

# Summary of consultation on proposals for change to the law

March 2022

## **Review of Mental Health and Incapacity law in Scotland**

### **Summary of our consultation on proposals for change to the law**

The Review was set up by Scottish Ministers, with the aim of improving 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.

The aim of this consultation is to find out what people think about the Review's proposals for changes to the law before a final report is sent to the Scottish Ministers by the end of September 2022.

This is a summary of the proposals being consulted on. You can find the full consultation, including a glossary of terms used, and respond to it on our website by 27 May 2022 at: [www.SMHLR.scot](http://www.SMHLR.scot)

### **The main proposals the Review seeks views on are:**

1. A change in the purpose of the law, to one of ensuring people with a mental disorder have their human rights respected, protected and fulfilled with changes to principles and practice for supporting this
2. Developing a system wide approach to supported decision making to enable people to be supported to be fully engaged in decisions about all aspects of their lives
3. How carers can be better supported when caring for someone with mental illness or disability
4. A new approach to the way people are provided with help and support, aiming to ensure this is given in a timely way, with the person's whole situation being assessed and their rights considered
5. A change in the approach taken to persons who cannot make decisions for themselves and who may need intervention in their life, for their own health and wellbeing, or that of others.
6. Proposals for reducing coercive treatment across mental health and incapacity practice
7. Proposals for a strong accountability framework, proper oversight of systems and accessible remedies for individuals when things go wrong
8. Proposals to address some of the issues faced by children and young people under mental health practice

9. Proposals to address some of the challenges in Adults with Incapacity legislation
10. Options for addressing the challenges around the ECHR requirements for persons deprived of their liberty
11. Views sought on removal of the term 'mental disorder'
12. Views sought on whether fused, or more aligned legislation is needed across mental health, incapacity and adult protection legislation.

*Not all of the work the Review is undertaking is being consulted on in this paper. Work is ongoing in particular, on the way compulsory treatment orders in hospital and the community are used, the interface between criminal and mental health law, options for change to advance statements, and named persons. These issues will be developed over the next few weeks and the Review will be asking for views, from those who will be most impacted by the proposals.*

## **What is the purpose of the law?**

Chapter 2, pages 29 - 43 in full consultation paper.

The current purpose of the law is mainly about protecting people from undue interference in their lives. The Review thinks that this purpose should change to that of ensuring that the human rights of people with a mental disorder are respected, protected and fulfilled. The Review thinks to achieve this we need specific provision in law for people whose decision making ability may be impaired.

If new law is to be more about helping people with mental disorder live well and enjoy their lives without stigma, then the Review thinks that a new approach to principles in the law is required.

The Review thinks that principles for reformed mental health and incapacity law should be based on principles already established in human rights instruments. The Review is suggesting four core principles:

**Respect for dignity** – human dignity is important to international human rights, and to domestic law. Respect for dignity helps us to assess whether particular actions are consistent with human dignity.

**Respect for autonomy** - this is the freedom to make your own or decision, or be assisted to do so. It is fundamental to the UNCRPD with respect to legal capacity and respect for rights will and preferences and should be underpinned in law.

**Non-discrimination and equality** – these are core to the UNCRPD. It means we need to remove the barriers that prevent disabled people from participating as equal citizens in society and having control over their lives.

**Inclusion** – people have a right to be included regardless of any label. This affirms the right of people with mental disorder to participate not just in their care and treatment but in wider society.

As with the current principles these need to be considered together and sometimes may need to be balanced against each other.

### **Enabling people to live fulfilling lives**

The Review considers that as well as new principles much more needs to be done if the law is to shift to ensure that the human rights of people with a mental disorder are to be respected and fulfilled, enabling people to live fulfilling lives.

Many of the human rights which enable people to have a fulfilling life are economic, social and cultural rights (ESC rights). These rights are progressively realised by States (countries). This means States must take steps to the maximum of their available resources, with a view to achieving fulfilment of these rights, through all appropriate means, including legislation.

The National Taskforce for Human Rights Leadership in Scotland has recommended the steps that need to be taken to ensure Scotland achieves full realisation of economic, social and cultural rights, and these are being considered in forthcoming legislation on human rights by the Scottish Government. However, the Review considers that there are some specific issues affecting people with mental disorder which might need to be tackled by specialist design and specific law. And we need to consider what duties might need to be placed on bodies that provide services.

We think the following things are necessary:

- 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.

The Review is also thinking about some of the following to reflect the suggested change in the purpose of the law and to address particular human rights:

**Stigma** - A positive duty on the Scottish Government to address stigma and discrimination against people with a mental disorder

**Right to health** – a change to sections 25 – 27 of the 2003 Act 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. This could also include broadening the duties with regard to the provision of suitable accommodation and addressing the wider barriers to inclusion in society experienced by many.

**Accessible information** – changes to sections 260 and 261 of the 2003 Act, to ensure accessible information is available to people with mental disorder, whenever they may need it, not just when they may be subject to detention / compulsion as is currently the case.

### **The need for system wide change**

The Review team considers that to fully achieve a shift to mental health and incapacity law in Scotland that has the purpose of ensuring the rights of people with a mental disorder are fulfilled, system as well as legal change will be required.

For example, Scotland will need to follow the requirements of the UNCRPD with significant lived experience input at all levels of service delivery. This needs to be done properly with supports in place for it to be equitable. Consideration may need to be given to ensuring budget decisions reflect human rights standards and support will need to be provided to professionals to ensure they have the knowledge, resources and authority to give full effect to the human rights of individuals.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Supported decision making**

Chapter 3, pages 44 - 60 of the full consultation paper.

Supported decision making (SDM) is support that helps a person to form a view about what they want to happen and how it should happen so that it has legal effect. It includes support for the person to put those decisions into effect. It can also include support to challenge barriers that prevent the person from making decisions. This is essential if people with disabilities are to participate on an equal footing with others, in decisions about their lives. The UNCRPD places States under a duty to do this.

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 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.

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.

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

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. Some people may have reduced or limited capacity due to dementia while others may have 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.

It is clear that a range of options for supported decision making are required. But it is important to remember that much of what we are thinking of when we refer to SD 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.

## **Proposed range of support to be offered**

### **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. At present they are not used as often as they could be, and have been criticised for being too narrow in their approach.

The Review is suggesting a new approach originally proposed by the [Rome Review](#), of a statement of rights, will and preferences. This could be about all or anything that affects the person's mental disorder and would not only be about crisis situations and medical treatment but about the support, care and treatment the person felt they needed across all areas of their life.

### **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 with other changes to Adults with Incapacity legislation in chapter 10.

### **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 alongside other suggestions for changes to Adults with Incapacity legislation.

### **Independent Advocacy**

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.

### **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 to help in criminal cases which involved 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. 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 from criminal proceedings. This should not happen simply because a person was not given sufficient support to understand their situation.

The Review agrees in principle 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, but 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.

### **Named persons**

The named person role was created by the 2003 Act. The named person is there to represent and safeguard the interests of the patient, but does not necessarily represent the patient or the patient's views. Named persons used to be appointed by default but since changes made to the 2003 Act by the 2015 Act, a patient will now only have a named person if they appoint one and that person accepts that role. This has resulted in very few named persons being appointed and patients losing out on that support in tribunals. The review is considering what changes need to be made to the named persons scheme.

### **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.

### **How can we make this work?**

The Review considers a comprehensive integrated approach is needed, based on an accepted understanding of supported decision making rights and principles. The work needs to be taken forward with practitioners and people with lived experience and we suggest that the work on developing a National Care Service may provide an opportunity to have a whole systems approach.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **The role and rights of carers**

Chapter 4, pages 61 - 65 of the full consultation paper.

The Review has been told that unpaid carers providing support to people with mental disorder are often excluded from any involvement in the decision making relating to the care and treatment of the person they are caring for. This is despite the right for carers to actively participate in decisions about care, with consent is in the Carers (Scotland) Act 2016.

Many carers reported that they were not kept informed about their family member's progress and were not given any support for themselves.

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. 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.

### **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

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## Human Rights Enablement

Chapter 5, pages 66 - 77 of the full consultation paper.

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.

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. We call this framework a Human Rights Enablement (HRE). It is not a one off event but a process that should underpin how decisions and actions are likely to affect the human rights of an individual

### **The important components of HRE are:**

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.

## **Enabling human rights in practice**

Public bodies that act in situations currently covered by mental health, adults with incapacity and adult support legislation would be expected to undertake an HRE

There is already a complex set of assessment processes in health and social care. A HRE is not meant 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.

### **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.
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.
5. An HRE should be produced jointly between the practitioner and the person. As an HRE is to cover the breadth of a person's needs, including economic and social rights as well as clinical rights, it will normally require input from a number of persons.
6. An HRE is supplementary to any current assessment of needs so the person with responsibility for initiating the HRE is the person who undertakes the care/treatment/needs assessment.

The HRE should evolve as different practitioners become involved and consider the person's needs from their specialist perspective. But the use of the HRE framework will depend on the individual's needs at a given time.

For example:

- Some people's needs will be simple; the level of HRE should be commensurate with this.
- 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.

- Some people will simply want the intervention they see as warranted and would see an HRE as unnecessary and intrusive bureaucracy. 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.

There will be cases where it may be difficult to decide whether an HRE is required or not. So we suggest that decisions about when an HRE is definitely required is left to professional judgement.

## **Refusals**

A person has a right to refuse or decline an HRE – this must be a voluntary decision. If a refusal is not thought to be voluntary an HRE may need to be completed in any event of harm may otherwise result.

A decision about an HRE is distinct from any decision about proposed care or treatment.

## **Crisis intervention**

The HRE process may not be possible when the first contact with a person is in time of crisis. As much of the process as practical should be done at the time with a full review as soon as possible.

## **Actioning the outcome of an HRE**

Outcomes of the HRE will vary depending on a person's circumstances but action to enable fulfilment should be agreed with the person as far as possible.

## **Ongoing HRE**

It is proposed an HRE is a structure for continuous review by way of regular engagement.

A review can be triggered by

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.
9. In the absence of any of the above, a formal review should occur no later than one year from the date of the last review.

### **Remedy and appeal**

There should be a route of appeal on the outcome of the HRE as well as route to remedy, for example failure to deliver rights to which a person is entitled where it is reasonable these could be met. The following model is suggested:

- An escalating process with an internal review, followed by review by a body responsible for protecting rights such as the Mental Welfare Commission
- Final stage application to judicial body for review
- One or more bodies (such as the MWC or the Scottish Human Rights Commission. ) should have the right to ask the court to review whether it is reasonable that rights of any group/ individual not being met

### **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**

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.

## **Records**

Recording of HRE should be readily accessible and anyone involved with the care treatment and support of a person with mental disorder should have access to relevant information in the HRE, subject to consent.

## **Training**

A strategy of training and awareness raising will be required to develop a coordinated HRE structure.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Autonomous decision making test**

Chapter 6, pages 78 - 88 of the full consultation paper.

The review recommends that supported decision making and respect for the whole range of human rights becomes the tenet of Mental health and incapacity law in Scotland. But it is accepted 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 tests are currently used to justify intervention in the absence of the person's ability to consent. These tests have been subject to some criticism and views are sought in the consultation on whether they should remain or not.

**It may be that following this consultation, a reframed version of SIDMA or a capacity test will continue to be used but the Review would like to consider a possible alternative.**

The Review is proposing a test of autonomous decision making ability (ADM). The Review believes, 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.

A person may be unable to make an autonomous decision because of the impact of an illness or condition, or a crisis situation.

It is proposed that the supported decision making framework should be used as far as possible to reach an autonomous decision but the Review accepts that there needs to be a threshold at which, in limited circumstances, detention, involuntary

treatment and other decisions may be taken without the consent of the individual. This has been named the Autonomous decision making test.

### **Autonomous decision making (ADM) test**

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 context, 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. 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. 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

## **Autonomous decision-making (ADM) test in practice**

### **Non urgent situation**

The SD 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 suggested steps are outlined below:

1. 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.
2. If, despite every support, the person is unable to make an autonomous decision on the proposed intervention the reason for this must be recorded.
3. Before proceeding, the evaluation of human rights would be reviewed. 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. If this is the first contact an HRE should be completed, 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. 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**

It is recognised however, that in some situations where there is a serious and imminent risk of harm and action is needed to protect the rights of the person or others, it may not be possible to complete the ADM test process before starting immediate protections.

However, even in crisis, significant efforts should be made to provide every support for decision making and consideration must be given to any expressed advance wishes.

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.

As far as 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.

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?**

Views are sought on who should carry this out and what skills and experience may be required. The ADM test needs to be recorded, and the authority granted for non-consensual intervention last only as long as is needed to achieve the protection required.

The completion of the ADM test should include a review date, and authority should be granted for no longer than a year at a time and an accessible appeal process will be required.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Reduction of coercion**

Chapter 7, pages 89 - 105 of the full consultation paper.

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 the Mental Health Units (Use of Force) Act 2018 in England on the use of force against patients in mental health units, and how care homes operate, for example.

All of this involves coercion to some extent. Coercion is generally understood to involve force or the possibility of force. 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.

### **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.

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.

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. 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**

While views differ, the Review has 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. 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.

## **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.

“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. 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. 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 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 completely 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

1. Mainstream alternatives to coercion with a view to legal reform
2. Develop a well-stocked basket of non-coercive alternatives in practice

3. 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
4. Establish an exchange of good practice between and within countries
5. Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.

The Review has considered 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.

### **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.

We also wish to consider extending the 'excessive security' appeal provisions 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.

## **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. 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.

We also consider that there may be a stronger requirement for services to record, reflect on and reduce coercive practices. But improving the recording and monitoring of coercion in Scotland would be a complex and long term task and one that must not become overly bureaucratic.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Accountability**

Chapter 8, pages 106 -131 of the full consultation paper

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.

We need to be sure that there are appropriate bodies responsible for ensuring our rights are respected, protected and fulfilled in different settings. There needs 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 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. The Scottish Government has accepted the recommendations of the Taskforce, including incorporation of human rights treaties into Scots Law.

- The inquiry into mental health services in NHS Tayside called for a national review of assurance and scrutiny of mental health services across Scotland.
- 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.
- The Programme for Government 2021-22 promises a Patient Safety Commissioner and a new Learning Disability, Autism and Neurodiversity law and Commissioner.
- The review of forensic mental health services identified the need for greater accountability and oversight of these services. The Scottish Government has set up a collaborative working group to decide what to do about that.

All these programmes of work may create new routes to remedy for people who may currently fall under our mental health and capacity law.

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.

### **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. We consider some here.

### **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'.

There have been longstanding concerns that recorded matters lack 'teeth' with a particularly concerning example given of a person with a learning disability in hospital waiting for discharge. The Tribunal made a recorded matter on this case in

2014 which was to identify accommodation and support for the person within six months. This had not been done six years later.

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.

### **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. 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.

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, 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 be designed around the needs of complainants. The review of forensic mental health services identified the need for transparent and trusted ways (both formal and informal) in which people and their families could raise concerns they have with their care and treatment.

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.
- There needs to be a way of checking that appropriate actions from a complaint decision are taken.
- 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.

### **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.

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. They felt this was especially important in the context of economic, cultural and social rights where issues often affect many people.

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 way.

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.

### **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.

### **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. 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.

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. They would need to be better supported and resourced to do this.

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.
- There should be a duty for NHS Board/local authorities to provide and resource this.
- Collective advocacy members and workers to lead on the development of a system for supporting, monitoring and evaluating collective advocacy groups. 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

## **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. 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 who is responsible for what. 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.

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.

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.

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

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.

## **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.

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 be 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.

We believe the Mental Welfare Commission's role should be extended if it is to more effectively reflect the wider human rights framework. These are our 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.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Children and young people**

Chapter 9, pages 132 - 150 of full consultation paper.

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 Scotland's law to move 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.

## **Principles**

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'.

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

## **Rights to support**

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.

We are considering a similar recommendation in respect of adults, 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. 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.

## **Crisis services**

A joint event held with the Review and 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.

We propose that 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.

### **16 and 17 year olds**

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. So we propose that children should be entitled to access CAMH Services where needed at least up to their 18th birthday.

### **Relatives and families**

We heard 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.

We propose:

- 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 appoint another person.

### **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. 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.

We are therefore seeking your views on how our thoughts on Supported Decision Making, Human Rights Enablement and the Autonomous Decision-Making Test, may apply to children and young people before making any recommendations for change here.

## **Advocacy**

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.

However, our initial proposals are:

- 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.

## **Accountability**

The MWC has a role in respect of children, but has generally focused on the small number of children who are in-patients. Many children with significant mental health issues, learning disability or autism will be in other settings, including residential schools, secure care or young offender's 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.

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 CYPCS. The Sharing Intelligence Network

chaired by HIS in respect of health and social care services may offer a partial model.

Our proposal is that 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.

### **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.

### **Safeguards for treatment**

There has been considerable concern and an investigation by the Children and Young People's Commissioner Scotland into restraint in educational settings.

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.

We propose that:

- 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.

### **Perinatal mental illness**

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 Mental Welfare Commission's themed visit in 2016 was that services needed to be significantly expanded and improved

We propose that the existing duty to support mothers in hospital with postnatal depression and similar conditions should be broadened to ensure a wider range of inpatient and community supports for women who need perinatal mental health care and their children.

## **Exploring integration of child law and mental health law**

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.

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

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Adults with Incapacity reform**

Chapter 10, page 151 - 170 of the full consultation paper.

These proposals for change come from work done over a number of years around the AWI legislation as well as more recent work undertaken by the Review.

### **Guardianship**

Currently the system is bound by delays, cumbersome and lacking flexibility.

Proposals for change are:

1. Guardianship, including the term, ceases, to be replaced by a new decision making framework to support a person.
2. There needs to be provision within the decision-making model for an emergency application.
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.

5. A Code of Practice will underpin the operation of the reframed process.

### **Decision making framework**

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

### **Decision making supporter**

The proposal is the creation of a formal role of decision making supporter to offer such assistance to the person as needed to arrive at an autonomous decision. The decision will remain that of the individual.

The person would self-nominate whom they wished as a supporter, by virtue of a preform, to be registered with the Office of the Public Guardian. More than one supporter could be appointed and the Public Guardian/ local authority/ Mental welfare commission should have investigatory powers where there are concerns about the actions of a supporter.

### **Decision Making representative**

Where a person is appointed without the consent of the adult (as is currently the case for guardianships) to take decisions on their behalf, judicial oversight will be required.

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 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. A Decision-making Representative may have health and welfare and / or property and / or financial powers.

As with guardianship its considered the Public Guardian, local authority and Mental Welfare Commission continue to be the relevant organisations to oversee representatives with the primary role being one of support. However, the level of supervision and support has diminished over the years due to the increase in guardianship orders so the consultation seeks views on an effective supervisory system, set against the proposed changes to the system overall.

Views are also sought on how a proportionate application system can be achieved.

### **Powers of Attorney**

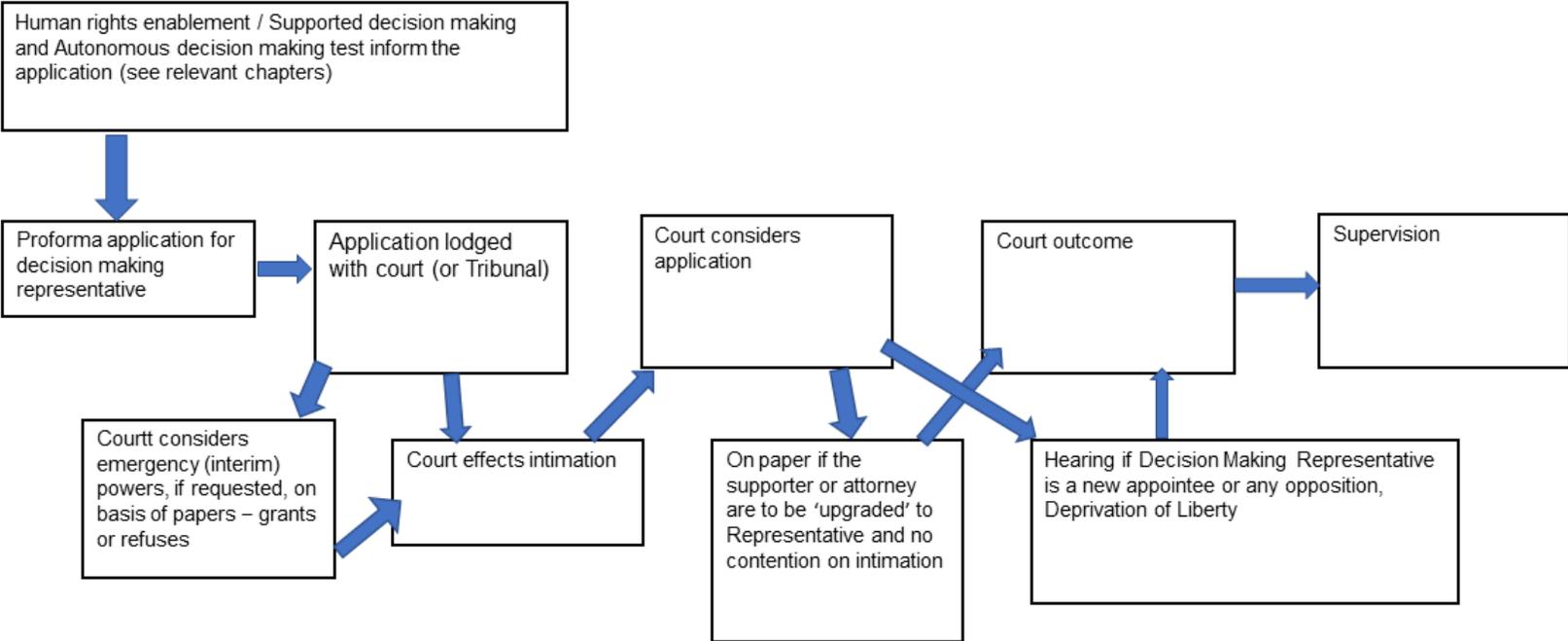
It is proposed that the current system of granting a power of attorney (PoA) remains essentially unchanged, however Scottish Government should ensure there is increased awareness of the importance of this document and active encouragement to grant a PoA. In addition, we propose:

1. Scottish Government, Office of the Public Guardian, Local Authorities and Mental Welfare Commission should ensure there is sufficient guidance for attorneys.
2. Scottish Government, the Office of the Public Guardian, Local Authorities and Mental Welfare Commission should 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.

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.

[Appendix A](#) on the next page illustrates the proposals including an option for an emergency application for a decision making representative.

Decision-making representative – proposed application model



## Part 5 of AWI –medical treatment and research

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.

### Proposals

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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. 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.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Deprivation of liberty**

Chapter 11, pages 12 -177 of the full consultation paper.

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 Bournemouth 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 'Bournemouth 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. This definition was reiterated by the UK Supreme Court in its subsequent Cheshire West ruling.

We require 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.

## **Proposals**

A proportionate approach is necessary. 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. There will need to be a standalone right of review available to the adult, or a person acting on their behalf (e.g. an attorney) where they are de facto detained in a 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 right for the Mental Welfare Commission to intervene in such cases if they have concerns. Views are sought on how to make this right of review truly accessible to the adult.

## 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 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. 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 and we consider a further option is needed – either 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.

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 of 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 but 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 to allow any appeal to be heard quickly to avoid a 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.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## Mental disorder

Chapter 12, pages 178-182 of the full consultation paper.

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

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.

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's proposals aim to increase the compliance of Scots law with ECHR and UNCRPD. The shift from a focus on mental disorder to a set of factors which may prevent autonomous decision making is a significant part of this approach. 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.

As the proposed changes to mental health and incapacity law will seek to enable people's human rights, we consider that this law should be widely accessible. 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.

And if we are to have fused or better aligned legislation the underlying concepts have to be consistent.

But this still leaves us with the challenge of finding language reflecting this which is also acceptable to those who may be subject to it.

Many are uncomfortable with the term mental disorder but we have found no simple and obvious alternative.

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.

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.

Views are sought on this broad approach and what terminology we could use instead of 'mental disorder'

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**

## **Fusion or aligned legislation**

Chapter 13, pages 183-188 of the full consultation paper.

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. This is not a new issue. Consistency between mental health and incapacity legislation was recommended by the Millan Review.

The Adult Support and Protection Act is now added into the discussion. 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.

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.

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 of the law. But there are many challenges with this proposal.

Adult support and protection practitioners have concerns that fusion would result in all adults at risk being viewed through a mental capacity / disorder lens. However moving the new proposals of human rights enablement to an autonomous decision making test could result in legislation providing wider options for care, support and treatment in a more cohesive manner than at present.

The judicial forum needs consideration too. The mix of tribunal and court oversight and disposals in the current law is criticised by many. Previous work in this area has recommended that the MHTS would be the most appropriate forum for unified legislation. The Law Society has endorsed this. And a single forum could be a stepping stone for fused legislation.

However perhaps alignment of the law would be a preferable immediate step. This would mean as far as possible there would be common principles, safeguards, and routes to remedy but maintenance of appropriate differences for people who at present may fall within the different laws. Aligned legislation may lend itself more readily to a single court or tribunal than the current system does.

**Please see the full consultation paper for more detail and specific questions on these proposals at: [www.SMHLR.scot](http://www.SMHLR.scot)**