



mental welfare
commission for scotland

Scottish Mental Health Law Review - consultation response

Corporate document

June 2022



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

On chapter 2: what is the purpose of the law?.....	9
1. What are your views on our purpose and principles?	9
Purpose.....	9
Principles	10
2. What do you think about the approach that we are proposing for Scottish Government to meet core minimum obligations for economic, social and cultural rights in this area?.....	11
3. What are your views on our suggestions for reforming sections 25 to 27 of the Mental Health Act?	12
4. Do you have suggestions on how law could be reformed to address stigma, and issues with attitudes towards mental disability?	13
5. Do you have suggestions on how the law could lead to prevention, and how the law could address the social determinants of mental health?.....	14
6. What are your views on our proposals on adequate income, housing and independent living, inclusion in society, and accessible information?	14
Please let us know if you have suggestions of other economic, social or cultural rights which you feel are particularly relevant to mental health?.....	14
7. What are your views on the system-wide changes which we think are needed?.....	15
8. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	15
On chapter 3: supported decision making.....	17
1. What are your thoughts on our proposals for a wide ranging supported decision making scheme ?	17
What do you consider would be the barriers to this?	19
How do you think the Supported Decision Making scheme should be taken forward? ..	19
2. How do we mitigate against undue influence or pressure in Supported Decision Making generally?.....	20
3. Should there be legal duties on public bodies to secure Supported Decision Making for people who need it? If so, given that advocacy is a form of SDM, what should be the relationship between that and the existing duties in respect of advocacy?.....	20
4. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	21
Question: What are your thoughts on the creation of a Centre of Excellence for Supported decision making?	21
On chapter 4: the role and rights of carers.....	22
1. What are your views on our proposals for mandatory Carer Awareness training for all mental health staff?.....	22
2. What are your views on information sharing with unpaid carers of all ages?.....	22
If you are an unpaid carer, what are your views on sharing information with mental health practitioners?.....	23

3. What is needed to ensure mental health services identify and engage with young carers?	23
4. What are your views on including unpaid carers in discharge planning and processes, as stated in Carers (Scotland) Act 2016?	23
5. What needs to happen to ensure unpaid carers of all ages are respected and valued?.	24
6. Please tell us anything else you think may be relevant to the role of unpaid carers when supporting someone experiencing mental disorder and working with services.....	24
On chapter 5: human rights enablement	25
1. What are your thoughts on the proposed Human Rights Enablement (HRE) framework?	25
2. How do you see the framework as proposed working in practice?	25
What barriers do you see to its operation in practice?.....	26
3. What are your thoughts on who should initiate an HRE ?	26
4. What are your views on the triggers for an HRE?	26
5. What are your views on the right to request a review and the right of remedy and appeal as proposed?.....	27
6. Would the body for remedy and appeal differ if the request for a review was in respect of a group of persons rather than an individual?	27
7. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	27
On chapter 6: autonomous decision making test	29
1. Capacity and SIDMA	29
If you would prefer a reframed definition, please feel free to comment on what you would wish to see adjusted. If so, please comment to let us know if would this include additional matters, or be a reworking to conjoin the current tests?	29
2. We seek your views on the concept of the test of autonomous decision-making, distinct from a capacity or SIDMA test.....	29
3. What are your views on the skills and experience required for someone to competently undertake a test of a person’s ability to make an autonomous decision?	30
4. What are your views on the ADM appeal process?	30
On chapter 7: reduction of coercion	31
1. Please share your views on how the Review understands coercion	31
2. What you think about the Review’s proposed approach to reducing coercion, including reducing the use of involuntary treatment?	31
3. Do you think that “coercion” or some other word(s) should be used to describe the use of force, the possible use of force, and the experience of coercion	32
4. Please share your views on whether law reform could drive changes which could reduce the use of coercion.	32
5. Do you think that safeguards for medical treatment in Part 16 of the Mental Health Act should be strengthened?.....	33

6. We seek your views on whether the Mental Welfare Commission should have stronger powers to oversee the use of coercive interventions and to identify areas for action.....	33
7. Please share any suggestions that you have for the Review’s ongoing work on understanding rising rates of detention and community-based Compulsory Treatment Orders	33
8. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	34
On chapter 8: accountability	35
1. What do you think about our proposals to give the Mental Health Tribunal increased powers to order that specific care and/or support be provided for a person?	35
2. What do you think about the ways we want to extend current excessive security appeals to anyone who feels they are being subjected to unjustified levels of restriction?	35
3. What you think about our ideas for reforming the ways a person can raise a concern or complain about their care and treatment?.....	36
Do you have any other ideas to make this process more effective and equitable?.....	36
4. What are your thoughts on collective advocacy groups raising court actions?	36
What are your thoughts about creating a way for collective advocacy groups to alternatively escalate unresolved human rights issues to an identified scrutiny body?..	36
Please let us know of any existing organisation that you feel should take on that role?	37
5. What are your views on why and how we think collective advocacy should be strengthened?	37
6. Do you have any suggestions to make the scrutiny landscape for mental health services more effective?	37
7. What do you think about the ways in which we think the role of the Mental Welfare Commission should be extended?	38
Do you have any other ideas?.....	38
On chapter 9: children and young people.....	40
1. Do you think the current 2003 Act principle for children is still needed?	40
2. What do you think about having a statutory duty on Scottish Ministers and health and care agencies to provide for children the minimum standards needed to secure the human rights set out in international treaties such as the UNCRC?.....	40
3. What are your views on reforming crisis services for children and young people experiencing acute mental distress?.....	41
4. What you think about law reform to ensure access to CAMH services up to at least the person’s 18th birthday and to ensure age appropriate services more generally?	42
5. What are your views on our ideas about relatives and families?	42
6. What are your thoughts on how supported decision making, human rights enablement and the autonomous decision making test in chapters 3, 5 and 6 might apply to children and young people?	43
7. What do you think about our proposals on advocacy and on accountability?.....	43

8. What are your views on autism, learning disability and neurodiversity and the possible law reforms for children and young people?	44
9. What do you think about our proposals on safeguards for treatment and services, and safeguards to protect the relationships between children and parents?	44
Please let us know what you think about our proposals to protect the relationships between children and parents.....	44
10. At this time, Scotland’s mental health law applies to compulsory mental health treatment at all ages. Do you have views on the idea of moving mental health law for children to connect it with other law for children, to apply across health, education and social care?	44
11. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	45
On chapter 10: Adults with Incapacity proposals, part 1 (guardianship).....	46
1. Part 1: Guardianship	46
2. Specifically, what are your views on the role of co-decision maker – and its omission from this model?	46
3. Will the proposed change address the issues currently experienced with guardianship?	47
4. What are your views about the proposed streamlined application process?	47
5. Does the proposed emergency provision in the model address the concerns about the current system?.....	48
6. Should the reframed model allow for the grant of a specific or one-off order (currently called an intervention order)?	48
7. Should the current access to funds process be subsumed within the new guardianship model?	48
8. Should the current management of residents’ finances process be subsumed within the new guardianship model?	48
9. What are your views on a system of supervision?	49
10. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	49
On chapter 10: Adults with Incapacity proposals, part 2 (power of attorney).....	50
2. What are the key points of guidance that need to be given to attorneys?.....	50
3. What support should be given to attorneys – by whom, when?.....	50
4. What are your thoughts on the reporting structure for someone with concerns?	51
5. What are your thoughts on the investigations structure?	51
6. What are your thoughts on authorities being able to supervise an attorney, on cause shown, following a statutory inquiry?	51
7. What are your thoughts on attorneys having power to authorise a deprivation of liberty (assuming this power has been granted in the power of attorney)?	51
9. What measures should be taken to increase the awareness of a PoA?	52

On chapter 10: Adults with Incapacity proposals, part 3 (medical treatment and research)	53
1. We seek your views on the recommendations we are proposing.....	53
2. What are your thoughts on the provisions within s47(7) on the use within the AWIA of force, detention and the relationship with the 2003 Act?	54
3. Is any change needed to the list of special treatments requiring additional safeguards, (section 48) or the procedures by which they are authorised?	55
4. Is any change needed to the dispute resolution procedure in section 50?	55
On chapter 11: deprivation of liberty	56
1. Please share your views on our proposals.	56
2. Please share your views on the proposed standard and urgent deprivation of liberty orders and the suggested process	56
3. How can we ensure that there is a real, effective and accessible ability for the adult and/or their representative to challenge the lawfulness of a deprivation of liberty order?	57
4. What do you see as potential barriers to the operation of deprivation of liberty orders?	57
5. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	57
On chapter 12: mental disorder	58
1. Should there be a gateway to mental health and capacity law which reflects a diagnostic criterion?	58
Please share your thoughts on what that gateway should be: what terminology should we use?	58
2. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....	58
On chapter 13: fusion or alignment?	60
1. Given the changes being proposed by the Review, do you think a single piece of legislation for mental health, incapacity and adult protection law is the best way forward?.....	60
2. What do you think about our suggestion of aligned legislation?	61
Which aspects of the law should be aligned and which should be left within standalone law?	61
3. Please tell us if you consider a single judicial forum should deal with all mental health, incapacity and adult protection cases	61
Should that forum be the sheriff court?	61
Should that forum be a tribunal?.....	61
Should there be a single forum only in the event of fused legislation?.....	61
Is a single forum your preferred way forward regardless of wider changes to the legislation?.....	61
If you consider aligned legislation is preferred, should a single judicial forum be part of that alignment?.....	62
Please share any reasons for your answers.	62

4. Please use the space provided below for any other comments you would like to make, relevant to this chapter.....62

About you..... 63

On chapter 2: what is the purpose of the law?

1. What are your views on our purpose and principles?

Purpose

The Consultation sets out the purpose of the law stating that it should be to ensure that all the human rights of people with mental disorder are respected, protected and fulfilled. The immediately following paragraph in the consultation sets out clearly who it considers to be in scope for these protections- those people whose decision making ability may be impaired.

It is instructive to see this revised purpose against previous iterations of what mental health law ought to achieve. As we set out in [our response to the first phase of the consultation](#) in May 2020:

“Mental health legislation can restrict and deprive a person of their liberty and can impose treatment that they do not want or cannot consent to. Traditionally one purpose of legislation was to ensure that people who are unwell are treated to restore them to health and reduce any risks that their altered state of health might pose to their safety and that of others. A further purpose was to ensure that when someone is made subject to detention or treatment that they cannot or do not consent to, that there is a mechanism for this detention to be reviewed, and safeguards are in place to ensure that people are treated in accordance with their human rights.

“Developments in International law would suggest that a Mental Health Act ought to go further and focus on the restoration of other rights that are impinged on by the presence of disability (such as serious mental illness). The Review of Scotland’s Mental Health Act gives us a great opportunity to fully consider those developments, alongside the UN Convention on the Rights of Persons with Disabilities which came into force after our current Act.”

Scotland’s legislation can be re-framed in such a way that the human rights of people with serious mental illness are clearly the centre.’

The Commission therefore welcomes the consultation’s proposal to broaden considerably the purpose of mental health law to protect all rights.

Further, reading the opening two paragraphs together, the Commission welcomes the scope in the purpose here that these protections ought to be for those people with a mental health condition (our choice of terminology here) whose decision-making ability may be impaired. This purpose sets out clearly that safeguards (currently not available to people who are treated under capacity based law i.e. Adults with Incapacity 2000 (AWI)) would be available to anyone whose decision-making is impaired thus closing a gap in mental health law in Scotland.

The purpose and scope sets out the case for fusion/alignment of the current mental health, capacity and adult support and protection legislation in a way that promotes rights in a universalist way.

Our aspiration for the new legislation is that no one with a mental health condition is excluded from the protections it should offer (or direct towards in aligned legislation). For example, the legislation must work for younger people who may not have yet acquired decision-making ability (for this to be impaired); people with conditions with fluctuating decision-making ability; or people with a mental health condition who may not have decision making inability but whose mental health condition is one that makes them vulnerable to others' limiting or marginalising them.

We believe that by redefining the 'test' for decision making as discussed in the chapter on autonomous decision making, there is scope to ensure a broader assessment that will not exclude those with fluctuating/developing capacity. There will be a need to ensure that any future act aligns well with existing or reformed adult support and protection legislation where the 'test' around decision-making ability does not apply in the same way.

A further comment we have is that in setting out a desire to meet all the human rights for this group through legislation specifically for people with a mental health condition requiring support for decision making, this may have consequence of paradoxically driving up the use of compulsion (if compulsion becomes the gateway to accessing these - we do not believe this should be the case). A later section of the consultation suggests that a Human Rights Enablement assessment is the mechanism for determining rights that are not met (regardless of use of compulsory powers). However at this point the detail becomes unclear as to how and more detail is required to determine how the HRE assessment helps meet the intended purpose for those who do not require support for decision making and can make autonomous decisions. Those that fall under the latter category are more likely to benefit from the provisions outlined.

So whilst we support the purpose, we are unsure whether the current proposals work for all with a 'mental disorder' (the consultation's language) or just those who are subject to the provisions of the Act as they require the use of compulsion.

Principles

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

The Millan Principles and the AWI principles form the basis for our approach on complex ethico-legal issues that are brought to the Commission's attention. It may be helpful to consider how the existing principles of both the AWI legislation and the MHA legislation map across to the proposed new principles.

We are concerned at the lack of reciprocity as a principle that does not appear explicitly within the descriptions of the new principles. This ought to be stated clearly as it informs the basis for the justification for imposing compulsory measures on a person without their consent and the availability of the appropriate resource. Although it is not a principle against which legislation is evaluated, it nonetheless provides a steer and reminder whenever compulsory powers are being used as to whether the intervention is delivering benefit to the person.

We endorse the whole-person approach that the consultation paper adopts in relation to the person whom decisions are being made with however we consider that the role of carers requires emphasising through a clearly stated principle on ensuring regard for carer views.

We consider that the broader UNCRC principle around children stated in chapter 9 ought to act as a guiding principle.

The Commission also notes that with regards functioning of the current Act there is often a sense that the principles are not fully realised.

There can be tension between the principles. We consider the approach suggested in the White Paper on reforms to the 1983 Act in England & Wales in the 'forms' for recording mental health compulsion decision making reference to the principles that will inform their new legislation to guide and support how decisions are made and recorded. It may be helpful to the Review team to consider this approach for our legislation too.

2. What do you think about the approach that we are proposing for Scottish Government to meet core minimum obligations for economic, social and cultural rights in this area?

The Commission welcomes the wider consideration of the rights of a person with a mental health condition which is at the heart of holistic value based practice. The Commission also welcomes the participatory approach referred to in order to define economic, social and cultural rights. The Commission notes the requirement of systematic monitoring to ensure these are met against the suggested standards that are mentioned in the consultation.

However, there is a risk in the broad approach that the consultation is suggesting as resources are finite. Therefore, there is a need to recast so that those who are subject to the greater degree of compulsion/restrictions/deprivations of liberty and who are at greatest risk of not meeting their full potential are supported in a proportionate and reciprocal manner.

The core minimum obligations as derived through some of the standards set out in the consultation apply to everyone in society and not just those with a mental health condition. The Commission considers that this may be an opportunity to ensure that the standards work that Scottish Government is currently consulting on and intends to use as a set for people with mental health conditions to be clear on expectations from services and reflect core minimum obligations. There needs to be clear duties on duty holders. We do not think this should necessarily wait for legislation. There is a mechanism for achieving better outcomes now.

A risk in the reciprocal, proportionate approach that the Commission is advocating in response to the question and recognises, is that paradoxically this may be a perverse incentive to drive up compulsion in order to ensure that people with mental health conditions are provided the resources that they need to flourish. However we think that mitigations are present within the model proposed and could be further developed to prevent this. The HRE described in a later chapter provides a mechanism at the very outset, before compulsory powers are even considered, to determine with a person what is required to help them meet their needs/potential.

With greater scrutiny of the use of compulsory powers and safeguards around these, it is possible to ensure that obligations are met for all as they arise; rather than because of being subject to any provision of a future act that requires treatment/deprivation/restriction of liberty.

3. What are your views on our suggestions for reforming sections 25 to 27 of the Mental Health Act?

The Commission agrees that monitoring and indeed awareness of s25-27 is inadequate.

There is a lack of clarity within the consultation as to whether there is an intended extension and strengthening of these requirements (as mentioned in one section; to address rights more fully e.g. housing, independent living, inclusion) or whether these duties are subsumed within the wider core minimum obligations concept described above, with the risks of dilution, if the latter. This would be helpful to clarify.

We note that the consultation clearly states that it is against setting any sort of threshold for the realisation of these targeted duties.

Although that would be consistent with a drive towards core minimum obligations for all, it does not reflect the reality that some people require a maximalist approach to meeting their needs. The principle of reciprocity is a steer towards the obligations of society/the State to people with a mental health condition that in some cases requires greater intervention.

There is an inherent risk in directing resources towards core minimal obligations that those who are most vulnerable and with severe enduring mental illness that leads to a disability (in the sense of the word that many would understand) and those that are disenfranchised inadvertently.

There is a recognition of this in the consultation itself as it states that:

“Section 25-27 of the 2003 Act should be extended and reframed to set out clear and attributable duties on NHS Boards and local authorities to provide mental health support to individuals with **significant** levels of need, reflecting the core minimum obligations.”

The bold font is our emphasis and we consider significant levels of need does represent a threshold approach albeit one that stresses need without reference to the nature of the condition/disorder. We would welcome clarity on whether this is intended to be a threshold approach and how that might be set.

(It would be helpful to revisit the discussions that took place on section 117 duties under the 1983 Act in England and Wales as part of the ‘Wessely Review’ and the expression of these discussions in the consequent White Paper. The interface with the proposed new National Care Service will also be critically important.)

4. Do you have suggestions on how law could be reformed to address stigma, and issues with attitudes towards mental disability?

Yes. Firstly, stigma is reduced through the active participation of people within society.

There is an opportunity for the law to ensure greater visibility and support for people with a mental health condition to be involved in directing how services are governed, developed, and scrutinised. There is also an opportunity to reduce stigma by requiring those public bodies, including the Commission, that are set up through mental health legislation to require the voices of people with experience of using services and carer voices at all levels of their working. This may lead to a wider effect across society. The benefits of diversity and inclusion have not yet been realised. The review provides an opportunity to do so.

Relatedly, by setting the parameters of the HRE approach, broadly, as the consultation sets out and by considering sharpening requirements to meet needs (s25-27, as above) there is an opportunity to ensure that people with greater need are provided with access to resources/supports that might enable them to meet their recovery goals and outcomes. This would have an impact on how people with severe mental illness and learning disabilities are seen in society.

Secondly, there have been great successes on opening up public conversations on mental health and particularly in dealing with subjects such as well-being, depression, self-harm, neuro-diversity and its effects. These need to be built upon. Research has consistently demonstrated that stigma around illness reduces when the illnesses are understood and seen as treatable. This may be out with the scope of the SMHLR but requiring those public bodies working with those with mental health conditions to collaborate to improve data-sets, and consequently research, may lead to the reduction of stigma and discrimination that the review seeks, in addition to the laws already present against discrimination.

It is also important to acknowledge that there is already a body of work to address stigma across Scotland by partnership efforts within and across HSCPs, Health Boards, local authorities and community and voluntary organisations. This work provides a foundation for extending mitigation around stigma.

Importantly, much of the work is targeted at children and young people. The clear common thread is that by actively involving those with lived experience, families and carers in telling their stories, there can be a human rights approach to tackling stigma as a nation.

Finally, a fused law based around inability to make decisions due to mental health conditions rather than a 'mental health act' that lies separately to an incapacity act, and applies to people with a mental disorder may also be a step towards reducing discrimination.

5. Do you have suggestions on how the law could lead to prevention, and how the law could address the social determinants of mental health?

Yes. Requirements set out under extending and strengthening of section 25-27 would lead to tertiary prevention, in preventing relapse. Although the HRE provides a mechanism prior to the use of compulsory powers, once these are used, it is important to consider the role of social circumstances reports (SCRs) and how these instruments can play a critically important role in requiring action or at least alerting systems to the need to address social determinants. The place for SCRs and the details for these are not considered in the current consultation but by ensuring that these are prepared by social work professionals (MHOs) with education/training and workforce levels being sufficient to meet demand – individual social determinants might be addressed.

At a population level, again through introducing systems leadership for the collection and development of data-sets and through a requirement for collaboration across mental health public sector bodies this might lead to a focus on ‘up-stream’ factors at a population level associated with public mental health and wellbeing.

A national mental health strategy which puts prevention and early intervention at its centre, alongside shared principles in keeping with this Review would also be a timely parallel development.

6. What are your views on our proposals on adequate income, housing and independent living, inclusion in society, and accessible information?

The Commission agrees with all of these as outcome measures but stresses the need for delivery against agreed standards for mental health, and proportionately for those in greater need, with an agreed framework for monitoring, scrutiny on how these are delivered and for whom. Without these factors, the outcomes may remain aspirational rather than realised in practice.

Please let us know if you have suggestions of other economic, social or cultural rights which you feel are particularly relevant to mental health?

Yes. There is a growing body of evidence that ‘belonging’ (corresponding to the consultation’s principle of inclusion) is important to maintain and to enable good mental health and recovery from mental illness. However there is little evidence that ‘belonging’ is measured for individuals using mental health services- quantitatively through questionnaires or through qualitative feedback, or through tools such as the recovery star etc. This does not just mean around vocational pursuits. Recent research conducted by the National Institute for Health Research (NIHR) published in the British Medical Journal ([‘Adults with learning disabilities want loving relationships, but may need support’](#)) highlighted how systems consider mental and physical health for people with learning disabilities but with little emphasis on developing inter-personal relationships (and belonging in the wider sense) . That is not to say that the Commission has not found some evidence of this in practice however, particularly in the context of quality third sector delivery in Scotland.

The extent to which current treaties consider how the State (through services) enables spaces for inter-personal growth/ developing and sustaining nurturing relationships is unclear- but the emphasis has been on 'mental' and 'physical' health of the person rather than 'social' needs. To some extent this might be addressed through the HRE processes, but this will require a significant change in culture, and services may need to be brought into existence/enhanced/ in order to make progress in this very important area.

7. What are your views on the system-wide changes which we think are needed?

The Commission agrees with the proposals to increase the patient voice at all levels in governance structures across health and social care. We note the recent developments in New Zealand with their reformed Mental Health and Wellbeing Commission developing assurance frameworks that are fully informed by the priorities of groups that have been marginalised.

We think that the potential for assurance and scrutiny and patient/individual/carer voice has not been fully realised in Scotland, and specifically not in the mental health sector.

We agree with the need for design changes, in the broadest sense, and not just limited to architectural change that is needed to some of the ageing mental health estate. The Double Diamond model for Scottish service design is helpful as a model.

It would be instructive that the service specifications (standards) work that is currently being undertaken by Scottish Government is not idealistic and aspirational but instead sets out clearly what services must provide and what individuals should expect, now. The Commission's experience is that there is huge variation in what people receive and it would be good to ensure that the core minimum obligations are tied into something tangible and meaningful for people in Scotland with mental health conditions. We strongly agree that a national strategy for mental health ought to follow and realise the standards, amongst other priorities. A realistic move would be to tie these instruments together so that the strategy is to realise standards and, the bold move would be to require that these are the obligations that the State has towards people with mental health conditions. Other jurisdictions have set out legally binding duties to provide mental health care so such a move could be seen as further development in the progressive realisation of CRPD, in clear, unambiguous terms.

8. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

We consider that the system wide changes as described above are material ways in which the culture of mental health services can be nudged in a direction that leads to greater transparency, co-production, and clarity; empowering individuals and promoting independence. The focus on individuals and outcomes important to them should avoid service driven practices, for example, the 'three strikes rule' whereby someone does not keep an

appointment they are discharged from services with the potential to compound feelings of hopelessness and abandonment.

The Commission referred to the work of Amartya Sen in its submission to the first-phase consultation (May 2020), particularly to work on the capabilities approach (as developed by Martha Nussbaum). The Commission considers that this provides a theoretical grounding to consider the extent to which services are re-enabling/ increasing the capabilities of people. The extent to which law reform can mandate this approach is not immediately apparent but the capabilities approach does map to human rights/conditions for flourishing and therefore, a Human Rights enablement approach is a practical manifestation of the capabilities approach and we were pleased to see this. The HRE approach may therefore lead to cultural change across mental health services.

We note that there is little in the consultation that speaks to the digital innovations that preceded the pandemic and that were reinforced and mainstreamed by the pandemic.

The opportunity for services to innovate requires consideration, particularly the interplay with mental health legislation. It would be helpful to the Review to consider the Scottish Government's digital first strategy, its mental health digital work stream and the intersection between how and what services might be provided digitally. During the pandemic the Commission received many queries about the limits to video technology and these require conscious development in intersection with law rather than organic development.

There is also a lack of acknowledgment of the risk constraint throughout the consultation and the extent to which considerations of risk drive professional and clinical decision making.

On chapter 3: supported decision making

1. What are your thoughts on our proposals for a wide ranging supported decision making scheme ?

The Commission considers the wide-ranging supports for decision-making brought together in this chapter a helpful way to consider the mechanisms currently available, that require sharpening, and new methods that should be added to this repertoire. This approach does pave the way to consider fused legislation around provision of support for decision making for those unable to make decisions due to a mental health condition.

We note that the repertoire contains provisions from the 2003 Act and 2000 Act and also helpfully discussed influences that might be seen as controlling (introducing an alignment with ASP 2007 legislation). We note that there is an absence of where and how to protect the interests of those who have not yet acquired decision making capacity for the relevant decision due to maturity, i.e. children and there ought to be consideration of specific and general supports for children too.

The Commission's views on the inadequacy of current arrangements around Advance Statements have been set out in our recent report on this subject. Only 6% of people eligible to have an advance statement had one when visited by the Commission's designated medical practitioners. We consider in depth the reasons that might lie behind this and made the following recommendations to SMHLR:

"We recommend that the Scottish Mental Health Law Review (SMHLR) considers whether it would be helpful to distinguish between an advance statement to refuse treatment from wishes about receiving specific treatments. This would be in keeping with the distinction between refusing treatment and requesting treatment in the more general sense.

"We also ask that the SMHLR consider whether a new mental health law should require that people are offered the opportunity of developing an advance statement when a person completes an episode of a relevant compulsory treatment or at an appropriate time following this. The current low uptake we describe, despite 15 years of advance statements in Scotland, suggests the need for more focussed intervention to increase the uptake.

"We note the findings from the previous Scottish Government review (The McManus review) on the low uptake. We consider that a competently made advance refusal for a specific treatment should have a higher bar associated with any override of this including greater scrutiny. This may address the concern that an advance statement currently can be too easily overridden. Such considerations would put the UNCRPD principle of respecting the rights, will and preference of a person with disabilities at the heart of a new act in a demonstrable way."

The Commission considers that it is ideally placed to undertake or organise for (through an enhancement of the DMP role) the enhanced scrutiny of a competently made advance statement to refuse a treatment for mental disorder (to take the language of the current Act). We would be happy to work with SMHLR to provide a clear estimate of the numbers from our

annual Advance Statement Override report that will allow an estimate of the resources that this would entail for this aspect of an enhanced mechanism to support a reformed Advance Statement.

On Advance directives (that is, akin to Advance Decisions to Refuse Treatments (ADRTs) as in the Mental Capacity Act 2005 for England and Wales meaning of ADRTs that we consider that the consultation is referring to), the Commission agrees that these ought to be legislated for in Scotland. Again this sets out a path for fusion, as to contrast with the England and Wales legislation, there are no 'advance statements' but there are ADRTs that can be used relating to any condition if a person has lost capacity. However, work undertaken at the University of Nottingham has demonstrated that ADRTs have a similarly low uptake to Advance Statements for a mental health condition that has a fluctuating course and is therefore a condition for which this would be helpful (please see references in the Commission's advance statement report).

The development of ADRTs would be a key aspect of a fused legislation for Scotland to ensure that there is equity for people with mental and physical health conditions. The Commission already has mechanisms for disputes between professionals and welfare guardians on section 50 concerns as set out within the AWI 2000 Act and therefore a model for consideration of ADRTS might be considered as an extension of this, with adequate resources at a pre-judicial step, as per the current section 50 arrangements.

On the Named Person provisions the Commission supports further consideration on reform as the current system is not working. The Commission's database demonstrates that only a quarter of people have a named person through their episode of detention (22% in 2018, 27% in 2019, and 23% in 2020) and that at the point of detention under a STDC the numbers are even lower ranging between 9% and 13% over the same time period. The numbers point towards a safeguard that has not been fully realised and the need for more work to promote uptake of the safeguard for individuals.

Our work on independent advocacy shows that this is not realised for all. We agree with the consultation's proposal that this should be offered to all across mental health and incapacity legislation. This should be available, not only at discrete points of legal processes but should be holistic and accessible to individuals at any point they would wish advocacy support (as highlighted in the Commission's report relating to people with a diagnosis of alcohol related brain damage in 2021). The Commission fully supports the consultation statement that advocacy support is a 'valuable tool for support for decision making'. We support the other suggestions considered including non-instructed advocacy.

The Commission considers that the purpose of support for decision making is as per the opening line of the consultation's chapter- to help a person form a view of what they want to happen (or in some cases as above - what they do not want to happen- or particular treatments that they do not want) and how to make it happen so that the view has legal effect.

Although not explicitly mentioned in the consultation chapter, the will and preference of the person so expressed may need to be considered alongside the rights of the individual; and the benefit that would accrue or not in the balancing of these factors. Quality assurance of SDM in practice will also be critically important.

What do you consider would be the barriers to this?

Supported decision making reinforces the existing legislative principles and values based practice. SDM requires the right staff with the right levels of time and input and sufficient communication skills.

There is widespread support across the sector for mechanisms to increase an individual's voice and that must include people with dementia, however this can take time to invest in relationships and we hear there is often a lack of resource to ensure that options are available.

There is also the real barrier of a lack of awareness - there needs to be mandated offers for these supports and demonstration of this, as per the Commission's recommendations. There is also a sense of some of these tools lacking meaning (McManus review on advance statement lack of uptake is instructive on this). There are tensions that remain unresolved between the will of a person and the preferences that they express in the here and now. This has not been addressed and remains a point of unease especially within older adult mental health services/ care home settings. There is also a lack of consideration regarding carer/significant other involvement/community relationships alongside the emphasis on autonomy.

Sometimes reverting to custom and practice is the greatest barrier to change.

How do you think the Supported Decision Making scheme should be taken forward?

A fused approach would allow these different mechanisms to be offered as a suite of measures rather than a hierarchy (although that might be needed at some times when there is conflict). Regardless of fusion, presenting these as options will help increase uptake. There is a risk of an individual being overwhelmed with the options and there needs to be a degree of support to help a person choose what mechanism feels right to them. It cannot be left to services. The Commission data shows clearly that the current legislation's promise has not materialised, despite helpful interventions by Scottish Government, sporadically by interested services/people, and the Commission itself; and therefore there is a need for sharper legislation to ensure that the options are offered, and acted on.

2. How do we mitigate against undue influence or pressure in Supported Decision Making generally?

Adult support and protection legislation considers undue influence in practice and there is much to learn from social work practitioners who assess undue influence through their enquiries and investigations according to ASP. Challenges to POA and directions to the sheriff court under AWI are also current options but the Commission accepts that this is not often used and that it should be more straightforward to mitigate in practice, be time bound and not restricted by cost.

Undue influence can be difficult to establish at times. Generally, the Commission would suggest a low-bar for those concerned or connected with an individual to be able to raise concerns about undue influence within the organisation they work in; or with an organisation that has duties to enquire. This needs to be powerfully communicated through both broadcast and outreach.

There are also tensions between the parental rights and views of a child that ought to be considered here to ensure that the proposals work across all age groups.

3. Should there be legal duties on public bodies to secure Supported Decision Making for people who need it? If so, given that advocacy is a form of SDM, what should be the relationship between that and the existing duties in respect of advocacy?

Agree – as set out above, the core minimum obligations should include the provision of support for decision making. Whilst this is a legislative mechanism, it would be helpful to consider how this maps/translates into the current standards work more generally. For those who are subject to compulsory interventions the standards and the legislation should mandate the offer of support for decision making with monitoring of the provisions made – its offer, receipt and uptake of advocacy support by protected characteristic and by area. Ultimately services ought to be held to account over the non-provision of advocacy services (children, young people, adults and older people) as set out in standards.

It is also an opportune time to reflect on independent advocacy, the role and expectations. We are told that approaches and support is not necessarily consistent between and across Scotland's HSCPs.

4. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

Question: What are your thoughts on the creation of a Centre of Excellence for Supported decision making?

The Commission considers that it would be helpful to further develop expertise around complex ethico-legal decision making within the context of any new law and principles that underpin this, practical measures around support for decision making, and be able to develop a partnership/collaboration with relevant centres to ensure that the knowledge is accessible to others too.

The current legislation establishes duties on the Commission under section 9 and 9A to provide advice to professionals/professional bodies and any person on matters related to the operation of mental health legislation. A centre of excellence must be service user, carer and professionally facing- the Commission's phone line that takes around 4500 calls a year often on complex ethico-legal issues provides a model and a structure for this work to be located within and through developing partnerships with relevant centres is ideally placed, with appropriate resources, to take this forward. SDM should not be isolated from other aspects of mental health care.

On chapter 4: the role and rights of carers

1. What are your views on our proposals for mandatory Carer Awareness training for all mental health staff?

Please share your views on our proposals for mandatory Carer Awareness training for all mental health staff: The Commission welcomes this however it is the detail that would make this meaningful

The Carers Act 2016 is very clear about the critical social, human rights and economic case for supporting carers with the key principle of the Act being carer involvement.

The Commission hears of many examples of failure to involve carers e.g. in discharge planning, failure to take calls/receive information from carers. Training therefore should be carer led for those professionals in training and ongoing refresher training for the multidisciplinary staff in post perhaps through existing structures for training professionals e.g. section 22 training, MHO/social work training, mental health nurse training etc.

The balance between sharing information and maintaining healthcare/social work/social care confidentiality is understood, however carer involvement is less well understood.

We also consider that embedding the voices of those with experience and the voices of carers through the governance structures of organisations can often orient services towards these issues more meaningfully. This should be undertaken in a considered manner, ensuring that carers are represented by a wide variety of experience, not solely in terms of the diagnosis of those cared for, but ensuring a balance in socio economic status, ethnicity, gender, age and other protected characteristics in proportion with the population of Scotland as a whole.

2. What are your views on information sharing with unpaid carers of all ages?

First of all, there needs to be respect for carers, an understanding of their unique role and a positive approach to support this continuing where the individual depends on this.

Rather than age, it is maturity that ought to determine what, how and when information is shared, against established principles (including Caldicott), and the rights of the individual about whom information is being shared, as well as considerations of the risks/concerns that the person receiving the information may experience.

If you are an unpaid carer, what are your views on sharing information with mental health practitioners?

Response from a member of our team with direct experience:

“I have always shared information with practitioners but the same courtesy has not been returned. Despite having consent from my relative services still struggle to fully understand confidentiality and better training around this is needed. I am in a much better position than anyone else to describe past and current issues and am aware when a professional is not getting the full picture.

A more transparent, trusting system needs to be developed reflecting the fact that the vast majority of families have only the best interests of their relative at heart.

The nature of mental illness means that occasions occur when relationships break down (e.g. at the time of detention) and it is vital to maintain family connections which are often crucial to recovery.”

3. What is needed to ensure mental health services identify and engage with young carers?

A principle around carers (of all ages) would be helpful. There are existing duties with regards those who are dependents on people who are receiving mental health care particularly at difficult points such as assessments under the mental health act. Co-locating these duties with a duty to enquire about any and all carer givers (of all ages) leading to the supports that are available through the Carers (Scotland) Act 2016 might help to increase identification and engagement with carers of all ages, and particularly for hidden carers and young carers.

The Commission would suggest that there is also scope to identify hidden carers via primary care services, including by General Practitioners at the point of referral to specialist services, but also by the extended primary care team, for example community link workers. This may particularly support the early identification of parent carers of children with additional support needs.

4. What are your views on including unpaid carers in discharge planning and processes, as stated in Carers (Scotland) Act 2016?

Despite the Carers Act, we still hear from carers about family members being discharged home sometimes with no planning or notice. Involvement of carers is critical for safe and legal discharges and to prevent re admission. We hear that the reality for some is that the Carers Act has little impact; the Commission is keen to learn more from carers about this apparent disconnect at times.

The development of case studies centred on the experience of carers may be a vital tool in building understanding of this disconnect noted by carers in our experience. This would also serve as a key resource in workforce development training for staff on carers referred to in Q18.

The Commission also considers that the existing legislation could be strengthened to include duties to consult with named persons (as a minimum) or in the absence of a named person with a person connected to the person subject to compulsory powers, wherever practicable, and within the rules of confidentiality at the point of revocation of powers.

This would go beyond existing duties to notify and become a more active process.

As the Commission recommended in its work on STDCs (that has been sent to the Review), the process of revocation of detentions needs to become a more active process and this is one practical example of this.

Through doing this for those subject to compulsory powers this then more powerfully establishes a norm of practice in areas where this does not currently take place.

5. What needs to happen to ensure unpaid carers of all ages are respected and valued?

Please note above responses regarding a principle around carers to orient the operation of legislation and then practical steps to ensure involvement at different junctures in care pathways.

There are many examples of services developing evening drop-in sessions to allow carers to have time with staff at less busy moments, of dedicated carer engagement sessions etc. Carers tell us that where it works well, it works very well, where it does not, there is a need for attitudinal change.

The Commission would like to see the voice of carers embedded within governance structures at all levels of health and social care services.

6. Please tell us anything else you think may be relevant to the role of unpaid carers when supporting someone experiencing mental disorder and working with services.

Carers are critically important partners however more detail is required to give assurance and hope of direction and change to ensure they are recognised as such. There is also no mention made of parents and their rights and responsibilities towards their children.

On chapter 5: human rights enablement

1. What are your thoughts on the proposed Human Rights Enablement (HRE) framework?

The Commission considers that the HRE as a framework is a helpful means to ensure that a person centred, human rights based, care plan becomes an established norm within mental healthcare services. Some practitioners are trained to have human rights at the core of their holistic practice so this is not new however a framework will support consistency across health/social work/social care/third sector.

The Commission notes that this is not intended to be another form but that it is intended to be a framework to approach care alongside components such as support for decision making and the autonomous decision making test.

We note that the framework would consider support to maximise autonomous decision making, establishing the will and preference of the person, and consideration of their rights and the rights of others.

For many years, the Commission has repeatedly discussed person centred care plans that guide, support and make transparent the goals and outcomes of care for and with individuals, often in inpatient settings. The Commission views HRE as a way to normalise and promote good care plans across all settings leading to a common approach in mental health services.

We note however that there is a lack of detail in the consultation regarding roles and responsibilities and structure to support e.g. the care programme approach works well where there is administrative support and systems which cut across agency boundaries. Case scenarios detailing the triggers to initiate an HRE (e.g. both crisis and planned situations?) and detailing how HRE is intended to work in practice may be helpful to understanding.

2. How do you see the framework as proposed working in practice?

Firstly, we consider that the components of the HRE ought to be set out as the approach that underpins any proposed legislation. This may require that it is incorporated as a principle, within an existing principle or runs across the principles as a practical expression of how the principles are to be evidenced.

Secondly, care plans for informal and formal care, whether people are in hospital or at home in the community; and prescribed forms that are used to evidence the requirement for compulsory care should use the same language to direct/reflect the relevant components of the HRE. (There may need to be some further stakeholder engagement to consider whether HRE is the best term for this approach as some may find the language alienating). The care plans/detention forms are then the means for maximising a person's ADM, understanding their will and preference, balancing this against their rights and others' rights without the need to create any sort of new upstream 'HRE form' in addition to a care plan/detention form.

In summary, HRE as a principle and framework embedded into practice through established mechanisms, rather than a new process – supported by training.

What barriers do you see to its operation in practice?

We note that the consultation does not specify which particular rights should be evaluated but this may be linked to the core minimum obligations.

In actioning the outcome of the HRE, the consultation describes how a refusal of the action to address gaps in the HRE may result in harm, and if the refusal is not an autonomous decision then necessary treatment should start whilst the rights of the person are enabled (i.e. for someone who is unwell – they are started on treatment).

Questions arise if the autonomous decision making test is not based around the construct of a mental health condition, the HRE approach may become so broad in operation that existing services would not be able to meet the demand.

3. What are your thoughts on who should initiate an HRE ?

The ‘first responder’ should start the HRE.

From the consultation’s description, the assessments made through the HRE approach can be both relatively straightforward and can at times lead to processes that may result in compulsory care and treatment.

The Commission considers that anyone should be able to request an assessment through the HRE approach and this approach should be shared across all parts of the mental healthcare system. However just as the HRE is a dynamic approach, as the needs become clearer, there will be a need to involve mutli-disciplinary professionals to action the outcome of an HRE. Shared ownership is important and learning should be taken from the care programme approach and single shared assessment implementation processes including the challenges associated.

4. What are your views on the triggers for an HRE?

We agree with the triggers as outlined, particularly the request from the person and their carer. Awareness raising would necessarily be required to ensure this. As noted previously, some case scenarios would help develop understanding in practice.

5. What are your views on the right to request a review and the right of remedy and appeal as proposed?

The route of remedy and appeal around the HRE and gaps identified and actions will depend upon the nature of the actions that followed e.g. if the HRE process determined compulsory care then appeals against this ought to be heard by the MHTS.

If the HRE determined a need for housing support, personal care, medication etc. and the person either disagreed or was not able to access what the team/individual undertaking the assessment considers that the person needs then as the consultation suggests- an internal review of this within the service, is an appropriate first step.

Clinicians, professional staff and services work with finite resources and it may not be possible for services to meet all the needs and outcomes identified. It is important that the regulatory burden that might ensue does not require more time from services to be spent in discussing options that they are not responsible for/able to access that then detracts from multidisciplinary engagement to meet those aspects of a person's care that they can resolve.

It is therefore important that the person whose HRE needs are not met is able to appeal in the stages outlined. We note and welcome the suggestion that the Commission be part of the review process. Our practitioners describe the amount of work that often follows an individual case currently where there are concerns around rights not being met (or deficiencies in care and treatment). This process requires the judgement of the Commission practitioner as to what cases to approach (threshold/proportionate) and how and is resource intensive.

There is a need to avoid an overly bureaucratic system and more clarity is required for the individual and those important to them as to how and when they might appropriately escalate a concern in the context of the HRE, out with the service provider that the Commission would then review. As the consultation states, the Commission's resource would require to increase to deliver this.

The Commission is concerned that those with the more severe enduring illnesses might require support to request a review and right to appeal and the consultation requires more detail on this.

6. Would the body for remedy and appeal differ if the request for a review was in respect of a group of persons rather than an individual?

Disagree – the Commission believes that there are clear advantages of considering these together.

7. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

As stated previously, case scenarios would be welcome in order to understand the implementation of HRE in practice.

On chapter 6: autonomous decision making test

1. Capacity and SIDMA

If you would prefer a reframed definition, please feel free to comment on what you would wish to see adjusted. If so, please comment to let us know if would this include additional matters, or be a reworking to conjoin the current tests?

Agree – the Commission’s views on SIDMA are as recorded here ([SIDMA research brief, 2021](#)) and colleagues at the Commission contributed to the first in-depth study that clearly sets out the evolution of the concept and the flaws with SIDMA in a peer-reviewed paper published in the International Journal of Law and Psychiatry ([SIDMA as a criterion for psychiatric compulsion: An analysis of compulsory treatment orders in Scotland](#), PubMed, nih.gov).

There are two key challenges. Firstly, as the above reports make clear, only 12% of reports on SIDMA meet the guidance on how it ought to be recorded. The test is therefore not working as intended.

Secondly, the lack of clarity makes the test unclear to those who are affected by it most-patients, individuals and carers. Following an episode of compulsion, many people want clarity on why they were detained and/or treated against their will. Notes and records form an important part of the discussion. The clearer the process is, the less likely it is to cause distress and/or harm and loss of trust.

The Commission considers the current test around incapacity as a workable test with potentially some modifications/clarifications around the ‘appreciate’ aspect to incorporate the influence of illness as the ADM construct (no.11).

It would be, in the Commission’s view, better to develop the capacity/incapacity test rather than introducing a new test. The reframed capacity test could incorporate the elements of the ADM construct with the notable requirement set out above.

The proponents of SIDMA at the time of Millan made much of the here and now nature of a capacity test that may fluctuate, whereas SIDMA, it was argued, was more able to incorporate longitudinal nature of decision-making and was less subject to fluctuations in capacity.

The AWI 2000 test does include ‘retain’ and ‘appreciate’ as cognitive constructs and therefore could incorporate these concerns without introducing a separate test for mental health standing alone from incapacity.

2. We seek your views on the concept of the test of autonomous decision-making, distinct from a capacity or SIDMA test.

The Commission considers much of what is outlined in the 13 points around the ADM to be derived from or reflect existing best practice.

We consider that it incorporates aspects from the AWI 2000 test around capacity and through point 11 incorporates the aspect of influence of the illness from SIDMA- paving the way for a fused single test.

We welcome the clear expression that the test must take into consideration the person's advance wishes; that it must establish the person's view or the best interpretation of this view; and that the test is not based on the existence of a diagnosis- although point 11 allows the consideration of the influence of illness.

We are concerned at the lack of exclusions to whom the test might apply. In setting out in point 3 that the test may apply to any person, and with wide reaching potential 'harm' as set out in point 7- this may open up the test to misapplication dependent on the values of the assessor.

The test as set out currently in the section 'the concept' lacks detail to determine what the underlying cognitive requirements actually are to evaluate whether the decision is autonomous.

There also appears to be an inconsistency in point 7 and point 9, the former suggesting that where a person cannot make an AD, the presumption is in favour of respecting will and preference unless this will cause harm being caused; and the latter suggesting an intervention is permitted if it will lead to more respect, protection and rights overall as well as to prevent harm to another person/persons.

We prefer the formulation in point 9 that incorporates rights, risks, benefits as well as will and preference.

3. What are your views on the skills and experience required for someone to competently undertake a test of a person's ability to make an autonomous decision?

The details of the constructs that underlie the ADM test are not sufficiently clear to determine this. We agree with the general direction that the HRE informed approach to the assessment ought to provide the clarity as to who is in the best place to undertake ADM, ordinarily, it ought to be the person who plans to undertake any intervention that the person requires to secure their rights. This will recognise skills and experience extend beyond medical roles e.g. SALT, OT, psychology, social work.

It might become difficult for one practitioner to undertake an ADM requiring another practitioner to give effect to the intervention that follows. The skills/experience required for undertaking the ADM should reflect the intervention/s identified as necessary in the HRE approach.

4. What are your views on the ADM appeal process?

The Commission agrees with the judicial consideration as set out.

On chapter 7: reduction of coercion

1. Please share your views on how the Review understands coercion

The Commission accepts that in the literature around psychiatric care, coercion has become a word that has come to mean restrictive care and compulsory treatment.

Coercion, in the view of the Commission, is always wrong but the Commission does not view all the practices that the review is bringing together under one umbrella term as coercive.

In saying this, we recognise and we hear from individuals that they experience some actions as coercive.

Restrictive practices require regulation, monitoring, scrutiny and analysis but there are moments in the care of an individual when these can be necessary to prevent harm to the person or to those around them. These are not necessarily coercive although they may involve the use of force.

Coercion in the Cambridge Dictionary is defined as ‘the use of force to persuade someone to do something that they are unwilling to do’ in operative terms, threat is used/implied to persuade or intimidate someone into taking a course of action that they disagree with.

It is a pejorative word that carries negative connotations and its use here distracts from the challenge that is to reduce the use of compulsory treatment and restrictive practices across settings. We prefer to use these terms.

In the Commission’s view, the example set out at the end of page 93 is one of genuine coercion where there is a threat that if a person tries to leave, they’ll be detained and make them take medication. This is persuasion under threat of use of compulsion. That is coercion and it is wrong, morally and clinically.

2. What you think about the Review’s proposed approach to reducing coercion, including reducing the use of involuntary treatment?

We agree with the approach outlined to reduce compulsory treatment and restrictive practices through practically realising alternatives to these, learning from best practice from across the world, and strengthening safeguards when restrictive practices are used.

The Commission noted and supported the potential for the DMP safeguard to play a greater role in reviewing the use of restrictive practices that are largely unregulated.

The DMP safeguard is a valuable safeguard for treatments that are not consented to with data suggesting that the Commission’s safeguard alters treatment plans in almost one-third of cases ([DMP Assessments research brief, 2022](#)).

What treatments and practices are safeguarded and how these are undertaken and indeed who is best placed to undertake them are all considerations that the Commission would be happy to undertake with the Review.

There may be a requirement for an initial phase of the Commission undertaking safeguards centrally, rather than through the DMP safeguard in order to build up the understanding of how any new safeguard might work.

We also strongly agree with the review's consideration of how monitoring could be more effective on restrictive practices in order to create systemic change. We note the proposal that the Commission has stronger powers to oversee the use of restrictive practices and identify areas for action. We also noted the reference to 'Seni's Law' at the outset of the chapter.

The review will be aware that the Commission has called for a national register of restraint as one of its recommendations to SG following its report into race inequality in mental health services in Scotland (a similar driver led to Seni's Law) in September 2021. We have not had a response on this recommendation.

We are aware of work to reduce restraint in various different settings undertaken by different organisations. Whilst this is very welcome, the differing approaches represents a challenge and we consider that the work that the review proposes requires systems leadership across the mental health sector with regards to what data is collected, who collects it, how the data is integrated to make it useful for services, researchers, patients/individuals, those important to them, and for system wide improvements.

There have been multiple attempts and much goodwill between organisations to enact these changes, some more successful than others.

The Commission considers that there ought to be a statutory duty placed on the Commission to determine what data is collected to ensure that there is appropriate systems level scrutiny of new proposed legislation. This would be in addition to its generally set duty to monitor the legislation. This would require collaboration with other public sector bodies to ensure that data is made available to ensure accurate recording and drive systems improvement, in keeping with rules regarding use of data.

3. Do you think that "coercion" or some other word(s) should be used to describe the use of force, the possible use of force, and the experience of coercion

I think some other word(s) should be used. Compulsory treatment and restrictive practices as an alternative to 'coercion'. Please see answer to question 1 above for reasons.

4. Please share your views on whether law reform could drive changes which could reduce the use of coercion.

As above, monitoring and scrutiny enhancements might help to drive change.

We agree that staff in the public sector need to be valued but we are unsure whether mental health law reform is the vehicle to deliver this. We are aware that there is work that is taking

place around standards and this might consider safe staffing levels, different roles and freeing up capacity to develop genuine therapeutic relationships.

There also needs to be a greater degree of support for staff to undertake requisite training and reflective practice to continue to maintain the compassion that brought them into the caring professions.

The pandemic has taken a toll on practitioner wellbeing and stress levels within a workforce that is facing recruitment and retention crises and this requires consideration at all levels.

5. Do you think that safeguards for medical treatment in Part 16 of the Mental Health Act should be strengthened?

Agree – we consider that the current range of treatments safeguarded has not kept pace with the developments in services. There is need for reform. Although this could be enacted through secondary legislation, in the Commission’s view, there is a need for a whole-scale review of what treatments are safeguarded and how this is done and by whom. There is scope to widen out the way this works.

6. We seek your views on whether the Mental Welfare Commission should have stronger powers to oversee the use of coercive interventions and to identify areas for action.

The Commission welcomes playing a stronger role in safeguarding restrictive practices as above both through reviewing individual instances and through a wider systems level monitoring and leadership role around this. There are two key areas that require consideration and balance:

Firstly, we are aware of the role of ‘critical friend’ that many professionals see the Commission in and it would be important that the Commission is able to maintain that position of respectful collaboration whilst strengthening its scrutiny and assurance role.

At the same time we are aware that many individuals and patients wish to see the Commission utilise its powers more visibly.

Achieving that balance of when and how to escalate to professional regulators, the sharing intelligence group for other scrutiny bodies, individual accountable officers within services, and to Scottish Ministers is part of the Commission’s approach to its functions. The balance is part of the way its powers were conceived and written into law.

7. Please share any suggestions that you have for the Review’s ongoing work on understanding rising rates of detention and community-based Compulsory Treatment Orders

The Commission is looking forward to working with the review on this. We have published on STDCs rising rates ([STDCs research brief, 2021](#)). We will be making our findings on CCTOs available to the Review in June 2022 with recommendations that might be helpful to develop a conversation on the reforms that are necessary to community based compulsory treatment orders.

The Commission will also be undertaking a themed visit to people subject to CCTOs this year to learn from their experiences and from the staff supporting them.

8. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

The consultation appears silent on scrutiny with regards to the informal child patient who lacks capacity to consent to treatment and hospital admission and where this is provided on the basis of parental consent.

On chapter 8: accountability

1. What do you think about our proposals to give the Mental Health Tribunal increased powers to order that specific care and/or support be provided for a person?

The Commission recognises the need and utility of a mechanism for the MHTS to increase the effectiveness of currently underutilised recorded matters. However, we are unsure about the recommendation that the Tribunal be able to require such care and support to prevent the need for compulsion.

This could require such a huge mobilisation of resource to support an individual that it might jeopardise the care and treatment of many others who are not subject to the safeguard of a tribunal adjudicating on what resources ought to be committed to prevent compulsion.

It may set up a perverse incentive to seek compulsion in order to shift resources towards the care of an individual. We consider that a more appropriate response would be to consider the core minimum obligations through the standards work that would allow a sense of what the person should expect from public services.

On the second recommendation that compulsion should respect the rights of the patient, we strongly agree and this is the essence of reciprocity.

2. What do you think about the ways we want to extend current excessive security appeals to anyone who feels they are being subjected to unjustified levels of restriction?

We agree with this proposal that would allow 'blanket' restrictions to be challenged.

It will be important that the locus of any intervention to reduce restrictions is aimed at the relevant management of the service rather than with the RMO, MHO or nursing staff who are often working within the structures that are imposed rather than creating these for each individual.

The Commission has also challenged and/or asked services to consider 'blanket' restrictions that serve operational needs but not individual patient needs.

In saying this, the Commission recognises that wards/ services require procedural rules and regulations to ensure effective and efficient services. The balance is that these rules should not become blanket restrictions.

3. What you think about our ideas for reforming the ways a person can raise a concern or complain about their care and treatment?

Page 115 of the consultation details feedback from individuals on their experience and barriers to complaining. This must be addressed. People receiving mental health support (whether formally or informally) require to be empowered to ensure equity of access to complaint investigations without fear of repercussion. Whilst it is important that local services have the opportunity to respond to complaints, the Commission welcomes the consultation's suggestions for reform, in particular the role of collective advocacy groups serving both hospital and community settings.

There is also a need for a joined up mechanism to ensure that the outcomes of complaints are scrutinised and fed into the wider system to improve outcomes for all.

Do you have any other ideas to make this process more effective and equitable?

Please see above.

4. What are your thoughts on collective advocacy groups raising court actions?

Some of the most constructive challenges to the Commission come from collective advocacy movements. We have been concerned at the relative lack of collective advocacy throughout the system. We are also keen that collective advocacy is properly resourced, structured and that advocacy feeds into the governance system at different levels of mental health services and health, social work and social care services generally.

The Commission is keen to follow the model being developed by the NZ mental health and wellbeing commission in working with key priority groups to determine its approach to developing an assurance framework that would allow unresolved issues to surface and understand the significance of the issue at a national level.

This is in keeping with the view that the consultation takes of the Commission being a voice that addresses/amplifies issues arising from mental health groups.

What are your thoughts about creating a way for collective advocacy groups to alternatively escalate unresolved human rights issues to an identified scrutiny body?

Please see above.

Please let us know of any existing organisation that you feel should take on that role?

Please see above. This is in keeping with the view that the consultation takes of the Commission being a voice that addresses/amplifies issues arising from mental health groups.

5. What are your views on why and how we think collective advocacy should be strengthened?

The Commission agrees with the proposals on page 122.

6. Do you have any suggestions to make the scrutiny landscape for mental health services more effective?

Yes. The Strang review highlighted concerns regarding the powers of the Commission and HIS and how the scrutiny landscape in mental health services is currently working.

We do not think the issues identified are unique to mental health services. There is a lack of clear scrutiny across the health sector in Scotland.

The development of the National Care Service also raises queries about how bodies such as the Care Inspectorate and the Commission and HIS should work together and where there are gaps and unhelpful overlaps.

For mental health services, the Commission considers that scrutiny should be based on agreed standards. Where the Commission and partner agencies identify deficiencies, there ought to be work undertaken by that service, if need be in partnership, and then this scrutiny and resultant activity ought to be fed back by the Commission to Scottish Parliament through an annual report of its activities, including its scrutiny activity. The landscape can appear cluttered and disjointed and clarity of leadership and sharing of intelligence is required.

This work follows from the Commission's visiting function that already serves a quality assurance function, one that is centred on the patient/individual's experience. The role will need to expand to cover more people living in the community, and to ensure that the governance arrangements are meeting the needs of patients/individuals and staff through reviewing the extent to which frontline staff are able to have their voices heard at the Board and how patient/service user voice is part of the governance arrangements.

The Commission is mindful that it should not lose sight of its role in delivering services that create the norms for ethico-legal complex cases through its phone advisory line. These calls drive the guidance notes and good practice guides that the Commission produces.

The model is of a much more 'nodal' regulatory structure encompassing information from partner organisations, the Commission's phone line, intelligence from its DMP system as well as its own visiting system. This is in comparison to high level regulatory structure that is further removed from the systems and services being regulated.

We recognise that this model increases complexity; and the consequent need for good networks and clarity of leadership as noted above. Information on the Commission's phone line is here ([Advice line calls research brief, 2022](#)).

7. What do you think about the ways in which we think the role of the Mental Welfare Commission should be extended?

We agree with the proposed extensions outlined on page 130 of the consultation.

In addition and as described above, we consider that there needs to be a duty beyond monitoring to determine what actually needs monitoring and to be able to require organisations to collaborate to provide the intelligence and data necessary to effect system changes. Inclusion of adult support and protection monitoring is welcome given the cross cutting dimensions in practice.

We strongly welcome the proposed strengthening of the requirement for greater lived experience in our work and governance as a means to ensure that the Commission remains focussed on what matters to the people who use services.

Do you have any other ideas?

The Commission has recently consulted on and submitted proposals to Scottish Government for a new system of review of deaths in mental health detention in Scotland and we are awaiting a decision at the time of writing.

We believe the Commission's proposals are proportionate, human rights compliant and offer the opportunity for learning and improvement.

We are keen to pursue whether increased powers to enforce change are indicated. To consider a level of accountability directly to the Scottish Parliament, including a power to make a report to Parliament where the Commission determine there is a serious failure by a public body to follow a recommendation by the Commission.

The Commission currently has a wide range of powers under section 11 in relation to its investigatory functions and ultimately under section 12.

Section 12 affords the Commission the power to cause an inquiry to be held for the purpose of carrying out an investigation. The current powers require a general updating of language and terminology to take into account the changes in the health and social care landscape in recent years.

The Commission usually receives a favourable response from care providers (NHS/LA/HSCP and third sector) when requesting information to help with our investigation work. However, we have noted that challenges to our authority are increasing and any future legislation should be explicit that the Commission's authority to request information and cooperation extends to many organisations e.g. Police Scotland, COPFS.

HM Inspector of Prisons for Scotland, the Chief Executive of Families Outside and the Chair of the Scottish Human Rights Commission recently concluded a review of deaths in prison custody in Scotland and made the key recommendation that a new independent body be set up to conduct timely reviews of every death in prison custody. Any investigatory and other powers for the Commission should be no less than this proposed body.

On chapter 9: children and young people

1. Do you think the current 2003 Act principle for children is still needed?

The principle should be replaced by a wider principle of respecting all the rights of the child under the UNCRC in any intervention Please explain your answer:

The Commission considers that the wider principle adopted from the UNCRC provides a clearer steer that it is not only in connection with actions regarding a child where the benefit of the child is central but any intervention that concerns children will keep the best interests of the child as a primary consideration.

The consultation does not reflect in detail on potential tension between the proposed recommended four principles of future legislation (non-discrimination, autonomy, dignity, and inclusion) and their relevance in children <18. Given the consultation defines autonomy (p15) as “the ability to be the author on one’s own life and have one’s will and preferences respected” then this creates problems if this principle is expected to apply universally to all ages of people within the future act given that the will and preference of children <18 should not always be given full effect due to their developing autonomy. The consultation’s authors themselves acknowledge this to be the case for children and young people on page 139. The best interest principle would therefore be a minimum standard.

The Commission was not sure whether the consultation included the views of children and young people at this stage. This would be helpful.

2. What do you think about having a statutory duty on Scottish Ministers and health and care agencies to provide for children the minimum standards needed to secure the human rights set out in international treaties such as the UNCRC?

We support the intention set out for a statutory duty towards children with a mental disorder (language used in the consultation) the minimum core obligations necessary to meet the rights set out for children in international treaties.

We consider that the national CAMHS specification should be evaluated to determine the extent to which these already require services to meet many of the resultant core obligations particularly around health needs.

However we note that there are many obligations that require read-through across health, social care, education and other service lines. We agree that the existing expectations through the legislation in section 23 need to be met and this will require accountability from Scottish Government to deliver on the standards.

It would be unrealistic to expect mental health services as currently constituted to be able to deliver on meeting all the rights set out in international treaties. We consider that incorporating additional (if any) rights that might apply to children and young people within the overall HRE

might be referred to within any 'forms' indicating how these have been considered, particularly in the context of the use of any compulsory powers would be helpful.

This might allow the sort of read-through that the HRE envisages and provides a means to ensure that rights are actually progressed and services (in the broadest sense) can be assured against the delivery of these for an individual.

This would also allow the Commission to determine progressive realisation and gaps and be able to make this information available to Scottish Parliament and to the UN Committee charged with assessing individual member State's progress towards to implementation.

3. What are your views on reforming crisis services for children and young people experiencing acute mental distress?

The Commission's reports have highlighted the greatest increase in compulsion has been for young people ages 16-17 and we undertook more detailed investigation to explore why this might be the case. We found that much of the detention was in response to self-harm and psychosis. We also noted that MHO consent for an EDC was only present in about 50% of the cases that we reviewed (['Young people detained for mental health treatment – self harm is a key characteristic'](#)).

Whilst we agree in principle with the requirement for MHO consent for an EDC involving a young person, we are unsure why this requirement should only be for young people. The expectation is that the safeguard is available for everyone and yet we are seeing a fall in the use across age ranges and particular gaps when we consider marginalised groups who are less likely to receive this safeguard.

The numbers of MHOs has remained relatively static over the previous few years, from SSSC data, despite the 5% rise in activity from the MHA (year on year) and 10% rise in the pandemic year 2020/21.

Despite raising this through the Commission reports there is little evidence that this is changing yet. The Commission considers that if the system is serious regarding multi-disciplinary involvement to ensure a wider perspective on restrictions, provisions in the law that allow detention to proceed from a community setting, on the basis of a single medical professional view point, need to be ended.

This will direct resources towards increasing the MHO workforce on a 24/7 basis and ensuring a MHO workforce which is experienced in working with children and families as well as all other individuals with mental health conditions.

Whilst the role of MHOs in detention is a key one for children and young people their role in authorising emergency detentions is limited unless they are able to access meaningful and realistic alternatives to admission for children <18. There is need to reform crisis services for children and young people to ensure a range of options are available to understand and meet the child and young person's needs on a 24/7 basis. These should be provided by both health and local authority as appropriate to the needs of the child <18. There is clearly a need (as highlighted in the audit report on rejected referrals from CAMHS) for increased provision

across children's services to meet the mental health needs of children and young people who do not have mental health conditions that require the specialist input of CAMHS.

Better response to crisis, however, should not be simply a matter of providing a range of options at the point of crisis but should involve timely provision of appropriate support and care for children and young people upstream of any crisis and before it happens in order to try and prevent crises.

4. What you think about law reform to ensure access to CAMH services up to at least the person's 18th birthday and to ensure age appropriate services more generally?

Yes, in keeping with CRC however the National Specification for CAMHS (February 2020) requires that all CAMHS services nationally should be available for children 0-18 years. This recommendation may not need therefore to be made into law.

The Commission has been recommending for many years inpatient provision to meet the needs of children <18 with forensic needs, with a learning disability and children <18 needing IPCU care. All of these groups of children and young people have presently no inpatient age appropriate provision in Scotland to meet their needs. It is encouraging that progress is being made to develop inpatient provision in Scotland more recently and progress in this respect is most advanced in relation to the development of the medium secure forensic unit in Ayrshire.

5. What are your views on our ideas about relatives and families?

The UNCRC recognises that the family is the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children. We agree with the suggestion that there is a need to take account of the needs of parents and families. We consider that enhancing the scrutiny and safeguards regarding young people and children who do not have maturity to consent/refuse consent to measures (including treatment) for mental health conditions – particularly where those measures involve restrictions in liberty or the use of force/persuasion- will ensure that relatives and families are placed under less pressure at a time of stress for them and their young person.

More robust safeguards might actually allow easier sharing of information as the decision making/ care-giving/ source of information roles that families and relatives might find themselves in would be less super-imposed, allowing some space for families and their young people.

6. What are your thoughts on how supported decision making, human rights enablement and the autonomous decision making test in chapters 3, 5 and 6 might apply to children and young people?

The details of these constructs will need to be clarified and then tested out against scenarios to demonstrate any issues in the application to children and young people.

Consideration of children and young people has not been integrated throughout the consultation so there are lots of questions remaining regarding potential tensions. The Commission's Children and Young People Team would welcome the opportunity to discuss these.

However, in principle, there would be considerable advantages to ensuring that all rights of the person with a mental health condition are considered regardless of age, and that particular duties around young people, are safeguarded through additional reference to this in the HRE approach.

AWI 2000 currently applies to those 16 and over. MHA 2003 applies across the age-ranges. An expanded Capacity/Incapacity test within the ADM framework that considers aspects around illness and maturity within the 'appreciate' construct of the current test of incapacity might enable a clearer test that works across all age-ranges.

If the young person is deemed to lack the ability to make decisions regarding a treatment/intervention that might require restriction/ force, rather than relying on parental consent (that the code of practice suggests against) safeguards and scrutiny would apply.

In a reformed legislation- this might mean an indication on the section 47/ compulsory power equivalent notification that the person in question was a young person and that would lead to necessary safeguards (developing the current DMP systems).

7. What do you think about our proposals on advocacy and on accountability?

On advocacy, we agree. On accountability, in keeping with the Commission's views regarding universalism, we do not think that it would be helpful to have a separate accountability structure regarding a young person's mental health. A common difficulty that the Commission hears of relates to transitions between CAMHS and adult mental health services.

Assurance models should bridge divides rather than echo them and therefore we consider that the assurance framework should be unitary across the age range, in keeping with our views set out in Chapter 8 responses.

8. What are your views on autism, learning disability and neurodiversity and the possible law reforms for children and young people?

Under the Education (Additional Support for Learning) (Scotland) Act 2004 (ASL 2004) children have a right to be offered a Co-ordinated Support Plan (CSP) based on their identified learning needs and a have a right of appeal to the Additional Support for Learning Tribunal relating to the presence of a CSP and its contents. It would be good to discuss the Review team's thinking in relation to this.

It is unclear how widely known these rights are among children or their wider families. Data from advocacy organisations such as Kindred may be very revealing in this regard.

It is however agreed that the protections set out in Rome are helpful, but in keeping with a universalist approach we consider that these should apply to all young people rather than solely to those with a neuro-diverse condition. We think there should be a co-ordinated support plan for all young people. The particular needs of parents of young people with intellectual disabilities and/or neurodiverse conditions ought to be reflected in the co-ordinated support plan created with them and the young person (wherever this is possible).

9. What do you think about our proposals on safeguards for treatment and services, and safeguards to protect the relationships between children and parents?

The Part 16 safeguards should be extended. This is in keeping with the general direction that the Commission outlines at other points in this response.

Please let us know what you think about our proposals to protect the relationships between children and parents.

We agree. (Please see Q5 response above).

10. At this time, Scotland's mental health law applies to compulsory mental health treatment at all ages. Do you have views on the idea of moving mental health law for children to connect it with other law for children, to apply across health, education and social care?

In the best interests of the children and young people under the age of 18 whose rights are presently protected and whose care and treatment is supported by the use of current mental health legislation we believe that mental health law for children in Scotland should remain unified with that of adults rather than be connected with other law for children applied across health education and social care.

The Commission considers that mental health legislation should apply across the age-range.

There are particular issues when considering young people who may not have acquired capacity. However as outlined above, where there is a deprivation of liberty, or treatments for mental disorder that are being suggested for which the young person cannot consent to or does not consent to, and where force is considered, then there should be a requirement for safeguards through mechanisms such as a DMP safeguard.

Rather than an age cut-off the consultation ought to explore with young people, families and practitioners the practicalities of a non-defined age cut-off, but an individual approach based around assessment of maturity and capacity to be able to consent, refuse consent to treatments for mental health conditions, including admissions.

If SIDMA is reported to work reasonably well with children and young people (p140 of the consultation) then there is reason to believe that a reformed capacity test/ADM test should also work reasonably well. Above we indicate how this might work within the 'appreciate' construct but this will require further clarification with young people and experts in children's psychology and health.

11. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

We consider that there should be a legislated duty to notify the Commission where a woman is admitted without her baby; and legislated duties to notify the Commission where a young person is admitted to an inappropriate setting. Currently services do inform us but at times reporting can be less than full. This prevents the scrutiny arrangements to determine progressive realisation for all, and identifying individual instances for those where the Commission wishes to follow-up.

The children's landscape has not been fully integrated within the whole consultation document as noted and requires further detailed consideration.

On chapter 10: Adults with Incapacity proposals, part 1 (guardianship)

1. Part 1: Guardianship

The Commission welcomes the recognition of the cumbersome process of AWI and the cost, including the differences re legal aid application between the MH Act and the AWI Act which requires to be addressed. There needs to be parity and parity in terms of priority for AWI legislation given it too can include significant restrictive practices to support and protect welfare, property and finance.

We welcome integration with the supported decision making model referred to in chapter 3 in relation to mental health law.

The Commission notes the tiers and framework suggestions however there is a requirement for more detail in order to be able to comment specifically on the drawbacks. For example, an application is to be made to the OPG to appoint a decision making supporter who has no formal powers of representation. An application suggests that criteria have to be met and an application may or may not be granted? If the person has no one they can self-nominate, is there an alternative for the person?

We suggest that the supporter role may need to consider the needs of the person whom they are supporting as well as will and preference.

There is an inherent risk that a focus solely on will and preference may prevent discussion on needs if these are not immediately clear to the person who is ultimately making the decision. The Commission appreciates that in many cases this will be a common-sense approach however it is helpful to clarify this at the outset.

We agree that the co-decision maker suggestion is cumbersome and would lead to confusion, we would also want to understand, in more detail, the differences between the decision making supporter and the PoA.

The current proposals for reforms are seen as helpful but it is unclear without the detail as to how workable this might be within current and modelled resource constraints.

2. Specifically, what are your views on the role of co-decision maker – and its omission from this model?

We agree that the co-decision maker suggestion is cumbersome and would lead to confusion.

3. Will the proposed change address the issues currently experienced with guardianship?

We agree that there is the potential for improvement. Our experience at the Commission has found that services and individuals experience difficulties with day to day issues of managing small amounts of income, low level health issues and tenancies in particular and we would like to see these made more straightforward, clear and meaningful.

In relation to a decision making representative we feel that this should be more streamlined and be clear that these applications are considering more significant aspects of an individual's life. The consultation makes reference to an abbreviated court application to become a decision maker; it would be good to hear more detail of this.

There is strong Commission consensus for these decisions to be made in a Tribunal type setting rather than a court. The current MHTS system is efficient and responsive and this would give timeous scrutiny and reflection and provide something of a less formal setting associated with criminal justice for individuals to attend and feel supported.

It is difficult to comment further without more detail, however, we do agree that the process to introduce 'emergency' powers is a helpful proposal. We would wish to see further detail to ensure that in the process of increasing speed without an obvious increase in capacity, that this is not achieved at the expense of proper scrutiny, particularly where an emergency intervention amounts to the use of force/restriction or deprivation of liberty.

4. What are your views about the proposed streamlined application process?

The Commission has some concerns regarding the 'upgrading' referred to in Appendix A as it is unclear currently how challenges at that stage might work, particularly from the person. The model is silent on time frames, legal aid application, roles and responsibilities etc. so, without more detail gives little assurance of streamlining.

Secondly, the emergency powers earlier in the system seem reasonable looking at the model, but the difficulty will be if there are delays between the imposition of emergency powers and the full scrutiny/hearing, this could be a significant deprivation/restriction to a person; and the model is silent on time-frames again.

We support that this is brought into the tribunal system as noted above (we note this is a query as yet) but expanding the tribunal to consider cases would fit within the direction of a single body overseeing deprivations/restrictions for people who are unable to make decisions despite support, due to a mental health condition (however caused).

5. Does the proposed emergency provision in the model address the concerns about the current system?

The Commission agrees given the current gap in emergency provision. However, the Commission would want to see an emergency clearly defined, this needs to be in relation to the individual concerned and not the circumstances, for example a general hospital may view it as an emergency for a patient with dementia to be discharged, but this may not be what constitutes an emergency for that individual. Emergency intervention will be necessary for individuals based on the individual's needs whether in hospital or in the community.

As noted above, any process which addresses the time consuming approach to meeting an individual's needs in a crisis is welcome but safeguards must be assured e.g. time limits on the order, a limit on any renewal etc.

It will be helpful to understand more detail in relation to the professionals involved e.g. any medical doctor, MHO consent required and so on.

6. Should the reframed model allow for the grant of a specific or one-off order (currently called an intervention order)?

Agree; the reframed model will allow for this.

7. Should the current access to funds process be subsumed within the new guardianship model?

Agree. It is not entirely clear that the model allows for this, the Commission suggests an estimate of the number of cases, and whether there may also need to be a tiered approach, to prevent the system becoming further constrained.

In saying this the Commission acknowledges the need for greater assurance (although this in of itself may require and be approached through local oversight means as well as recourse to and checks through assurance/scrutiny mechanisms).

8. Should the current management of residents' finances process be subsumed within the new guardianship model?

Whilst the Commission agrees, it is not possible to confirm that the proposed model will allow for this for the same reasons as described above.

9. What are your views on a system of supervision?

The Commission supports a view that local systems of assurance and scrutiny are the initial building blocks of scrutiny/supervision of the system with checks on this by and recourse to the Commission.

10. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

The Commission would want to add that AWI learning and knowledge remains inconsistent and a number of professionals remain confused regarding its implementation in practice. Our Authority to Discharge report has evidenced this. Whilst it is clear throughout the consultation that additional resource will be required, investment in developing a confident and competent workforce will be key to delivery of all outcomes arising from the SMHLR.

On chapter 10: Adults with Incapacity proposals, part 2 (power of attorney)

2. What are the key points of guidance that need to be given to attorneys?

We believe that the role of a PoA (welfare in particular) is often misunderstood, powers misinterpreted and can account for complex dynamics when multiple proxies are involved.

We consider that current key issues include conflict between attorneys; disagreements between attorneys and care providers; considerations of whether attorneys have the power to authorise/restrict liberty; conflict between attorneys and care homes when a person's will and preference do not coincide (matters of dress, diet, with whom the person may consort).

Local authority colleagues tell us that such issues often lead to adult support and protection inquiries/investigations.

There requires to be an improved application process to evidence suitability of proposed PoA alongside clear understanding of the role, what the powers are and what they mean. This should be the responsibility of all in the process and should be reinforced at each stage. Awareness campaigns in the media may have improved take up but knowledge of the role, in our experience, remains poor; in particular, a better focus /guidance on what happens if it does not go well needs to be detailed at the beginning. PoAs should have the ability give up the role if faced with stress or any burdens of care/impact on relationship.

We would agree that some parity is required in relation to PoA supervision. Our experience is that the AWI legislation does not appear to be used frequently to address PoA issues.

The Commission's phone line regularly receives calls on these matters and our guidance notes reflect the Commission's advice on these matters. Distilling these points down and having some of these uncomfortable conversations prior to a person losing capacity whilst they are making a power of attorney might be a helpful step.

3. What support should be given to attorneys – by whom, when?

Earlier in the process there can be a lack of clarity and there can be concerns regarding costs.

It would be helpful to clarify supports that are available both with regards information; accessibility of the information; risks; and financial and legal support in creating these.

The Commission's phone line illustrates some of the dilemmas that attorneys have.

Although we welcome the second suggestion in the consultation, we consider that it is set too broadly in placing the ask to SG, OPG, Local authorities and to ourselves and requires unambiguous allocation of leadership around ensuring that support is available – perhaps through creating a clear mechanism for attorneys to seek guidance prior to conflicts emerging that are often distressing for all involved.

4. What are your thoughts on the reporting structure for someone with concerns?

On both the question here and below, the Commission considers that the routes to investigation require clarification. Welfare and financial concerns are often interlinked. Multiple organisations undertaking investigation of PoA is not conducive to positive outcomes.

We welcome the proposal no.5 in the consultation however this will require more detail to ensure that it would be effective for local authorities.

5. What are your thoughts on the investigations structure?

Please see above.

6. What are your thoughts on authorities being able to supervise an attorney, on cause shown, following a statutory inquiry?

The Commission is in agreement.

7. What are your thoughts on attorneys having power to authorise a deprivation of liberty (assuming this power has been granted in the power of attorney)?

The bar and threshold around this needs to be set high and this must be very clearly specified within the document, perhaps as a separate optional measure. There should be a mechanism to have an opt-out from this and it must sit aside from the clauses that are often seen and reproduced in these documents. It would be helpful to consult on whether the default should be an opt-out.

We note the suggestion in the deprivation of liberty chapter that PoAs that authorise a deprivation of liberty are registered with the Commission or the OPG; and are subject to regular review. We would welcome clarity on whether that provision (proposals for orders no.1 applies only to those PoAs that authorise a DoL- we do not disagree, this is in keeping with the higher bar we believe ought to be associated with such powers, but more detail will be required to shape this and understand the resource implications depending on the mechanism of review intended/suggested).

Our comments are provided in the context of the Commission's Authority to Discharge report, in response to the concerns about inappropriate/illegal moves of people during the pandemic which showed that there was a lack of understanding about mechanisms/legalities around restrictions/deprivations of liberty.

9. What measures should be taken to increase the awareness of a PoA?

Both broadcast and outreach to the public and to targeted segments respectively as has been done recently by HSCPS and the OPG.

These are issues that affect many people and there remains a lack of awareness of the PoA mechanism early enough. Further investing in this mechanism/support would not only provide peace of mind to many individuals around who will make decisions with regards to them, but will also provide cost-savings across the public sector. The financial cost to making a power of attorney should be removed however as it is a barrier to adults engaging with and granting a PoA.

On chapter 10: Adults with Incapacity proposals, part 3 (medical treatment and research)

1. We seek your views on the recommendations we are proposing.

We welcome the recommendations and strongly agree with concerns raised in this chapter. We would urge the Review team to consider the recently rewritten Commission guidance on Right to Treat (February 2022) that outlines the current issues in the system.

On Common Law we state :

“The Common Law principle of acting in necessity is NOT replaced by the 2000 Act. They both have their place. However, wherever it is reasonable and practicable for the procedure or intervention to take place under a statutory process (most commonly, the AWI 2000) that provision should be used.”

On the issue raised in the consultation regarding section 49, in Right to Treat we state as below and we draw the Review’s attention to the italicised paragraph particularly.

“The Act prohibits the practitioner from providing a treatment under the general authority to treat (a section 47 certificate) if they are aware that there is a part six application (i.e., an application for an intervention order or welfare guardianship) underway that would provide the proxy the power to refuse or consent to the treatment in question. In that situation, the treatment in question, may only be given for the preservation of life or to prevent a serious deterioration in the patient’s condition (s49) until the application is determined, unless there is already a court-order prohibiting that treatment (in that case, it cannot be given).

“We note that this was an area of discussion in the G v West Lothian case in which the Sheriff Principal considered that in this situation (a person requiring treatment whilst application for welfare guardianship was underway) an interim welfare guardianship (with the powers to consent) was the mechanism to ensure treatment was provided rather than intervention orders, or invoking the Mental Health Act.

“We think that there needs to be further clarity in the interpretation of the law as we consider that for treatments that do not amount to the preservation of life, but are necessary for the wellbeing of the person, having to seek an interim guardianship pending a full guardianship (with wide welfare powers) might be disproportionate and cause undue delay for treatments especially, where there are no disagreements between the clinical team and the applicants

“However our view here is not a definitive legal one and we would suggest any clinician in this situation discuss with the Central Legal Office and with ourselves.”

To avoid any ambiguity we have footnoted with a clear view from the Commission:

“The Commission believes that the purpose of section 49 is to ensure that a particular treatment is not given to a person when there is an application underway providing the proxy the ability to refuse or consent to this treatment. We do not believe that the intention is to prevent any treatment under section 47, just the relevant treatment.”

Within the same document, Right to Treat 2022, we would also draw the Review's attention to footnote 19 that references the different definitions of treatment within current legislative provisions that govern treatment. Although somewhat niche, we make the observation that the definition gap leads to some of the inequity reported in this chapter.

We state in the document that we would raise the observations in footnote 19 to the SMHLR. We use this consultation as another route to do so, and would be happy to discuss our concern around aligning/fusing definitions further.

2. What are your thoughts on the provisions within s47(7) on the use within the AWIA of force, detention and the relationship with the 2003 Act?

The Commission is concerned about the way in which section 47 is used to provide what is sometimes termed 'initial' or 'one-off' or 'irregular' treatments that require the use of force with the proviso that if it is used more regularly the MHA 2003 will be used.

There is no clear way of knowing immediately the extent to which this is happening and harnessing new data and technology to be able to report and identify this both for system wide monitoring, understanding patterns, and identifying particular areas where this is a greater cause for concern and indeed for individuals would be a helpful development.

We are aware that often this occurs in areas where there are fewer doctors and that there are particular issues in rural and remote settings, however it is not fair that safeguards depend on where in Scotland a person lives.

The use of section 47 is far too permissive currently.

We disagree with proposal 3 (on page 169) on section 47 being re-interpreted to reflect that the treatment authorised must be that that reflects the patients will and preference. This is because there also needs to be a consideration of the patient's rights and needs and crossing over all of these, benefit.

However, we do think that benefit needs to be better understood and formulated so that this is not just about 'medical' benefit but about overarching 'benefit'. Our recent guidance, Right to Treat (Feb 2022) quotes from and endorses Baroness Hale's expression of this in Aintree. We also refer to Montgomery V Lanarkshire in this updated guidance as we think that the standard of consent (reflecting what is important to the person) is the standard that applies to considerations of 'benefit' for the person who cannot consent due to incapacity.

3. Is any change needed to the list of special treatments requiring additional safeguards, (section 48) or the procedures by which they are authorised?

Safeguards should be the same across all legislation, not confined to one Act, to ensure that the practical experience of treatment and safeguards for two people in a similar position but treated under AWI or MHA are brought together.

Please share your views on Transcranial Magnetic Stimulation (TMS) being added to the list of special treatments requiring additional safeguards in section 48. :

Agree as above, safeguards need to be universal and apply across the MHA and AWI acts. Please see Right to Treat where we take the example of ECT. We note the Review's comments on depot medication and section 47 and the use of force and strongly agree.

4. Is any change needed to the dispute resolution procedure in section 50?

We note the Review's comments. In fact, during the pandemic the Commission has operated this procedure at least 6 times (although not all of these are related to a guardian's refusal of vaccination for the person they are the Guardian for).

We intend to write to professional bodies to seek their input into our current process around identifying the right clinician to act as the nominated practitioner however we see merit in retaining the final say as an independent body assuring that the person we ask to undertake this role satisfies our requirement regarding independence.

On the reverse situation of a Guardian requiring a treatment, that the Review considers, we take the following view that is reproduced from our *Right to Treat* guidance (February 2022):

"The non-provision of treatment cannot be made a subject of disagreement with an appeal to the Commission for the appointment of a nominated practitioner i.e. the proxy cannot require that the practitioner provide a particular treatment. If a disagreement arises in these circumstances, this is not grounds to trigger the section 50 dispute resolution process. In that circumstance, we have suggested that proxies ask for a clinical second opinion at the Health Board. They would also have a right to make a complaint via the NHS complaints procedure, if that is appropriate."

This is in keeping with wider medical ethics and law principles regarding treatment requests.

On chapter 11: deprivation of liberty

1. Please share your views on our proposals.

We agree with the proposals around very carefully constructed and understood PoA being able to provide clear authorisation for a deprivation of liberty (DoL); please see response under PoA section.

We also agree that a DMR should not automatically be given these powers.

We agree with the proposal for the reformed section 47 that would allow a DoL (subject to scrutiny) in hospital including with regard to the conveyance to hospital. We also agree with the Review's suggestion that the DoL/LPS system is less preferable to judicial oversight as suggested by the Scottish Law Commission.

We agree that any process must be proportionate.

The document is suggesting that where individuals are settled in a domestic setting and in the absence of any concerns, deprivation of liberty may not apply. Further clarity is required as to what constitutes a 'domestic' setting. We understand from the consultation that where people are already living in settings which may constitute a deprivation of liberty e.g. care home, if will and preference to remain is confirmed then further judicial oversight is not indicated? Comprehensive guidance will be required as suggested by the Review team. Staff who phone the Commission's advice line can get highly anxious re this issue and would welcome clear guidance and support to implement.

We raise the provision within the 2003 Act that allows a person who is 'informal' but experiences their care as amounting to a deprivation of liberty appeal to the Tribunal that they are 'de facto' detained. We note that the Review mentions the Bournemouth gap, however we note that the English Act does not contain a similar section. The Commission raises the consideration of whether a similar provision that worked across aligned legislation (if fusion is not pursued) might safeguard rights. (The obvious caveat is that not everyone is aware of the provision.)

The safeguards should be proportionate, realisable, and apply across settings where a person is deprived of their liberty, regardless of age.

2. Please share your views on the proposed standard and urgent deprivation of liberty orders and the suggested process

We agree with the direction re: standard and urgent but require more detail on both, including maximum limits for renewals on the 'urgent' order.

3. How can we ensure that there is a real, effective and accessible ability for the adult and/or their representative to challenge the lawfulness of a deprivation of liberty order?

Wherever the result of the HRE/ADM process amounts to an application for a DoL and this has not been subject to scrutiny from the judicial process there should be immediate access/offer of independent advocacy. This should be recorded and notified to allow instances and systems wide gaps to be reported on.

4. What do you see as potential barriers to the operation of deprivation of liberty orders?

Resource constraints are regularly reported currently and this will be a barrier if resources are not increased to deliver on these intentions. What else may you wish to see included?:

There needs to be clarity regarding how this intersects with parental consent for a deprivation of liberty.

5. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

In answer to the question, 'who do you think should be able to apply for a deprivation of liberty order?' the Commission suggests the professionally registered person(s) conducting the HRE/SDM and ADM that leads to a decision to deprive a person of their liberty.

On chapter 12: mental disorder

1. Should there be a gateway to mental health and capacity law which reflects a diagnostic criterion?

Disagree – it is the consequence of a diagnosis/condition that leads a person to be unable to make the relevant decision, despite supports for decision making, that should be the gateway not the diagnosis per se.

The gateway should reflect the particular consequence that warrants any intervention by the State. A diagnosis alone should never be the reason for any consideration of intervention.

The Commission suggests that the gateway is the inability to make a relevant decision due to impairment of decision making because of a mental health condition, despite provision of supports for decision making.

The gateway should ensure that someone receives or continues to receive Support for Decision Making, a Human Rights Enablement approach informed assessment of need and the development of the relevant care plan.

Any compulsion/ non-consensual treatment would require a further gateway predicated on whether that person is likely to experience or cause others to experience harm of a significance that requires compulsion; and that the elements of the HRE (written/expressed broadly enough to consider the relevant Rights of others) that require intervention can be met through the said non-consensual/compulsory intervention.

Please share your thoughts on what that gateway should be: what terminology should we use?

'Mental health condition' is the suggested terminology. Other terminology suggests a deficit rather than strength based approach.

2. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

Removing diagnosis completely would not be seen as a progressive step.

It would lead to a greater reliance on the values of the professionals making the assessment.

It would reduce objectivity and potentially remove the protections that a diagnosis can offer. It runs counter to the SG move towards ICD 11. It runs counter to increasing sophistication of treatments tailored around diagnoses and then further refined for individualised medicine.

The meaning of ECHR 5(e) requires that the restriction that is relevant here to the Right to Liberty are due to what we would prefer to refer to as a mental health condition. We do not consider that the approach suggested is contrary to Article 14 of the UNCRPD (it is decision making ability that is the entry point, a diagnosis is an underlying factor).

We would also like to highlight here that from our work on investigations of mental health homicides, we believe we currently have a 'grey area' in mental health legislation and clinical practice with substance misuse psychosis.

Currently in the mental health act, the 'mental disorder' term includes mental illness, personality disorders and LD. But, 'a person is not mentally disordered by reason only of any of the following— dependence on, or use of, alcohol or drugs'

Whilst clinicians would not consider detaining anyone if the presentation was due to inebriation or intoxication with alcohol or drugs alone, many would pragmatically consider detention if the person had a substance misuse psychosis, assuming the other criteria are met.

On chapter 13: fusion or alignment?

1. Given the changes being proposed by the Review, do you think a single piece of legislation for mental health, incapacity and adult protection law is the best way forward?

We would welcome further consideration of fusion of AWI legislation and Mental Health Act legislation and combined legislation should be aligned with ASP legislation.

This is because MHA and AWI legislation are both predicated on an inability to make the relevant decision about care and treatment due to the presence of an impairment in decision making whereas ASP legislation is a broader protective piece of legislation.

The proposed HRE approach is a shared one that ought to cut-across all three pieces of legislation. The support for decision-making safeguards should also apply across the board. Autonomous decision making provides a shared framework for undertaking tests around decision making that can apply across age groups and conditions. The safeguards that should be available to people should be the same rather than different.

A single legislation taking HRE/SDM and ADM into account for those lacking 'capacity' and HRE and SDM into account for those who may require support and protection is the clearest way forward.

NI has fused around capacity and as this is gradually being implemented, there are steps yet to be taken to ensure that young people do not remain on an outdated mental health order legislation. (It is important to note that NI did not have legislation that applied to people lacking capacity.)

Scotland already has complexities around the care of young people with MHA and parental consent both being potential legal mechanisms for the care of someone under 16 who requires treatment for mental health difficulties, and is unable or refuses consent; however the code of practice clearly steers towards the MHA where the treatment may involve force or deprivation of liberty.

In the same way, a code of practice accompanying fused legislation would require/ensure that the care of a young person who is either lacking or has not achieved the capacity to make decisions regarding treatment would be under the fused legislation (rather than under parental consent). Young people would be afforded the safeguards and protections afforded to all under a new legislation; with additional safeguards as discussed above for young people; and for their parents under the co-ordinated support plan.

A fused legislation across all ages, groups and conditions with tailored provisions may reduce complexity and offer greater safeguards.

Forensic patients (patients who currently receive forensic disposals) will require modifications. HRE approach and SDM should apply but the ADM test may need to be reconsidered with regards to decisions about settings of care and treatment. The consultation does not discuss this and we would welcome further consideration of how these constructs apply to particular groups.

In the absence of detailed consideration of fusion in the consultation and indeed detailed consideration of adult support and protection legislation, these are initial thoughts only. We are aware however that multiple routes of inquiry currently in law, linear legislative pathways and a lack of understanding of cross cutting issues across different legislation can lead to individuals not being supported or protected.

2. What do you think about our suggestion of aligned legislation?

Alignment would be the 'next best thing' to a 'universalism informed fusion' of the acts. However, it represents significant difficulties in terms of practical issues.

Which aspects of the law should be aligned and which should be left within standalone law?

The Commission has referenced points of fusion throughout this response. Further detailed consideration is required however, as stated previously, linear approaches in practice result in cross cutting protections not always being understood and realised for the individual. Please see below investigation.

3. Please tell us if you consider a single judicial forum should deal with all mental health, incapacity and adult protection cases

Yes

Should that forum be the sheriff court?

Disagree

Should that forum be a tribunal?

Agree

Should there be a single forum only in the event of fused legislation?

Agree

Is a single forum your preferred way forward regardless of wider changes to the legislation?

Agree

If you consider aligned legislation is preferred, should a single judicial forum be part of that alignment?

Agree

Please share any reasons for your answers.

The Tribunal should be expanded to cover all these cases. The tribunal has the expertise around complex cases around MHA 2003 that often involve considerations of incapacity and support and protection.

In addition, there is the benefit of a single scrutiny leadership body being able to refer cases to a single judicial forum and vice versa, this would increase the efficiency and effectiveness of the safeguards for those whose decision-making ability is impaired, despite provision of support, due to a mental health condition.

4. Please use the space provided below for any other comments you would like to make, relevant to this chapter.

The Commission has undertaken an investigation into a death in detention where there were difficulties with the interaction between the three pieces of legislation: the Adult Support and Protection (Scotland) Act 2007, under which investigations were carried out; the Mental Health (Care and Treatment (Scotland) Act 2003, which was used to detain for assessment, and the Adults with Incapacity (Scotland) Act 2003, under which an application for welfare guardianship was made. We are keen to share the findings of this investigation with the Review team.

No mention is made in this chapter (although acknowledged in chapter 9) that due to the challenges of fusion fused legislation might mean that mental health legislation for children and young people may well be removed from that of adults as has occurred in NI. We are keen to ensure that this issue is not overlooked resulting in unintended consequences.

About you

The consultation was clearly written and this was welcome. It is assumed that the purpose is still about gathering information and perhaps this dictated the length which for some may have been off putting. However it is noted that not all questions required to be answered and this is helpful.

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