?

Access to Funds and Management of Residents’ Finances

The tentative conclusions of the Review are to subsume the current access to funds scheme and the management of residents’ finances within the new decision-making framework but we seek your views on this.

Codes of Practice and Guidance

Codes of Practice and Guidance will offer more detailed explanatory narrative, including to decision-making supporters and representatives of their role and responsibilities, how to act within their remit, what to do if their powers seem insufficient, the avoidance of undue pressure, how to deal with conflicts of interest where these arise and where they can access support.

Transitional Provisions

We recognise that there will need to be transitional provisions to address the position of current guardians under the AWI Act. This will be for any future legislation to consider.

Summary

- The emphasis is on support - please see the chapter on the supported decision-making framework – but, most particularly, there is a new role of decision-making supporter, which the person can nominate, simply, to assist them with decision-making and which legitimises the role of supporter.
- A supporter does not have to be appointed under a power of attorney, nor is a court appointment (currently guardianship) required to give recognised status to a supporter.
- If a supporter subsequently finds they need power to act, this can be granted by way of a PoA, assuming the criteria for granting a PoA are met, or, if not, by way of an abbreviated court application to become a decision-making representative.
- The requirement primarily to support decision-making is emphasised even with a court appointed representative.

- We seek your views on the new model. For example, what do you see as its advantages? What do you see as its drawbacks? What adjustments, if any, would you suggest?
- Specifically, what are your views on the role of co-decision maker – and its omission from this model?
- Will the proposed change address the issues currently experienced with guardianship? Please explain your answer.
- What are you views about the proposed streamlined application process?
- Does the proposed emergency provision in the model address the concerns about the current system?
- Should the reframed model allow for the grant of a specific or one-off order (currently called an intervention order)? If so, will the reframed model allow for this?
- Should the current access to funds process be subsumed within the new model? If so, will the model allow for this?
- Should the current management of residents' finances process be subsumed within the new model? If so, will the model allow for this?
- What are your views on a system of supervision?

Please offer any relevant views, you do not need to limit yourself to addressing these questions.

Power of Attorney

Position statement

The Review encourages the greater use of powers of attorney (PoAs) but have hesitancy about any reduction in safeguards. In principle, the Review supports making the PoA process simpler, but there is a requirement for greater clarity as to when a PoA comes into effect, in a way which can be objectively assessed and on the role of attorneys, for example that they must take into account the will and preferences of the adult.

An attorney should primarily be a supporter, but one who has decision-making powers as may be required. The attorney should be required to comply with the supported decision-making framework covered in chapter 3. Additionally, an attorney should comply with the principles of HRE (chapter 5) and should consider the person's ability to make an autonomous decision (see chapter 6) before proceeding to make any decisions, or take actions, on the person's behalf. A formal HRE and ADM test is not expected of a lay attorney, but, as now, the keeping of appropriate records would be expected.

We acknowledge that attorneys need more support as well as more awareness of the role before accepting and their obligations once undertaking the role.

As has been mentioned, the current landscape for reporting of concerns, in this case about an attorney, is confusing; people do not know what to report, who to report this to, if they should report something, or when they may report something. As a consequence, some concerns may go unreported. We seek your views on how we can clarify the structure for reporting of concerns.

The current system of investigation when concerns are reported is fragmented, with the same artificial division between welfare and finance that has already been mentioned. We seek your views on how we may achieve a more streamlined system.

Finally, clarity is needed in respect of welfare attorneys' power to authorise a deprivation of liberty, see chapter 11.

Proposals

The current system of granting a PoA remains essentially unchanged, however Scottish Government should ensure there is increased awareness of the importance of this document and active encouragement to grant a PoA.

1. Scottish Government, Office of the Public Guardian, Local Authorities and Mental Welfare Commission ensure there is sufficient guidance for attorneys. Guidance would include the primary role as supporter, when powers of decision-making may be used, as well as the limitation of powers.

2. Scottish Government, the Office of the Public Guardian, Local Authorities and Mental Welfare Commission ensure there is increased support for attorneys.

3. There is increased public awareness of the investigatory functions of the various authorities and the option to report concerns.

4. The investigatory routes when concerns arise should be simplified. The responsibilities of the various authorities for investigation needs clarity. Please see chapter 8 on accountability.

5. That authorities are permitted to supervise an attorney, on cause shown, following their own investigation, pursuant to their statutory function – with a judicial right of appeal for the attorney.

6. That clarity is offered on the powers of a welfare attorney to deprive a person of their liberty.

What are your views generally on PoA and the recommendations we are proposing? Particularly we welcome your thoughts on:

- What measures should be taken to increase the awareness of a PoA?
- Key points of guidance that need to be given to attorneys.
- What support should be given to attorneys – by whom, when?
- The reporting structure for someone with concerns
- The investigations structure
- Authorities being able to supervise an attorney, on cause shown, following a statutory inquiry.
- Attorneys having power to authorise a deprivation of liberty (assuming this power has been granted in the PoA).

We will be taking into account comments submitted to the 2018 AWI consultation so you do not need to repeat earlier opinion, unless you wish to.

Part 5: Medical Treatment and Research

The approach of Part 5

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.

Section 47

Section 47 [141] currently 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 may be too broadly worded and suggestive of a paternalistic best interests approach. We believe the wording of the legislation should reflect our approach to maximising the autonomy of the adult and respecting their will and preferences.

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.

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[141] 2000 asp 1 s 47 et seq.

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.

Who can grant a section 47 certificate?

Provided they are suitably trained and supervised, we believe other practitioners, including psychologists, should be authorised to issue a section 47 certificate relating to the treatment they offer. We seek your views.

Audit

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 audit and analysis of practice.

Force, detention and the relationship with the 2003 Act

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 2003 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 2003 Act. There is no specification of how long is ‘so long as is necessary’, and this could cover multiple interventions over a period. 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. The section 47 authority might also cover physical or mechanical restraint, if it is felt to be a ‘procedure designed to safeguard or promote physical or mental health’. The Code of Practice encourages doctors to consider use of the 2003 Act where giving treatment for mental disorder to an unwilling patient, but does not require this.[142]

The AWI Act does not make specific provision for covert medication. The MWC has issued guidance on this [143], but it has no statutory force.

Access to justice

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). We believe greater safeguards are required for the adult, who may find it difficult to access and instruct an application to the sheriff.

Section 48: Exceptions to authority to treat

Ministers have made regulations specifying additional safeguards for the following treatments:

- Sterilisation where there is no serious malfunction or disease of the reproductive organs

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[142] Para 2.47

[143] Mental Welfare Commission for Scotland (2017) Covert medication.

- Surgical implantation of hormones to reduce sex drive
- Drug treatment to reduce sex drive
- ECT
- Abortion
- Any medical treatment leading unavoidably to sterilisation.

We believe these should remain. It has been suggested that Transcranial Magnetic Stimulation (TMS) should be added; we are interested in views.

Sections 49 and 50: Guardians, welfare attorneys and disputes

Section 49

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’.

We have heard evidence 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.

Section 50

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 determines 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 acknowledge these issues but, on balance, feel the procedure works reasonably well, and does not require to be substantially amended. We seek your views.

Proposals

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 when issuing a section 47 certificate.

1. Revised guidance should give 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. Please see chapter 3 on supported decision-making.

2. There should be a review of training of doctors and other professionals who are authorised to grant section 47 certificates, which should include an

understanding of relevant human rights issues, and the principles of the legislation.

3. 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 will and preferences.

4. The legislation or associated guidance should more clearly set out the limits of the use of common law powers, as an alternative to Part 5.

5. Section 47 and associated regulations should be reviewed to widen the categories of healthcare professional who can assess incapacity and issue a section 47 certificate.

6. There should be a process of electronic recording and auditing of section 47 certificates. We believe the MWC may be best placed to oversee this.

7. We wish to consider stronger safeguards for the provisions within section 47(7) on the use within the AWI Act of force and detention, and to clarify the relationship with the 2003 Act

8. There should be a simplified process whereby an adult can challenge a decision to grant a section 47 certificate, or a treatment authorised under that certificate. Views are sought on how best to achieve this.

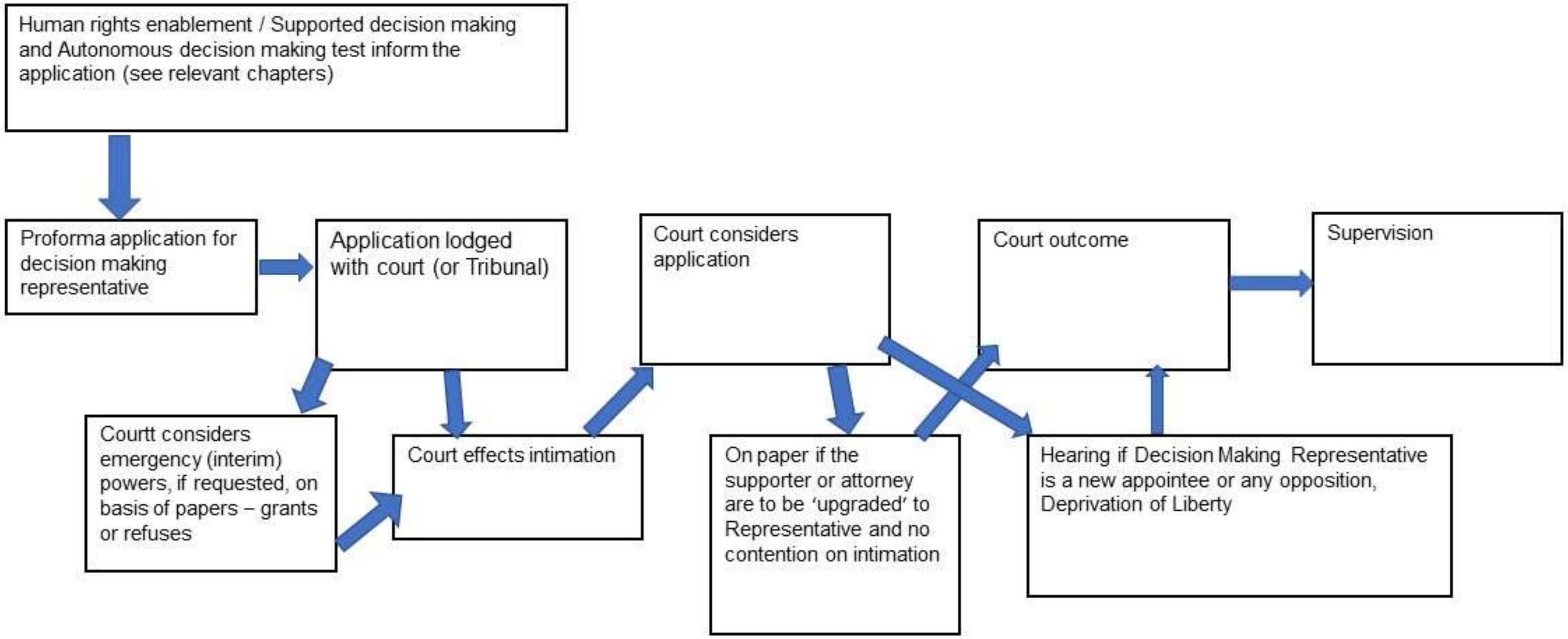
9. It should be lawful to give treatment which is reasonably necessary to a patient under Part 5 (section 49) where an application for a Decision Making Representative is in train, provided the application does not involve a dispute regarding the particular treatment.

We seek your views on what we are proposing.

- What are your thoughts on the provisions within s47(7) on the use within the AWI Act of force and detention, and the relationship with the 2003 Act?
- Is any change needed to the list of special treatments requiring additional safeguards (section 48) or the procedures by which they are authorised?
- It has been suggested that Transcranial Magnetic Stimulation (TMS) should be added to the list of special treatments requiring additional safeguards in section 48. What are your views?
- Is any change needed to the dispute resolution procedure in section 50?

Appendix A

Decision-making representative – proposed application model



11. Deprivation of Liberty

Deprivation of Liberty orders

We recognise that there is a gap in Scots law around the deprivation of liberty for persons who lack capacity to consent to this voluntarily. This gap has existed since the Bournewood case. Article 5 of the European Convention on Human Rights (ECHR) precludes arbitrary or unjustified deprivations of liberty. The European Court of Human Rights ruled in *HL v UK* (the 'Bournewood ruling') 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. [144] This definition was reiterated by the UK Supreme Court in its subsequent *Cheshire West* ruling. [145]

In October 2014, the Scottish Law Commission ('the Commission') published a report which focussed on the question of deprivation of liberty, for people who lack the capacity to consent to this voluntarily. The Commission's report concluded that adults without capacity are being confined to hospital wards and residential facilities in Scotland without any underlying legal process, which is potentially contrary to Article 5 of the ECHR.[146]

There must therefore be a lawful process in Scotland to authorise deprivations of liberty, including those where there is no objection from the adult or their family.

At the same time, any process must be a proportionate one, which does not make the lives of disabled people subject to more legal scrutiny than is necessary. This needs to be particularly considered when we think of people living in domestic settings with family or foster care style relationships. It is disproportionate to suggest

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[144] HL v The United Kingdom: 45508/99 [2004] ECHR 720.

[145] P v Cheshire West and Chester Council: [2014] UKSC 19

[146] See Scottish Law Commission (2014): Report of Adults with Incapacity; and European Court of Human Rights (2021): Guide on Article 5 of the European Court on Human Rights: Rights to liberty and security.

that in the absence of any concerns, the adult in such situations should be treated as being deprived of their liberty and the family subject to monitoring by the State.

It is also important to note that a restriction of someone's choices engaging Article 8 ECHR (respect for private and family life) relates to a restriction which falls short of a deprivation of liberty.[147] It is the restriction of Article 5 rights that we are considering here, that is those situations where a person is subject to continuous supervision and control and is not free to leave.

We consider that the supported decision making model, with its focus on will and preferences, and support for decision making, means it should be possible for more people to be considered able to consent to their living arrangements, even where they are subject to continuous supervision. But this will not cover everyone.

Proposals

As stated above we consider a proportionate approach is necessary. Deprivation of liberty may be necessary for a person's safety and wellbeing, to provide care and support.

For those situations where a person cannot make an autonomous decision but we can be satisfied that with support they have expressed a will and preference to remain in their current living arrangements, even if these arrangements would otherwise constitute a deprivation of liberty, we do not think there is any need for further judicial oversight.

As the Commission proposed in its 2014 report, there should however be a stand-alone 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 care setting – i.e. if they are not subject to any order but are in fact deprived of their liberty. There should also be a

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[147] See European Court of Human Rights (2021): Guide on Article 8 of the European Convention of Human Rights: Right to respect for private and family life, home and correspondence.

right for the Mental Welfare Commission to intervene in such cases if they have concerns.

The challenge will be to ensure that this right is truly accessible to the adult in these situations. By this we mean a real and effective ability to challenge the lawfulness of a deprivation of liberty in a court/tribunal and be discharged from it, if it is found to be unlawful. In other words, this must be genuinely accessible to a person who has decision-making challenges. We seek your views on how this might be achieved. The case of MH v UK is relevant here where the European Court of Human Rights pointed out that special safeguards are required for persons who may lack capacity to initiate appeal or review proceedings themselves. [148]

In these situations we also propose that there should be comprehensive guidance similar to that currently provided for actions under section 13ZA of the Social Work (Scotland) Act 1968. There should also be provision in law giving legal protection to any caregiver who is acting in good faith and in line with the principles of the legislation.

Proposals for orders

For those situations where the will and preference of a person cannot be established, and for their care and wellbeing they will be subject to continuous supervision and control, and not free to leave, we have a number of proposals:

1. A Power of Attorney, with prescribed wording, may grant advance consent for the attorney to restrict the granter's liberty, where the deprivation is proportionate and will demonstrably lead to more respect, protection, and fulfilment of the person's rights overall. Regular review would be required and we suggest registration with an external body such as the Mental Welfare Commission or the Public Guardian.
2. Authorisation of a decision making representative, or an intervention order, as set out in the previous chapter on Adults with Incapacity, by a court or tribunal. The court or tribunal should also be able to grant this power in advance to a decision

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[148] MH v The United Kingdom: 11577/06 [2013] ECHR 1008

making representative, where the need for this can be reasonably foreseen. But this power should **not** be automatically included in a grant of powers to a decision making representative.

3. We are conscious that the concept of a person empowering someone to consent on their behalf to a future deprivation of liberty, where they no longer have capacity to do so has been hinted at but not further developed by the European Court of Human Rights.[149] However we consider that such an action is compatible as it accords with the autonomous will of a person.
4. In hospital, the proposed changes to section 47 of the Adults with Incapacity Act as set out in chapter 10, would allow a doctor to authorise deprivation of liberty in hospital during treatment, and conveyance to hospital for treatment.

However these proposals will not cover all eventualities. There will be significant numbers of people who do not have an attorney or a decision making representative, who cannot consent to their care arrangements even with support, and who are being deprived of their liberty. We consider there are two options here. We can either have a non-judicial process, such as the Deprivation of liberty /Liberty protection schemes in England or a judicial process as suggested by the Scottish Law Commission in their 2014 report.

We would appreciate views on these options. Currently we are 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 suggest there will be a need for standard and urgent orders for deprivation of liberty and the court or tribunal could grant these as stand-alone orders, or as part of decision making representative process.

Standard orders for deprivation of liberty

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 chapter

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[149] Stanev v Bulgaria, 36760/06 (2012) 55 EHRR 22

3. For example, a person in a care home 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 - to allow them to leave the home would endanger their safety.

A deprivation of liberty authorisation needs 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. These authorisations are necessary whether the deprivation of liberty is temporary or permanent.

An application would be made to the court or tribunal for a hearing for a deprivation of liberty order for the adult. We would appreciate views on who should be able to make such an application.

Any authority for deprivation or liberty is 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. Authority should be granted for no longer than six months. Authority must be revoked sooner if the person regains their autonomous decision-making ability. These are just suggested timescales - the details of the duration of such an order would be for subsequent legislation to determine.

There must 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.

This is to safeguard a person’s Article 5 ECHR right. Restrictions to a person’s autonomy in other ways will be assessed and authorised, where appropriate using the human rights enablement (HRE) and autonomous decision making (ADM) frameworks.

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.

Recording of the order

The record of the deprivation of liberty order, its duration and review date should be stored in the person’s records alongside the HRE and ADM, as referred to in chapters 3 and 4.

We welcome your views on any aspect of this chapter but in particular we would like you to consider the following questions :

- What are your views on the deprivation of liberty proposals?
- Who do you think should be able to apply for a deprivation of liberty order?
- What are your views on the safeguards in the process?
- How can we ensure that there is a real, effective and accessible ability for the adult and / or their representative to challenge the lawfulness of a deprivation of liberty order?
- What do you see as potential barriers to its operation?
- What else may you wish to see included?

12. Mental disorder

The concept of ‘mental disorder’ appears within Mental Health legislation as a fundamental gateway. If you come within the definition of mental disorder, the Act may apply to you. If you do not, it does not.

This partly reflects the fact that 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’. ECHR caselaw (the Winterwerp ruling) has established that lawful psychiatric detention requires objective medical evidence of a true mental disorder. [150]

The concept of mental disorder also appears in Adults with Incapacity legislation. An intervention may be made in a person’s life under the AWI Act if that person is incapable due to a mental disorder. 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 factors.

The Review is looking at several issues with ‘mental disorder’ 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.

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[150] Winterwerp v Netherlands 6301/73 [1979] ECHR 4

This diagnostic criterion of ‘mental disorder’ has been criticised as being a violation of the anti-discrimination requirements of article 5 of UNCRPD.

The Review is aiming to make recommendations for changes to the law which would increase the compliance of Scots law with both ECHR and UNCRPD. A significant change proposed is the approach set out in chapters 5 and 6 around human rights enablement (HRE) and autonomous decision making. This seeks to shift focus from a diagnosis of ‘mental disorder’ to a set of factors which may prevent autonomous decision making. Impaired judgement as a consequence of a mental health condition is likely to be one of the most frequent of these factors, but only when the disability in autonomous decision making 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.

In the last interim report we said:

> *Our preliminary view is that this new, human rights based legal framework should apply to persons with mental illness, learning disability, personality disorder, dementia, autism and other types of neurodiversity. It may also apply in relevant circumstances to other conditions which may impair a person’s decision-making ability. In general, these groups would currently be covered by the definition of ‘mental disorder’ in the 2003 Act.*
>
> *We are aware that ‘mental disorder’ is regarded by many as a stigmatising and offensive term, and we intend to suggest alternative terminology in our recommendations. We have been discussing the possibility of using the term ‘mental and intellectual disabilities’, but we wish to engage further with people, particularly those with lived experience, before making our final recommendations.* [151]

Our thinking is that legislation that has at its heart the aim of enabling people’s rights rather than removing them, should be widely accessible. We are proposing a change

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[151] Scottish Mental Health Law Review (2021) Interim report. July 2021.

to mental health and incapacity 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 mental disorder might apply to them.

In general, we are attracted to having universal legal frameworks which cover people from all diagnostic categories and people who do not have a diagnosis. At the same time, we recognise the force of the criticism that the 2003 Act was designed primarily with a focus on mental illness. We want to ensure that new legislation will equally meet the needs of other groups.

This is however a very complex area and one which the Review wishes to work through with views gathered in this consultation.

It is also an important issue for the consideration of fused legislation. If we are to have fusion, or even better-aligned legislation, the underlying concepts have to be consistent.

None of this removes the challenge of finding language which reflects these legal concepts and is also acceptable to people with lived experience who may be subject to this language.

Appropriate use of correct language can be a challenge in all walks of life, but particularly with regard to the 2003 Act, and the use of the term ‘mental disorder’.

We have heard during the Review, that many are uncomfortable with this term, that it is the language of deficit, and a less pejorative term should be used that values diversity and respects differences.

But there is no simple and obvious form of words we have found that improves on this so we need to consider what is wrong with the various options to try and find a way forward.

In particular, the inclusion of learning disability within this definition is regarded by many people with learning disability as insulting. There has long been a feeling among learning disability groups that people with learning disability were not best served by the 2003 Act, a feeling which was evidenced by the Rome Review. Many learning disability groups have said 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.

They would prefer to see learning disability removed from the definition of mental disorder, and new legislation established and drafted specifically to meet their needs.

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.

Suggestions have also been made that rather than reduce the conditions captured by the definition of mental disorder it should be extended to include for example other neurodevelopmental disorders and confusional states associated with physical health disorders to ensure individuals can effectively be managed with appropriate safeguards to ensure their human rights.

The significant change with the HRE and ADM proposals is that it is the impairment of autonomous decision making that justifies involuntary treatment, not mental disorder of itself. Any definition therefore needs to focus on a temporary or longer term inability to make a decision.

We are therefore seeking views firstly on this broad approach and whether it might create harmful unintended consequences and we would be grateful for views on this.

We would also like your views on what terminology we could use instead of ‘mental disorder’. We have been thinking of something like mental disturbance or disability, such that autonomy has been affected and cannot be restored quickly. The UNCRPD talks about psychosocial and intellectual disabilities. We have also considered terms such as ‘mental health conditions’. There is however no clear answer so your views are sought.

We welcome any comments, suggestion or thoughts you have on what we have said in this chapter. We would also particularly be interested to know your views on:

- Should there be a gateway to mental health and capacity law which reflects a diagnostic criterion?
- If so, what should that gateway be and what terminology should we use?

13. Fusion or aligned legislation

Within the terms of reference of the Review, we are asked to consider the need for the convergence of mental health, incapacity and adult protection legislation. The debate around this is not new.

The Millan Review recommended consistency between mental health and incapacity legislation and that in due course mental health and incapacity legislation should be consolidated into a single Act.

This proposal has continued to be debated, with the addition of the Adult Support and Protection (Scotland) Act 2007, given that there is potential for this Act along with the 2003 Act and the AWI Act to impact on the same people. And often, 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. But on a broader scale, recent human rights developments relating to interventions and non-consensual care and treatment of persons with mental disorder led to the request within the terms of reference for the Review to consider unified legislation in this area.

We know from evidence given to the Review by the Mental Welfare Commission that a high proportion of adults considered under adult support and protection legislation have a mental disorder (as currently defined in the 2003 Act). And outcomes for such referrals rely on the AWI Act or 2003 Act, with the ASP Act serving as a gateway for initial enquiry and investigation. But the way the three Acts work together may not always offer the right help for a vulnerable adult in the right way at the right time.

For example, adults with a mental disorder and a lack of insight into their circumstances as a consequence may be at risk of harm. They may not see the need for protection under the ASP Act, but the 2003 Act does not have powers to protect their welfare, finances or property.

Similarly, the Mental Welfare Commission has told us of many calls to their helpline questioning whether the AWI Act or 2003 Act should be used in a given situation.

During the work of this Review, whilst there have been many pleas for the three Acts we currently work with to be streamlined and work better together, there is no unanimity about the need for a single piece of legislation. We consider however that in the light of the proposed changes to create a human rights enablement approach, and the new autonomous decision making test, the case for a single piece of law becomes clearer.

The proposed new approach of HRE and ADM across both mental health and incapacity practice, proposed in chapters 5 and 6, arguably lends itself to a single system, perhaps akin to that developed in the Mental Capacity (Northern Ireland) Act 2016. [152] This Act was passed following the conclusions of the Bamford Review that the presence of a mental health problem or learning disability should not automatically lead to an assumption that a person is incapable of exercising their rights. A person with capacity therefore has the right to refuse treatment, for both physical and mental health conditions, and this should be respected.

This approach supports that taken by the UNCRPD with regard to the rights of persons with disabilities, including the rights to health, to exercise legal capacity and to liberty.

A single piece of legislation gives the opportunity to create a consistent approach for persons included under it. By adopting the same eligibility criteria for all persons with psychiatric and non-psychiatric medical conditions equally, we promote fairness and respect non-discrimination.

It would also create opportunities to consider how coercion is defined, understood, monitored and reduced across all settings; to identify how current law permits coercive practices across settings; to identify what safeguards exist at present; and to identify gaps in current law.

Fused legislation could provide consistency and clarity within the law, plugging the gaps that currently exist and removing the current confusion that can occur as to

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[152] Mental Capacity Act (Northern Ireland) 2016 c.18

what legislation to use when, to best meet the needs of an individual. It could provide clarity around who is responsible for a person's care and enable easier access to and support for the exercise of legal capacity and support for decision making. It would also remove the issue of separate and possibly conflicting court and tribunal orders, as can currently arise.

However there are many challenges in adopting fused legislation, including who is potentially subject to the legislation.

Adult support and protection practitioners in particular have expressed concerns. Whilst there may be strong arguments for bringing together persons currently within the remit of the AWI Act and 2003 Act, the ASP Act is different, with a different gateway. It does not have the same capacity test. Rather, the Act applies to 'adults at risk' who are:

- unable to safeguard their own well-being, property, rights or other interests
- are at risk of harm, and
- 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. [153]

The view has been expressed that adults at risk should not be viewed through a mental capacity / mental disorder lens.

That argument however applies to the legislation as it is currently. The new approach suggested by the Review, of human rights enablement and moving to an autonomous decision making test, could easily encompass those who are deemed at present to be adults at risk, and the legislation could provide the wide range of options for care, support and treatment in a more cohesive and accessible manner than is the case at present.

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[153] Adult Support and Protection (Scotland) Act 2007 asp 10 s 3

The Wessely report[154] did not wholly endorse fused legislation in England but set down five ‘confidence tests’ for a move towards capacity based legislation, meaning that admission or treatment could never be lawful if a person with capacity refuses it.

These tests were:

- The view of service users (the phrase used by the Wessely Review).
- The impact of ‘fusion’ legislation in Northern Ireland.
- Whether assessment of capacity is reliable enough to provide the sole basis for care and treatment.
- Associated processes are adapted to support the change.
- Whether capacity based legislation can take into account what is in the public interest.

Unfortunately the legislation in Northern Ireland is not yet fully in force. But with the proposed changes in favour of human rights enablement and autonomous decision making, we are taking account of the views of people with lived experience, and balancing that with the public interest. Over the course of the next year or so there will hopefully be opportunities to learn from Northern Ireland’s experiences.

That being said, in the event of fused law, there would be a need for very clear definitions, so it is explicit who may fall within the scope of the legislation and in what way.

There also remains the question of the judicial forum. A perpetual criticism of mental health, incapacity and adult support legislation is the mix of tribunal and court oversight and disposals. AWI and ASP cases are considered by the Sheriff court – albeit the latter in far fewer numbers than the former - and the Mental Health Tribunal

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[154] Wessely, S. (2018) Modernising the Mental Health Act – final report from the independent review

for Scotland considers cases under the 2003 Act. At present an individual could be subject to hearings before the Sheriff under the AWI Act and ASP Act, and the MHTS under the 2003 Act, which is clearly unwelcome.

The work jointly undertaken by the Centre for Mental Health and Capacity Law and the Mental Welfare Commission in 2017, looking at the case for reform of Scotland's mental health and capacity law, [155] recommended that the Mental Health Tribunal would be the most appropriate forum for unified legislation.

The Law Society for Scotland has also recommended that the MHTS would be the preferred forum for a single piece of legislation.

A single forum for all mental health and incapacity legislation could be a stepping stone towards fused legislation in due course.

Alignment of the law?

The terms of reference for this Review require us to consider whether convergence of three pieces of legislation is the way ahead, however, we have also been considering whether it is perhaps better to consider alignment of the law rather than a leap to a single piece of legislation.

By alignment we mean that as far as possible we have common principles, safeguards, routes to remedy etc., but maintain appropriate differences for people who at present may fall within adult protection, adults with incapacity or mental health legislation. This could be viewed as a stepping stone towards longer term change.

It would be necessary to be clear where the demarcations lay between the laws. The current challenges of individuals falling between the laws, or professionals not

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[155] Edinburgh Napier University and the Mental Welfare Commission for Scotland (2017) Scotland's Mental Health and Capacity Law: the Case for Reform.

knowing which route to take to best help an individual, would need to be overcome but alignment may be a helpful way forward in the first instance. And aligned legislation may lend itself to a single court or tribunal more readily than the current suite of legislation does.

The Review will consider feedback from this consultation before coming to a final view on fused or aligned legislation.

We welcome any comments, suggestions or thoughts you have on what we have said in this chapter. We would be particularly interested to know:

- Given the changes being proposed by the Review, do you think a single piece of legislation for mental health, incapacity and adult protection law is the best way forward? Please provide explanation for your answer.
- You may consider that two or three pieces of law would be preferred, each dealing with specific issues across mental health, incapacity and adult protection law. If so please tell us, giving an explanation for your answer.
- What do you think about our suggestion of aligned legislation? Which aspects of the law should be aligned and which should be left within standalone law?
- Finally please tell us if you consider a single judicial forum should deal with all mental health, incapacity and adult protection cases, and
    - If that forum should be the Sheriff court or a tribunal
    - If there should be a single forum only in the event of fused legislation, or if a single forum is your preferred way forward regardless of wider changes to the legislation
    - If you consider aligned legislation is preferred, should a single judicial forum be part of that alignment?

Scottish Mental Health Law Review

Respondent Information Form

Please Note this form **must** be completed and returned with your response.

To find out how we handle your personal data, please see our privacy policy: Privacy Policy | Scottish Mental Health Law Review

Are you responding as an individual or an organisation?

☐ Individual

☐ Organisation

Full name or organisation's name

Phone number	

Address

Postcode	
Email	

Please indicate your publishing preference:

☐ Publish response with name

☐ Publish response only (without name)

☐ Do not publish response

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.