

# SMHLR

SCOTTISH MENTAL HEALTH LAW REVIEW

## Executive Summary of the Interim Report

December 2020

## **Scottish Mental Health Law Review**

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The past six months have seen a lot of progress on the Scottish Mental Health Law Review (the Review). Full details are available in the December interim report. This provides a short summary of the main points including summaries from each of the Advisory groups working on different areas of the Review.

### **Timetable for the Review**

The final report for the Review will be published in September 2022. This will enable the Review to take advantage of 3 international events taking place in June /July 2022, uniquely due to delays because of Covid -19. These are the World Congress on Adult Guardianship (Edinburgh June 2022), the UK / Irish Mental Diversity Law Network Conference (Nottingham June 2022) and the International Academy of Mental health and Incapacity Law Congress, (Lyon July 2022).

Interim reports on the progress of the Review will be published every six months between now and the end of the Review.

Karen Martin and Graham Morgan, members of the Executive team with lived experience have taken on the role of joint Vice Chair, and another member with lived experience will be sought for the Executive team in January 2021.

### **Engagement with stakeholders**

In the next phase of the Review, groups of stakeholders, both lived experience and practitioners will be invited to comment on early ideas from the Advisory Groups. In addition 2 reference groups will be set up, to go into more detail about proposals for change, after initial comments have been considered.

We also anticipate 2 more Advisory Groups being established to look at the interface between criminal law and mental health law, and accountability.

## **Fusion**

At this stage we are not in a position to make any comment on whether or not fused mental health and capacity legislation is the way forward for Scotland but Review team members are very conscious that in seeking to bring about better outcomes for persons with mental disabilities we must be prepared to think beyond existing models. We will continue to assess this as the work of the Review progresses.

## **Other reviews**

The Review chair and others from the Executive team have been in discussions with the chairs of the Forensic Mental Health Services Review, the review of Adult Social Care and the Human Rights Taskforce. The recommendations from these reviews, when issued, will be considered carefully by the Review team.

Decisions from the Scottish Government on the recommendations from the Independent review of Learning Disability and Autism in the Mental Health Act (the Rome Review), are still awaited. Delays have been due to the Covid-19 pandemic. However a number of the recommendations form part of the considerations of the Advisory Groups on capacity and supported decision making, and economic, social and cultural rights.

## **Advisory Groups**

### **Children and Young People**

This group was set up in late summer 2020. Its terms of reference are to review developments in mental health law and practice to meet the mental health needs of children and young people since the 2003 Act

came into force, and make recommendations to the Executive Team, with specific consideration of:

- The duties in the 2003 Act relating to children and young people
- The interaction between mental health and child law and practice
- The rights and needs of parents and family carers
- The implications of incorporation of the UN Convention on the Rights of the Child (UN CRC) for mental health law
- The findings of the Children and Young People's Mental Health Task Force, the Youth Commission on Mental Health Services and the Care Review.

### **What has been done?**

The Advisory Group met four times to agree terms of reference and a process for gathering evidence, review evidence gathered and discuss the issues raised.

There were two complementary strands of evidence taking. The first was a series of 9 formal evidence sessions involving 22 expert stakeholders and advisory group members, led by Colin McKay and conducted online. The witnesses are listed at Annex A.

The second was a more informal set of discussions involving carers/parents and young people, led by Karen Martin. These were, by request, mainly conducted via telephone.

### **Areas of Concern**

Several issues emerged from the evidence collected from carers/parents and young people about whether the rights of children and young people were fully respected:

#### *Right to Free Association (Article 15 UNCRC)*

The young people who provided evidence all felt that a peer worker would have been welcomed within CAMHS (both in-patient and out-patient). Having someone of a similar age was felt to be important.

### *Provision of Information (Article 13 UNCRC)*

Lack of information about a particular condition caused concern for one young person with ASD. To enable young people to express their views and opinions it is crucial that accurate information is provided. The UNCRC makes this clear and there needs to be more effort made to ensure such information is provided to allow young people to make decisions.

### *Dignity and Respect (Article 37 UNCRC)*

The young people interviewed shared the same concerns as carers/parents around inconsistency of staff and changing of staff. Another shared concern was staff being late for appointments.

The use of restraint techniques was raised by some carers/parents and young people. Some had witnessed the use of restraint and one young person had been the subject of a restraint technique.

Lack of understanding of LGBTQ+ issues was mentioned by one young person and a carer/parent, and lack of any kind of peer support for young people in general was poor.

### *Involvement of Parents in Care and Treatment (Article 5 UNCRC)*

For many carers/parents this was patchy and depended on how vocal the carer/parent was. Involvement in discharge, a right extended to carers under the Carers (Scotland) Act 2016, was again a mixed story with many carers feeling that staff were not aware of this duty under the Carers Act.

### Evidence from professional stakeholders

#### **Child and adolescent mental health services (CAMHS)**

Evidence received reinforced the message of earlier reviews<sup>1</sup>, of a system under pressure at all levels, caused by a combination of

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<sup>1</sup> <https://www.gov.scot/publications/children-young-peoples-mental-health-taskforce-delivery-plan/>

emerging need (particularly children with neurodevelopmental conditions), gaps in services, and pathways involving long delays in assessment without ensuring appropriate support is provided. The Mental Welfare Commission has reported<sup>2</sup> rising rates of detention of children and young people, particularly emergency and short-term detention of young people aged 16-17. There has been a rise in the recording of suicidality, trauma and personality disorder.

The rise in detention may reflect a lack of alternatives to hospital, particularly out of hours – The Edinburgh Crisis Centre<sup>3</sup> was cited as a good model, but such services are not available across much of the country. The lack of input by Mental Health Officers was a concern – around half of the emergency detentions had no MHO input<sup>4</sup>. In the 2003 Act, the MHO has a key role in assessing the welfare needs of the child or young person, and whether there are less restrictive alternatives to hospital detention. We heard evidence that MHO services are not always well integrated with children and family services.

There are identified gaps in specialist CAMHS, and serious workforce issues, but an even greater problem appears to be the lack of appropriate support at the level between primary care and specialist CAMH Services. Repeated failed interactions with the system can lead to self-harm and increased suicidality.<sup>5</sup>

Despite the Government's long-standing support for preventive services and early intervention, the system is not well placed to deliver this. Austerity has led to services prioritising the most urgent and highest level of need, meaning that children and young people often have to wait until they are 'ill enough' to get help.

Often the children and young people who are least well served are those with complex needs which may be linked to neurodevelopment

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<sup>2</sup> [https://www.mwscot.org.uk/sites/default/files/2020-10/YoungPeopleDetainedUnderMHA\\_October2020.pdf](https://www.mwscot.org.uk/sites/default/files/2020-10/YoungPeopleDetainedUnderMHA_October2020.pdf)

<sup>3</sup> [www.edinburghcrisiscentre.org.uk](http://www.edinburghcrisiscentre.org.uk)

<sup>4</sup> [https://www.mwscot.org.uk/sites/default/files/2020-10/YoungPeopleDetainedUnderMHA\\_October2020.pdf](https://www.mwscot.org.uk/sites/default/files/2020-10/YoungPeopleDetainedUnderMHA_October2020.pdf)

<sup>5</sup> <https://www.gov.scot/publications/rejected-referrals-child-adolescent-mental-health-services-camhs-qualitative-quantitative/>

conditions such as autism or ADHD, or labels such as attachment disorder or conduct disorder. These, in turn, may reflect experience of trauma, abuse, neglect, poverty and difficult family circumstances. Issues of stigma and fear of the consequences of seeking help were a barrier for some families. Some families seeking CAMHS feared social work involvement for its connotations of child protection, while some families involved with social work feared the stigma of a mental health label.

The ideal might be a more multi-disciplinary CAMH Service, with a wider range of services and therapies on offer, working closely with other sources of support, and with a focus on meeting the needs of the child as a whole. The importance of services being relationship based and supportive was emphasised.

Transitions to adult services were also a concern. Adult mental health services have a very different model, and a transition in the middle of treatment, or based primarily on chronological age, can be harmful. However, the pressures on CAMHS are such that they may feel it necessary to pass on a young person to adult services, to free up resources for younger children who urgently need help.

We were told that the Scottish Government is taking action to address many of these issues, including the use of a new service specification setting out what CAMHS is commissioned to provide, and work with Children and Family Partnerships in Community Planning Partnerships on a service framework for children who require less medicalised support. A service specification and improved post-diagnostic support is also being developed for children with neurodevelopmental conditions. Overall, a lot of energy and political will is being devoted to this issue, but it is clear that there is a lot to do.

### The wider system of support for children and young people

The need to address the mental health needs of children and young people is as much an issue for other aspects of the care, education and justice systems as it is for CAMHS. 64% of people in the justice system

have four or more different mental health diagnoses<sup>6</sup>. Secure care may be used to manage risk and behaviour which reflect significant mental health needs. The majority of children appearing before the Additional Support Needs Tribunal have a mental disorder as defined in the 2003 Act.

Although the different service planning arrangements aspire to a holistic approach, they are predominantly driven by the system to which they relate. This fragmented approach affects both the bodies delivering support, and the legal framework intended to hold these bodies accountable. A child experiencing acute mental distress may find themselves before a children's hearing, a civil court, a criminal court, a mental health tribunal, or an additional support needs tribunal; or any combination of these. The outcome for the child, which may include a judicially ordered deprivation of liberty, may depend as much on how they entered the system as what the child needs and deserves. This is a complex problem, which cannot be solved solely by revising mental health law.

However, this may be a rare opportunity for wider reform. Alongside this review, other significant changes are underway – particularly the incorporation of the UN Convention on the Rights of the Child (UN CRC), and the work of The Promise following the Care Review. As well as looking at reform of mental health law as it applies across the life course, the group believes serious consideration should be given to the development of a unified legal and judicial framework with responsibility for overseeing decisions on all aspects of the health, welfare and education needs for children and young people.

This would be a long-term ambition, and there are many practical and conceptual difficulties to be considered before recommending this. So more immediate and practical steps which might strengthen joint working, improve the co-ordination of service planning, and strengthen accountability need consideration.

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<sup>6</sup> <https://www.cycj.org.uk/wp-content/uploads/2018/10/Balancing-Rights-and-Risk.pdf>

## The Mental Health (Care and Treatment) (Scotland) Act 2003 and children

Overall, witnesses with did not identify serious difficulties with the core provisions of the 2003 Act concerning detention and compulsory treatment for the small number of children with a severe mental illness. However, a number of areas for improvement were identified.

### *Mental disorder*

It was suggested that the gateway criterion of ‘mental disorder’ can be problematic in dividing people who may need compulsory mental health interventions and those who may be subject to coercive interventions in other parts of the system. The question of compatibility of this criterion with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was raised. This is a major issue for the review, with differing perspectives on how to reconcile the importance of diagnostic clarity to justify compulsory medical treatment with the CRPD requirement of non-discrimination.

### *Advocacy*

The right in the Act to access independent advocacy is an important one, but the availability of advocacy is increasingly constrained and focused on issues of detention rather than preventive work. The Mental Welfare Commission has identified gaps around child-specific advocacy.<sup>7</sup>

### *Compulsory interventions*

There was concern about a possible reluctance in some areas to use Compulsory Treatment Orders, with the suggestion that some children with long-standing issues instead experience a series of short-term detentions. This is potentially destabilising for the young person and their family and reduces the effectiveness of judicial oversight by the Tribunal. It also means the child will be subjected to multiple legal

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<sup>7</sup> [https://www.mwscot.org.uk/sites/default/files/2019-06/the\\_right\\_to\\_advocacy\\_march\\_2018.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/the_right_to_advocacy_march_2018.pdf)

processes. This may require more detailed examination to understand the reasons for it.

Apart from some provisions of the 2003 Act which require extra consideration be given to the needs of children, the Act is the same for children and adults. This was felt to be a strength. It avoids creating age-based barriers to support (even if those barriers may exist in the way services are organised). In some cases, it can be helpful to maintain a therapeutic relationship with young people by making clear that the intervention is not based on their age and stage.

For children with mental illness, the tests for compulsion<sup>8</sup> worked well. The requirement to show significantly impaired decision-making ability was felt to be an important safeguard against an over-paternalistic approach with young people.

However, the tests were problematic for autistic children and young people. Autism does not easily fit into any of the three sub-categories of mental disorder (mental illness, personality disorder and learning disability), and the requirement that an order be 'necessary' was less of a safeguard than it appeared. If medication is not the main intervention, hospital admission may only be necessary because the appropriate community services are not available.

It was suggested that we consider ways in which primary care could play a greater role in formal interventions under the Act, possibly making greater use of technology to do so.

### *Safeguards for interventions*

Seclusion or restraint may be authorised by detention under the 2003 Act but is not specifically mentioned in the legislation – in contrast to the safeguards for medication in Part 16. As discussed above restraint can be highly traumatic, and there may be a need to consider additional safeguards. There has been serious concern about restraint and seclusion in educational settings for children with additional support

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<sup>8</sup> 2003 Act s64(5) sets out the grounds that must be met for a CTO

needs<sup>9</sup>, and work is underway to improve standards and training and ensure better oversight.

The Mental Welfare Commission would like to see additional safeguards (such as authorisation by a Designated Medical Practitioner) for artificial nutrition, even where the child is not subject to detention.

### *Duties to provide services*

It was felt that s23 of the 2003 Act (a duty to provide appropriate services and accommodation to any patient under 18 who is detained) had driven improvements in hospital services. Other provisions had proved less effective. The 2003 Act imposes duties on local authorities<sup>10</sup> to provide care and support services, and services to promote well-being and social development, including social, cultural and recreational activities. These duties largely apply to children just as much as to adults, but we found little evidence that local authorities could demonstrate how they were being met.

The Mental Welfare Commission (MWC) pointed out that children who are in-patients or in specialised services are often a long way from home and called for better support for families to maintain contact.

### *Named person*

In 2015 the 2003 Act was amended so that a patient aged 16 or over would no longer have a 'default' named person and would choose their own. However, for children, the named person remains the person with parental responsibility<sup>11</sup>. There was a generally held view that it is inconsistent with the UNCRC that a child who is capable of choosing their named person does not have the right to do so.

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<sup>9</sup> <https://cypcs.org.uk/investigations/investigation-restraint-and-seclusion/>

<sup>10</sup> 2003 Act ss25-27

<sup>11</sup> 2003 Act, s252

## The requirements of the UNCRC

Legislation has been introduced in the Scottish Parliament to incorporate the UNCRC into domestic law<sup>12</sup>. If passed, this would require any current or future legislation to be interpreted in a way which is compatible with UNCRC and, where this is not possible, a court may strike down that legislation.

### **What we will do next?**

#### *Further engagement*

- We will work with the Royal College of Psychiatrists to identify young people with experience of detention who are willing to be interviewed about the experience, and how it could be improved
- We will work with the Royal College of Psychiatrists and other stakeholders to identify current problems and dilemmas in operating the 2003 Act, and possible solutions
- Following evidence from a representative of the Royal College of GPs, we plan to issue a questionnaire to a small group of GPs on ways in which the current system could be improved
- We will speak to teachers about the role of schools in supporting children's mental health, and how this could be made more effective

#### *Improving information and awareness*

- With the Communications Group, we will review what can be done to improve information and support for families and the awareness by professionals of the rights of children in mental health services

#### *Policy analysis*

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<sup>12</sup> <https://beta.parliament.scot/bills/united-nations-convention-on-the-rights-of-the-child-incorporation-scotland-bill>

- We will commission a detailed academic analysis of the 2003 Act and the implications of the UNCRC
- We will map out the judicial and planning system affecting children and young people with significant support needs, including for their mental health, and test out ideas for a more holistic system, beginning with an invited stakeholder event in early 2021
- We will consider the recommendations of the Independent Review of Learning Disability and Autism in the Mental Health Act ( the Rome review) for children and young people

### **Communication and Engagement Advisory Group**

This group was set up in autumn 2019. In the past 6 months they considered the key areas they wished to look at further based on information gathered from the first consultation. These are:

- Inclusion of Carers in the care and treatment of patients
- Awareness of rights of the patient – including Human Rights and how these translate to service delivery, from both professional and patient’s perspective.
- Improved communication on the right to advocacy.
- Digital gap – lots of services and information moving online and not being accessible for everybody.
- Improved communication between services and professionals to enable holistic, wrap around care, including a joined-up approach with welfare (DWP) to ensure delivery of economic and social rights.
- Lack of accessible advice and guidance to support people in making informed decisions about their care and treatment.

The lack of involvement of carers in the care and treatment of person with lived experience was of major concern for the group. The initial consultation found that many carers felt ‘left-out’, ‘ignored’ and ‘under-valued’.

The Communication and Engagement Advisory Group were pleased to learn about the ongoing work around implementation of the Triangle of Care<sup>13</sup> within some mental health services in Scotland. The group are keen to explore how this has worked in practice and if lessons can be taken from this work to improve communication.

Another impressive initiative to enhance staff understanding of unpaid carers is the promotion of Equal Partners in Care.<sup>14</sup> This is promoted to all staff within mental health services and gives a very good overview of the issues facing unpaid carers of all ages.

The Group would like to recommend the implementation of the above as ways to improve communication and understanding of role of unpaid carers and their rights.

In moving forward, the Communications and Engagement Advisory Group will work closely with other Advisory Groups on the Review to ensure full engagement with relevant stakeholders in the particular areas of the groups.

There is also a cross over with the Scottish Government's digital exclusion work and the group feel that this is an area to explore. People experiencing mental ill-health can be marginalised due to their illness. Digital exclusion is something that can add to that marginalisation, affecting the rights of participation and access to health.

Early in January the group will send out a questionnaire to practitioners to find out their knowledge and understanding of the role of unpaid carers of people experiencing mental ill-health. This is to identify gaps in knowledge and share these with third sector organisations, as well as health and social care services, in the aim of improving training and communication. Through doing this it is hoped that carers will be valued and identified as key partners in care and treatment as much as is possible.

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<sup>13</sup> <https://carers.org/resources/all-resources/78-triangle-of-care-a-guide-to-best-practice-in-mental-health-care-in-scotland->

<sup>14</sup> [Equal Partners in Care | Turas | Learn \(nhs.scot\)](#)

## **Compulsion Advisory Group**

This was the second Advisory Group set up in the autumn of 2019. It was the group most affected by Covid-19 restrictions and has only met twice since the last interim report.

The aim of this group is to make sure that the Executive Team is well advised on the use of compulsion and the way persons subject to compulsion under the Act receive care and treatment, and how this should happen, having regard to developments in human rights, in particular, UNCRPD.

In the past six months, the group has considered the substantial amounts of information received during the consultation, around the subject of compulsory measures of care. They also considered the findings of a literature review from Professor Jill Stavert looking at international developments in this area. In the next phase of work there will be a focus on alternatives to coercion, and those countries who are developing protections on a human rights basis.

The group had a session with Arun Chopra, Medical director of the Mental Welfare Commission, discussing the data the MWC has collected around short term detention certificates, compulsory treatment orders and its recent report on detention of 16 and 17 year olds. The group noted the marked regional variation across the country on the use of compulsory measures and will explore this in the next phase.

The group is still at the stage of gathering and understanding evidence. We need to consider in more detail:

- the impact and lasting implications of pre-existing resource shortages, as compounded by the pandemic
- the issues around the increase in compulsory detention and treatment
- duration of the use of compulsion
- repeat use of compulsion
- the use of restraint

- the reasons for variation in compulsory orders across Scotland, in terms of time of the week and place in the country

### **Areas for future work**

In addition to looking at better and earlier support which might avoid the need for the use of compulsion, the group will also explore the issues of concern outlined above. It will consider changes which have been made to address the challenges of the pandemic. Some may have useful lessons for future practice. The group has also discussed the need to look at current statutory safeguards and the role and practice of the Mental Health Tribunals and the Mental Welfare Commission. This may be done by establishing a separate Advisory Group in 2021. The intersection of mental health and criminal law has come up as an issue and this too may become the subject of a separate Advisory Group.

### **Capacity and Supported Decision Making Advisory Group**

This group was set up in late summer 2020. Its terms of reference are:

To help to inform the Review Executive Team about how, and if, assessments of (a) capacity and significantly impaired decision-making ability (SIDMA); and (b) support for decision-making can:

- improve the experience, and meet the needs, of persons with lived experience of mental illness, learning disability and dementia and their carers; and
- Be most effectively reflected in mental health and capacity law.

In order to meet these Terms of Reference the Advisory Group agreed that the following need to be considered:

- Should capacity thresholds be used for non-consensual interventions?

- If capacity thresholds are used as the basis for non-consensual care and treatment and/or accessing support, how can this best be framed in the law?
- What should support for decision-making achieve and is there any evidence yet of this happening/what is needed for this to happen?
- How can support for decision-making best be reflected in the law?

The group started their work by asking what lived experience members considered that mental health and capacity law ought to be achieving. This was then followed by considering the role that capacity or SIDMA assessments do or might play, if improved, in achieving this and whether this might be better achieved by other means, for example, human rights assessments as recommended by the Independent Review of Learning Disability and Autism in the Mental Health Act. Following this, the role of support for decision-making will be considered.

### **Summary of current discussion outcomes from the Capacity Assessments and Human Rights Subgroup**

We acknowledge that there is still some way, including consultation, to go before the Review will be able to make concrete recommendations on the role of capacity and SIDMA thresholds, any alternatives and support for decision-making. But some of the issues discussed in detail so far are as follows:

*What outcomes do people with lived experience and carers want from mental health, mental capacity and adult support and protection law?*

- Law in this area should significantly assist meeting the short and long-term needs of persons with mental illness, personality disorder, learning disabilities, dementia and other related conditions. This must not be confined only to care and treatment options, but should include non-medicalised options and reflect the whole range of a person's human rights
- Needs assessments should involve professionals and also involve the person and their carers. There must be a presumption in

favour of acting in accordance with the person's will and preferences and, where necessary, support must be provided to ensure that this occurs. Moreover, the determination of such needs must be transparent and accountable with clear and detailed records being kept.

- The focus must be on empowering the individual rather than what facilitates or suits the service provision system with a presumption in favour of avoiding detention and coercive approaches and seeking alternative forms of support to achieve individual needs. The preference should be for non-consensual interventions (detention, care and treatment, guardianship) to be for only as long as is absolutely necessary and any action or intervention must be non-discriminatory and proportionate to need ensuring that the person is not left without essential support and protection.

*What outcomes do people with lived experience and carers want from a capacity/incapacity/SIDMA/human rights assessment?*

- These assessments must involve *more* than one person ensuring different views are taken into account with the person as an equal and supported partner, and carers where appropriate.
- A capacity assessment should involve more than an assessment of cognitive functioning. Thought must also be given to impact of emotion and illness on a person's decision-making and whether or not this is a significant consideration in such assessments. Relational autonomy, taking in account the social context within which individuals exist, must also be taken into account. Importantly, however, the assessment must not be paternalistic or discriminatory. And there must be an effective appeal mechanism, of which the person is aware and has access to, to challenge the validity of the assessment.

However if the Review is to make recommendations that will result in real change which improves meeting the needs, and respects the rights, of persons with lived experience, then it is important that we also

consider what might be required and need to be overcome in order to achieve this. The following requirements and potential obstacles have been identified so far.

- *Information and training*

Information and training for professionals (involving an inter-professional dimension) and clear information for persons with lived experience and carers and families is vital.

- *Supported decision-making*

Supported decision-making, for example, in the form of individual and collective advocacy, advance planning, trusted persons and other forms of support, to ensure the primacy of an individual's will and preferences must be provided and the need for it clearly recognised, resourced and respected in legislation and practice. This must also encompass resources and any other requirements to set up meaningful supported decision-making arrangements.

- *Use of language: a shared approach*

It was noted that legal and human rights language can seem (and be) complicated and that different persons and professions may use different terminology for the same things. This can be a real impediment to shared understandings and therefore culture change. Any legislation and/or its implementation and codes of practice and guidance must therefore use language that is easily and universally understandable and there must be a shared human rights vocabulary.

### Potential obstacles

In considering how the above might be achieved this group will also have to consider the potential challenges and obstacles to bringing about real change. These might well include resourcing constraints, particularly in light of economic policy resulting from the coronavirus

crisis. However, the importance of adequate resourcing cannot be over-emphasised given the impact of interventions on the liberty and autonomy of persons with mental disabilities and that fact that information we have received to date indicates that the existing systems are not adequately resourced to realise the principles of the current mental health, incapacity and adult support and protection legislation.

## **Next Steps**

### *a. Creation of 'test scenarios' and consultation*

It became clear to the Capacity and Human Rights Assessments subgroup that, even between its members, whilst there might be broad agreement on what ought to be the objectives of mental health, mental capacity and adult support and protection law there was no universal consensus on how such objectives can be reached.

Recognising that wider consultation is required it was therefore decided, to agree a list of current discussion outcomes which will be considered against 'real life' scenarios provided and informed by professionals and persons with lived experience. The scenarios are being kindly prepared by the Royal College of Psychiatrists (Scotland), Mental Health Officers, Advocacy and lived experience and will then be tested with targeted lived experience and practitioner stakeholder groups to gain their views. Of course, other issues may arise that require consideration and consultation as the group continues with its work.

### *b. Clarification of 'will and preferences'*

There needs to be greater clarification of what it means to give priority to a person's 'will and preferences' and how these might be ascertained in all situations, including at a time of crisis. In this respect it is noted that the term 'rights, will and preferences' both:

- i. Promotes a person's autonomy; and also
- ii. Recognises that a person's rights must be enjoyed in conjunction with the rights of others and a balance must sometimes be struck between

these different rights. Thus, provided there is no discrimination based on a person's disability, rights may be limited.

### **Economic, Social and Cultural Rights Advisory Group**

This group was also set up in late summer 2020 and has the following terms of reference:

To identify measures, including law, policy and accountability frameworks, which could be taken to ensure that the social, economic and cultural rights of people who are potentially the subject of mental health or incapacity legislation are secured, and to make proposals to the Chair and Executive team for consideration.

#### **What has been done?**

The Advisory Group met four times to agree its terms of reference and way of working, and to discuss the issues raised.

Graham Morgan prepared a report summarising earlier consultations with people with lived experience of mental illness on what rights were important to them. Dr Katie Boyle, Associate Professor of International Human Rights Law at the University of Stirling kindly attended the first meeting to assist our understanding of the topic. Chloe Trew of the Scottish Human Rights Commission (SHRC) gave a presentation to the Advisory Group outlining the basis of economic, social and cultural rights in international human rights standards.

The group carried out four formal evidence sessions online with key stakeholders.

The group focused at this stage on mental illness. In the next phase of our work we intend to consider the needs of autistic people and people with learning disabilities, building on work already done by the Rome Review. We also intend to engage with groups who support and represent people with dementia.

## **Key findings**

### What are economic, social and cultural rights?

The European Convention on Human Rights (ECHR), which has been incorporated in Scots law, largely reflects civil and political rights. Mental health law has traditionally been concerned mainly with civil rights, such as the rights to liberty and personal autonomy. The law places limits on what the State can do to an individual by ensuring that there is a lawful basis with appropriate safeguards if a person is detained or required to accept medical treatment.

Economic, social and cultural rights require the State proactively to take steps to provide certain goods to a reasonable level to ensure citizens can live fulfilled and meaningful lives. These are sometimes called 'positive' rights. (The difference between the two kinds of right should not be overstated – many civil and political rights already require the State to provide goods, such as functioning civil courts with access to justice, a humane prison system and so on.)

These rights are to be secured without discrimination, and it has been made clear that this includes discrimination on the basis of mental health status.

At the moment, there is little direct provision in Scots law around economic, social and cultural rights.

### The importance of economic, social and cultural rights for people with mental illness

There was a clear message from the evidence we received that, for many people with mental illness, although the provisions of mental health law were very important, economic, social and cultural rights were even more significant. The following list highlights some of the most important issues people with mental illness face, and links them to rights set out in the International covenant on Economic, Social and Cultural

rights (ICESCR) and the Convention on rights of Persons with Disabilities (CRPD).

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

Importantly, this right is not restricted to medical treatment. The UN Committee on Economic, Social and Cultural Rights has made clear that “the right to health embraces a wide range of socio economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing ... and a healthy environment”.<sup>15</sup>

Three levels of necessary action were identified in our evidence as being relevant to the right to health for people with mental illness:

- A public health approach including a focus on prevention and supportive communities, with better primary care
- More and better support, including access to non-medical support, for people who need significant help but not in-patient care, particularly for groups who are not currently well served – such as autistic people or those with a label of personality disorder
- More holistic support for people with severe and enduring illness, including better after-care as well as improvements to in-patient support.

This includes attention at all levels to the physical health of people experiencing mental illness. The huge disparity in life expectancy between the general population and people with long term mental illness or learning disabilities is long-standing, and is only one of many inequalities in health outcomes.

People wanted a wider range of supports, including alternatives to a medically led approach, access to psychological support, more information and greater choice.

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<sup>15</sup> General Comment No. 14 (2000) - The right to the highest attainable standard of health E/C.12/2000/4, para 4 <https://undocs.org/en/E/C.12/2000/4>

Former inpatients talked of an environment which can sometimes be toxic and unwelcoming, and clinicians of needing more time and smaller caseloads to develop better therapeutic relationships.

At the same time, some people found it very hard to be admitted to hospital despite being in considerable distress. People said it was increasingly common for the police rather than mental health services to be the first port of call when people were in crisis.

This highlighted the need both for preventive work in the community and for a right to have a service at a time of need. This would not always be a hospital bed – people with lived experience wanted somewhere they could go to be with their community, where they can be seen, and have their needs attended to. The experience for a number of years has been of criteria to access help becoming tighter – potentially leading to worse long-term outcomes, and an increased use of compulsion. In recent months, the fragility of community support has been dramatically highlighted by the Covid-19 emergency.

*Right to an adequate standard of living, social security and social protection (ICESCR Articles 9 and 11, CRPD Article 28)*

There is a strong mutually reinforcing relationship between poverty and poor mental health. People found the benefits system was often hostile and did not recognise the barriers faced by people with mental illness, both in assessing entitlement to benefits and in applying sanctions to people who struggled to comply with complex requirements. The commitment to a human rights approach in the new Scottish social security system was welcome, but it is too early to assess the difference this might make.

*Right to housing (ICESCR Article 11, CRPD Article 28), and to independent living (CRPD Article 19)*

Access to housing was seen as vital to allowing people to secure their CRPD right to ‘to live in the community, with choices equal to others’. The lack of stable tenancies in the community was one of the key things

preventing people from being discharged quickly after a period in hospital. We heard that some 'points' systems for allocation of social housing still did not give the same recognition to mental disabilities as to physical disabilities, and also that there is a strong interdependency between housing conditions and mental health: housing which is not of an acceptable standard can create or exacerbate mental health issues.

*Right to employment (ICESCR Article 6, CRPD Article 27)*

The level of unemployment among people with a mental illness is extremely high, and spending time in hospital can be hugely disruptive to maintaining employment. People want to work, but face stigma and discrimination. Other barriers included a lack of clear routes to employment for people who may need additional support – or simply a more humane and compassionate place to work. Some people feared even trying vocational or rehabilitation activity in case they were regarded for benefit purposes as fit for work which they could not sustain.

*Right to participate in the community and cultural life (ICESCR Article 15, CRPD Article 30)*

These rights in particular appear under-recognised. Many people with mental illness are lonely, bored and isolated. People living in the community may not see anyone else for days at a time and may lack the confidence to seek out company. People said they need places of support and activity, of food and friendship, where they can go to, especially when they have lost faith in other services. Many drop-in centres and other resources have closed in recent years. There are some new equivalents, but these are few and far between. The availability and sustainability of such resources and facilities have been further compromised by the Covid-19 emergency.

People in hospital also often lack meaningful activity, and too often leave hospital without the support they need to help them regain a place in the community.

## *Right to education (ICESCR Article 13, CRPD Article 24)*

The right to education, including lifelong learning, as set out in the CRPD<sup>16</sup>, is important in itself, and is a key enabler of access to other rights such as employment and independent living. As part of this, education about human rights was seen as vital, so that people could understand and claim those rights.

### Incorporation of economic, social and cultural rights into Scots law

The Review has been tasked with making recommendations which ensure that people's economic, social and cultural rights are reflected in mental health law. The way in which that can best be achieved will depend in large part on other work which is underway to develop proposals to establish a statutory framework for human rights in Scotland.

The National Taskforce for Human Rights Leadership<sup>17</sup> was established in 2019, following the recommendations of the First Minister's Advisory Group on Human Rights. The Taskforce is due to report in the new year. There are several aspects of their recommendations which will be relevant to the work of the Review:

- There are different models of incorporation with the potential for a different relationship between any overarching human rights legislation and legislation in particular areas, including the 2003 Act.
- The Taskforce is considering how the rights of particular groups should be incorporated, including where there is a specific human rights instrument related to that group, such as the CRPD

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<sup>16</sup> Article 24 includes the following: "States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:

a. The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;  
b. The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;  
c. Enabling persons with disabilities to participate effectively in a free society."

<sup>17</sup> <https://www.gov.scot/groups/national-taskforce-for-human-rights-leadership/>

- The Taskforce will be making recommendations on the practical implementation of these rights, how they should affect the work of bodies who oversee public services, and options for legal enforceability and access to justice.

We have established links with the Taskforce, and will monitor closely its work before developing our own proposals, which we hope can align closely with the approach it recommends.

### The implications for mental health law

In general, we are attracted to a 'maximalist' approach. This provides for the strongest possible form of incorporation of economic, social and cultural rights, with clear duties on public bodies and robust enforcement mechanisms, but there are many detailed questions to consider. Potentially this reform would be as significant as the incorporation of the European Convention on Human Rights into domestic law, with implications which will take years to work through.

Incorporating economic, social and cultural rights could mean a fundamental shift in the role and structure of mental health law – going beyond regulating psychiatric interventions to upholding the human dignity and right to a fulfilling life of people with mental illness or intellectual disabilities.

This is not completely new. The 2003 Act and the preceding Millan report are, in a number of respects, wider in scope than compulsory care and treatment, and reflect economic, social and cultural rights. We heard evidence that these provisions are important, but some have only been implemented to a limited extent.

Sections 25-27 of the Act create duties on local authorities to provide a range of care and support services to people who have or have had a mental disorder, including residential accommodation, personal support, social, cultural and recreational activities, training and support in obtaining employment, and assistance with travel. However, various organisations have found it impossible to find any data to evaluate the extent to which those duties are being fulfilled. It is not clear that the

existence of these duties has done anything to protect local authority support for mental health services from the effects of austerity in recent years.

The duty on local authorities and the NHS to make advocacy available<sup>18</sup> has had a more tangible effect, and independent advocacy is an established part of the mental health system. However, we heard evidence that advocacy services are under significant pressure to focus on statutory interventions (e.g. supporting people at tribunals) with less scope for the wider aim of empowering people with mental illness to take greater control of all decisions affecting them.

There is also very limited support for collective advocacy, which is an important mechanism to fulfil the obligation on States in the CRPD<sup>19</sup> to ensure that people with disabilities and their organisations are consulted and involved in all policies and decisions which affect them.

### Accountability, monitoring and standard setting

A clear message from the evidence we received is that good laws on their own are not enough. There are a number of positive recent examples of rights-based legislation in health and social care, including self-directed support and the Carers (Scotland) Act 2016.

However, there has often been a gap between the aspirations of the legislation and its more limited practical effect. It is suggested law to secure economic, social and cultural rights needs to be part of a wider accountability framework. Fortunately, there has been a great deal of work done in Scotland and internationally to set out the key elements of that framework<sup>20</sup>.

The first requirement is that those delivering services should understand their responsibilities. The Taskforce is considering how best to build

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<sup>18</sup> 2003 Act s259

<sup>19</sup> CRPD Article 4 para 3

<sup>20</sup> <https://inclusionScotland.org/incorporation-of-united-nations-convention-on-the-rights-of-people-with-disabilities-crpdc-into-scots-law/>

capacity to improve understanding in public bodies, and we will consider how this can be applied to our work in the Review.

We also heard evidence that user involvement in strategic decisions is still too often consultation rather than genuine co-production, and that the consultation often does not feel meaningful.

We recognise that financial restraints will always limit the way in which economic, social and cultural rights are secured, but a human rights-based approach to budgeting can inform how decisions are made.

The Independent Inquiry into Mental Health Services in Tayside<sup>21</sup> concluded that the assurance and scrutiny of mental health services in Scotland needs to be reviewed, and we understand the Scottish Government is taking this forward. We will consider carefully how this should inform our work.

We are particularly interested in what role the law might play in setting out clear expectations of high quality services. The Welsh Assembly has passed a 'Mental Health Measure'<sup>22</sup> intended to ensure people receive the right care and support, and we will investigate what impact this has had.

The Mental Welfare Commission is an important element of the accountability framework, and owes its existence to the 2003 Act. Any change to the scope of the 2003 Act will have implications for the Commission. The Commission has undertaken its own consultation<sup>23</sup> with stakeholders, which highlighted a degree of support for it to have greater powers.

This is a strongly held view by many users and carers, but professionals working in services have also said to the Commission and to us that integrated Health and Social Care is not held to account as effectively as it could be. The landscape is more complex than in 2003, and the

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<sup>21</sup> <https://independentinquiry.org/>

<sup>22</sup> [www.mentalhealthwales.net/mental-health-measure](http://www.mentalhealthwales.net/mental-health-measure)

<sup>23</sup> [https://www.mwscot.org.uk/sites/default/files/2020-08/MWC\\_StakeholderResearch\\_FinalReport\\_Aug2020.pdf](https://www.mwscot.org.uk/sites/default/files/2020-08/MWC_StakeholderResearch_FinalReport_Aug2020.pdf)

accountability framework does not fully reflect this – particularly in overseeing how service users and families navigate the maze of care pathways.

The 2003 Act sought to give some legal force to the principle of reciprocity by the introduction of ‘recorded matters’ – allowing the Tribunal to set out steps which should be taken to ensure that a person subject to compulsion was receiving appropriate care. There is evidence that this can sometimes act as an effective prompt to speed up, for example, discharge planning. However, it was suggested that in many cases it is a limited safeguard. Ultimately, apart from limited exceptions, the Tribunal cannot insist that a person gets a particular service, if the grounds for compulsion are met.

There are understandable reasons for this, and it may reflect a wider concern in the judiciary that they should not take over responsibility from public bodies for making difficult decisions about how scarce public funds should be allocated. However, if economic, social and cultural rights are rights at all, they must be able to be legally enforced. The Taskforce is looking at different ways in which this can be done.

## **What we will do next**

### *Further engagement*

- We will undertake a series of engagement events with peer support and collective advocacy organisations, to deepen our understanding of what rights are most important to people with lived experience, and how they can be helped to secure them
- We will consult with people and organisations with expertise in relation to particular protected equality characteristics (including sex, race and sexuality), and dementia, learning disability and autism to identify particular rights issues of importance to them

### *Analysis and policy development*

- We will commission a detailed analysis of the provisions of the 2003 Act and the implications for them of economic, social and cultural rights
- We will engage with the National Taskforce for Human Rights Leadership, and assess the implications of its recommendations, once known, including implications for the powers of the Mental Health Tribunal
- We will review the Welsh ‘Mental Health Measure’ and consider what impact it has had, and whether it could be usefully applied in Scotland
- We will map out the current provision for collective advocacy
- We will work with the Mental Welfare Commission and other stakeholders to review its powers and responsibilities

### **Next Steps for the Review**

The findings so far, will now be carried into Phase 3 of the review, where we will obtain opinions on recommendations for change to mental health law and practice .Progress on this phase will be documented in the next interim report, which the Review plans to publish in June 2021. In the meantime you can find the latest information on our [website](#)

We would like to take this opportunity to thank everyone who has contributed to the work of the Review so far.

**SECRETARIAT MENTAL HEALTH LAW REVIEW  
DECEMBER 2020**

**[WWW.MENTALHEALTHLAW.SCOT](http://WWW.MENTALHEALTHLAW.SCOT)**