Response from the RCPsychiS to the Scottish Mental Health Law Review consultation (the Scott Review)

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Chapter 2: What is the purpose of the law?

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

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

A word on terminology…

- **Defined mental health condition** – While we use 'mental disorder' when referring to current legislation or to the debate around whether the term should be removed, we would endorse a move in future legislation to switch to 'defined mental health condition'. In using this, we believe this term should be applicable where possible across all three pieces of legislation being scrutinised by the Review. It should also be applicable to those with a learning disability/autistic spectrum disorder, but not to those groups currently excluded, of which more detail is provided in Chapter 12.
- **Learning disability** – Our preferred term for patients with a learning disability is intellectual disability, as used in clinical guidance, but we recognise learning disability is the accepted term in legislation so seek to use it where possible.
- **Incapacity/capacity legislation** – We refer to the AwI Act as both incapacity and capacity legislation, reflect the usage of both terms.
- **Mental health legislation** – we use this term (unless explicitly stated) to refer to the three acts the Scott Review was charged with considering.

The overarching summary of our response as endorsed by the Scottish Academy of Royal Medical Colleges (our answer to Question 1 follows)

Who we are

The Royal College of Psychiatrists in Scotland is the professional medical body responsible for:

- setting standards and promoting excellence in specialist mental health care
- supporting and representing the psychiatry profession, including our 1,400 members in Scotland
- collective action to improve support, care, and treatment for people with mental ill health.

Our members:

- Provide specialist care for those with defined mental health conditions. This care can be lifesaving, facilitating and supporting a tremendous improvement in a person's condition, recovery and quality of life.

- This specialist care is delivered in a wide range of settings, and takes place alongside and in partnership with multidisciplinary teams from a clinical and non-clinical background in communities, primary and secondary care.

How we developed our response

- We issued a call for evidence to all of our 1,400 members for written responses.
- This is supplemented by 7 workshops covering each of the chapters, with over 120 participants in these discussions. These participants represented wider collective groups by specialty, setting and geography.
- Our range of participants extended to lived experience representatives and across the different clinical specialisms of our membership.

Our overarching response

The College welcomes and fully supports efforts to review mental health, incapacity, and adult support and protection legislation. We share the Scottish Mental Health Law Review's aim of improving the rights and protections for people subject to mental health law and to remove barriers to those caring for their health and welfare.

Human rights and the need to safeguard them is at the core of the professional duty of psychiatrists and clinicians as frontline professionals and medical experts. This extends to training, professional guidelines and standards of practice.

Throughout this process, we have urged an approach which builds on the already strong principles-based legislation in Scotland. Revisions should be directed towards further compliance with international human rights obligations while ensuring the legislation remains practical and incorporates a needs-based approach. It is on this basis that we engage with the proposals the Review has set out.

We are grateful to the Review for its efforts to date to support us and other organisations and professions to consider the practical implications of changes to mental health law, including through clinical scenarios. In developing the proposals in this report into fully realised legislation and subsequent guidance, we would urge the Review to continue to utilise these alongside discussions with all those involved in providing or accessing care under the provisions of mental health legislation, to ensure that change is both progressive and attainable.

We welcome the changed perspective that the Review proposes towards a positive fulfilment of rights. People with defined mental health conditions should be able to enjoy the full range of rights applicable to all citizens, and we support this mission.

Our overarching comments are as follows:

- **Scope** – The proposals extend far beyond the core purpose of mental health legislation, and its initially intended beneficiaries, those with a defined mental health condition. We endorse the position of the Review that some provisions will need to be in laws which apply to everyone. We would advocate for a focused set of instruments in the context of the provision of mental health care, that would allow the promotion of rights for those who are amongst the most disadvantaged in society.
- **Inclusion** – Any new legislation must work for all people of all ages, including children and young people and people with learning disabilities. We recognise this may be difficult for the forensic population, but these should apply to this population to the greatest possible extent.
- **Workforce implications** – We urge that specific evaluations of the workforce and resource implications of proposals from the Review are undertaken ahead of any legislative process, across all relevant settings. Identification and resourcing for additional requirements is essential to ensure we have a workforce able to meet the needs of people with defined mental health conditions and to minimise where possible the need for compulsory and/or restrictive practices.
- **Clinical diagnosis** – While recognising the need to reduce stigma and reduce it around defined mental health conditions, removing the criterion within legislation of a mental health diagnosis or condition is not the way forward. The use of diagnostic criteria allows a link to be made between a condition, its effects, potential interventions, and the use of legal frameworks to provide said interventions. It allows an approach based on objective evidence which can then be effectively challenged, thereby improving the protection of rights.
- **Applicability across patient groups** – We remain concerned that certain proposals, such as human rights enablement, are written with particular patient groups in mind, reducing their applicability across those with a defined mental health condition.
- **Non-consensual treatment –** We agree with the Review’s conclusion that there should be an aim to minimise the use of compulsory or non-consensual, treatment but that it cannot currently be eliminated. We consider that the term “coercion” is perceived as stigmatising towards those providing care, and carries connotations of nefarious motivations rather than the use of compulsory measures to deliver essential, potentially lifesaving care and treatment, balancing conflicting rights and impaired decision-making capacity.
- **Conflicting rights –** Rights inevitably can come into conflict. It is essential that any legislative framework can encompass such factors, and invoke principles to assist in determining how to reach a balance in often complex and challenging situations. We wish to ensure the right to life and to health encompasses a right to treatments which are effective in

maintaining/restoring health. This right must be maintained alongside rights to autonomy, dignity, social, cultural, and economic rights, and liberty and security.

- **Decision making frameworks –** We support proposals to optimise people's ability to make their own decisions or to have as much input and influence into the process as possible. Supported decision making, improved links with carers and autonomous decision-making processes are all very welcome. We await additional detail to enable further thinking, consultation, and development on how they would be applied in practice.
- **Practical reality** – There will always be a balance to be reached in developing proposals which seek to bring about fundamental change while recognising the practical implications of such change. We urge continued work and engagement to ensure that there are not unintended consequences. In particular, we wish to ensure that resources reach those most in need, that systems are accessible, and that fundamental rights such as the right to life and the right to health can be promoted and protected.
- **Responsibilities and resource** – For the Review's ambitions to be realised, it is necessary for there to be a clear demarcation of who is responsible for the delivery of the wider set of social, economic and cultural rights, the resourcing for this, and where accountability is held. Minimum obligations are one mechanism of achieving this. Clarity will be required to ensure accountability for these rests with the organisation or body which is able to deliver the provisions required.
- **Delivery of the principles of HRE framework** – To ensure these principles are utilised at the point of need, we would urge the Review to advocate for the principles of the HRE framework to be delivered through currently utilised assessments and practice, mainstreaming them now to the benefit of our patients.
- **Delayed discharges** – Delayed discharges from hospital, particularly for people with a learning disability and dementia, are a clear example of a failure to uphold patient's rights. Addressing delayed discharges should be a key test of the success of the legislative changes being proposed.
- **Autonomous Decision-Making Test in place of SIDMA** – We agree with the Review that SIDMA is no longer fit for purpose and support, in principle, their proposals for an autonomous decision-making test.
- **Children and young people** – There are significant concerns around the proposals for children and young people lose the protections and safeguards pf mental health legislation. We do not believe separate children's legislation would deliver the protections and safeguards available under current legislation.
- **Deprivation of Liberty** – As part of a 'progressive alignment' of mental health legislation, some lawful authorisation for deprivation of liberty must be

subsumed within the revamped guardianship processes, with the same timescales as provided for under the Mental Health Act.

- **Exclusions** – It is important to maintain protections for certain groups who are currently excluded under mental health legislation. This includes people with a drug and/or alcohol addiction.
- **Not ready for fusion** – We would urge the Review to pay cognisance to the tests for implementing fused mental health and capacity legislation proposed in the Wessely Review. From our perspective, we do not believe these tests can be met in this process that achieves a universal approach inclusive of children and young people and people with learning disabilities.
- **Progressive alignment** – We recommend the progressive alignment of mental health and capacity legislation that minimises the variation in safeguards and protections people can access depending on which piece of legislation applies to their particular circumstances. The population who come under mental health legislation should be consistent across the three acts.
- **Changes which can happen ahead of a legislative process** – This is an ambitious set of proposals which would make Scotland a world leader in the provision of human rights in mental health. In meeting this ambition through a comprehensive set of changes to legislation, we cannot delay changes which could be enacted in the immediate and near future. We call on the Scottish Government to enact the following ahead of any legislative process:
    - Entrapped patients awaiting a complex package of support in the community can appeal to a tribunal, which would create a statutory duty for such support packages to be provided.
    - Excessive security appeals to be applicable to people in low security settings
    - To move towards decisions on mental health law currently taken in the sheriff court to be taken up by the Tribunal.
    - Shifting the Commission from reporting to ministers to reporting to parliament.
    - Reflecting the aspirations of the 2015 Act, ensure digital, up-to-date access to advance statements be made available to both patients and staff charged with their care.
- **Further consultation –** We recognise that there are outstanding areas of consultation including around community CTOs. We would welcome ongoing involvement with the process of consultation and development to ensure genuine improvements in rights and care for people whose lives are impacted by mental health legislation are delivered.

Hereafter is our response to Question 1 on Principles and Purpose

- **Positive fulfilment of rights** – Our members welcome an evolution in law to bring about a positive fulfilment of human rights for our patients which goes beyond current legislative safeguards. We recognise the inequalities and disadvantages experienced by many of the people we support with mental ill-health, autistic spectrum disorder and intellectual disability, including rights to health alongside economic, social and cultural rights. Efforts to address the inequities they face are welcome.
- **Not losing sight of key protections** – As a College, we would urge the Review to ensure it does not lose sight of the fundamental purpose of mental health legislation in providing essential safeguards, checks and balance around the provision of non-consensual treatment for those unable to consent, which is often necessary and lifesaving; such treatment sustains a person's right to health and right to life.
- **Moving beyond scope of mental health law** – We as a College would also consider that broadening the scope of the proposed legislation to encompass a wider societal change, while welcome in principle, extends beyond mental health law. The most ambitious aspects of Human Rights Enablement would be best delivered through wider human rights legislation and applicable to all. We are aware of the broader social and legislative context, including proposed Scottish human rights legislation and consider that broader aspirational recommendations be part of those developments.
- **Biopsychosocial model** – Our members provide specialist care for those with moderate to severe 'mental disorder' using a biopsychosocial approach. This treatment can be lifesaving and facilitate a life-changing improvement in a person's quality of life and recovery. A recognition of this from the outset of future legislation in the principles would be welcome. Doctors have also been (and will continue to be) powerful advocates for the rights of our patients.
- **Meeting the needs of those with a defined mental health condition** – People with a defined mental health condition face stigma, social exclusion, and challenges accessing health and social care services. Mental health legislation should prioritise their rights being promoted and enhanced and avoid stigmatising language.
- **Applicability** – In relation to the statement: *"At this stage, we cannot say precisely which provisions should be in mental health and capacity law, and which provisions should be in laws which applies to everyone."* In setting out proposals around what would be of benefit to the whole society in Scotland, there is a significant risk that the rights of those with a defined mental health condition, who are at the most jeopardy of infringement of their freedom would paradoxically suffer diminished protections and safeguards.
- **Engaging all key stakeholders** – In setting these overarching principles out, we believe there is also an opportunity to recognise the need for the key

stakeholders in mental health care to be engaged with in future service development. This includes lived experience groups, the third and community sector, and frontline clinicians with professional experience working in specialist services.

- **Strang Inquiry** – The experience of NHS Tayside detailed by the Strang Inquiry, should be considered in the development of the purpose and principles. This includes recommendations around meaningful engagement at an Integrated Joint Board and Health Board level with those with lived and professional experience in their local areas. This should extend to reviewing the outcomes of critical incidents, monitoring key governance measures and strategic planning of services.
- **People with learning disabilities** – Such engagement is particularly important for the complex needs of people with a learning disability, who require the right interventions to ensure the higher rights of both mental health and physical health co-morbidities this group presents with are effectively addressed. It is extremely important for people with a learning disability not to be excluded from mental health legislation, and their removal would harm their ability to access the safeguards and protections provided for under mental health legislation.
- **Meeting the needs of people with a "mental disorder"** – The overarching purpose of the review recognises the needs of people with a "mental disorder" are to be addressed through legislation. *"The principal aim of the Review is to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder, and to remove barriers to those caring for their health and welfare".* We welcome this.
- **Difficulties of removing clinical diagnosis** – It makes later discussions on removing the term 'mental disorder' and clinical diagnosis as a pathway within mental health legislation problematic. We know that those with defined mental health conditions are a particularly disadvantaged group with specific difficulties and needs. Some of those needs will be governed by their identified condition and diagnosis.
- **Harmonising terminology** – We need to ensure our terminology is harmonised across legislation. This would recognise the need for consistency in definitions to meet Scotland's obligations under international conventions and to avoid legislative challenges. These conventions include the European Convention on Human Rights.
- **Competing rights** – While recognising the need for the positive fulfilment of rights, scenarios where there is a competing set of rights (such as right to life versus right to autonomy) need to be explicitly considered in the development of legislation, including through clinical scenarios.

- **Right to health and life –** The explicit recognition of the right to health and the right to life as a key purpose in the delivery of interventions would benefit the proposals, and reflect the prioritisation of this right in clinical settings.
- **Risk** – The role of mental health legislation in the consideration and approach to risk of harm to oneself or others is of crucial importance and needs to be recognised. Risk is an important consideration in many situations if rights are to be infringed. Risk is often a key factor when considering when one right takes precedence over another in a person who lacks the ability to make an autonomous decision. We would urge any subsequent legislation to account for this factor.
- **Risk in a forensic context** – The forensic aspects of legislation are considered separately but it is important to distinguish in law that the 'significant risk' of harm is always less than the concept of 'serious risk' of harm found in forensic mental health legislation. We consider it appropriate to disaggregate these tests in statute.
- **Other legislation to account for** – The Review should be mindful of the principles enshrined in victim's legislation in Scotland. This mostly applies to forensic aspects of the legislation, but there is also applicability to civil provisions.
- **Investment** – Our members fully endorse the position that without adequate resources, staffing, and investment, it will be impossible to realise the ambitions of the Review, irrespective of the recommendations it makes. As will be discussed, there is a danger of setting obligations that cannot be met.
- **Modern technology** – Throughout the Review, there is a failure to consider the potential advantages, efficiencies and best practices which could be supported by a digital first approach. We would encourage recognition that we have an increasingly digitised mental health care system; individuals should be able to access key information about their health and Tribunals online; forms should be completed and submitted electronically; remote assessments should be recognised as a legitimate option where appropriate. Our experience during the pandemic reveals what can be done in certain circumstances.

Reciprocity

- **Importance of retaining reciprocity** – Reciprocity has an important role in promoting patients' rights and holding clinicians and services to account, particularly when there is use of compulsion. Our members and other professionals value this and have seen it in routine practice such as the Tribunal where it can be a powerful tool to achieve access to care and to advocate for patients' rights. The removal of reciprocity risks the potential for harms and failure to fulfil a person's rights if clinicians, patients, and carers were unable to use this principle in the context of devising plans of care and support

- **Barriers to application** – Delivery of the reciprocity principle can at times be difficult. Nevertheless, we consider it a clear and useful fundamental principle on which to engage with health and social care providers to enable appropriate resources. Strengthening its application through the utilisation of other recommendations such as minimum obligations and improved scrutiny provided a way forward to enhance its efficacy. There is the option of extending the principle for anyone who has been disadvantaged by their defined mental health condition. This would include those who have required hospital treatment.

Beneficence

- **Clinical view on best interest –** This principle must be retained and only in very specific circumstances should clinicians not act in the best interests of their patients. The key exception is the decision of a patient who has the ability to withhold consent or who has made a valid advance statement. It is and will remain common for there to be no advanced statement for an individual who lacks decision making ability to be in place. Conversely, legal changes must never be allowed to create a situation where a clinician can be compelled to act against their clinical judgement in a way they consider causes harm or is considered futile. The Review should take cognisance of existing case law. Another consideration is the importance of ‘best interests’ in term of children’s legislation and UN conventions.

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?

- **Recognising the wider needs of individuals** – We are in support of the wider needs of people with defined mental health conditions being considered and addressed. Health is not merely the absence of disease, and fulfilling economic, social and cultural rights should be a part of any functioning society.
- **Role of quality standards** – We would highlight the development of quality standards for adult secondary mental health services as an opportunity to deliver core minimum obligations in services now, rather than waiting on legislation.
- **‘Rush to the bottom’** – There is a danger that minimum obligations for economic, social and cultural rights could lead to a rush to the bottom in terms of the provision of clinical services. We would urge that it go hand in hand with comprehensive implementation of agreed standards of service with mechanisms of local governance. lived and professional experience involvement, common definitions, and expectations. There must be an open culture of reporting with a fully populated information systems so there is

transparency that money intended to support mental health is spent on mental health.

- **Difficult to deliver** – we are concerned about the practicalities and resources required. In setting these obligations without the resource or cultural changes needed to deliver these, the obligations will not be the lever for change the Review envisages.
- **Dangers of going too broad** – There is a risk of a paradoxical reduction in the availability of care and services for the most in need if a broad delivery of minimum obligations is mandated for the many, at the expense of interventions targeted at the minority of the population with specialist needs. In much the same way that, as a society, we endorse healthy living interventions to reduce the prevalence of cancer, as well as expecting world leading specialist health services for cancer care, we should expect both preventative and societal wellbeing initiatives in addition to and alongside continued specialist care for those with defined mental health conditions. There must be parity in the approach to mental ill health.
- **Responsibility** – The responsibility for the delivery of minimum obligations should lie at an organisational or government level, not at the level of an individual member of health or social care staff. Our members strongly oppose these responsibilities falling to frontline practitioners without the subsequent power to leverage them to the benefit of patients.

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

- **A right to health** – A right to health is a strong principle underlying current clinical practice in mental health settings. This focus should be retained in forthcoming legislation that emerges from the Review.
- **Physical health** – Enhancing the consideration of physical health in the context of defined mental health conditions is strongly welcomed by the College. In turn, consideration of the mental health in those with physical health conditions must be improved.
- **Wider social, economic and housing rights** – Improving access to housing and the fulfilment of social and cultural rights is welcome. The ability to deliver this under the auspices of mental health legislation is questionable, though. There must be a prioritisation of those with defined mental health conditions – especially whose rights have been infringed to housing. Standards should be set for the provision of supported accommodation with common definitions and measurement of a range of supported living environments.
- **Additional resource** – Additional resource can and will be required to deliver an expansion in the availability of community-based support.

- **Using wider human rights law** – Incorporating this within broader human rights legislation, with those with a defined mental health condition as a protected group, may be more appropriate and in keeping with UNCRPD.

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

- **Focused Interventions**– The proposals are welcome in principle. A recognition of the needs for those with defined mental health conditions and subsequent interventions commensurate with their needs is missing, though.
- **Forensic** – As a College, we believe tackling stigma and negative attitudes towards defined mental health conditions includes for forensic patients and the families of those affected. There must be parity in access to mental health care and standards between the community and prison. The current approach to the provision of psychology in prison is unacceptable.
- **Not having access to care** – A failure to adequately provide mental health care is an extension of stigma towards those with a defined mental health condition, as all citizens should be able to expect appropriate physical and mental health support and care.
- **Disqualifications as a result of their treatment / condition** – Either because of their defined mental health condition or their treatment, people are automatically disqualified from certain professions and activities. This could and should be addressed in equalities legislation.
- **Work of anti-stigma campaigns** – Our members consistently cite the positive work of anti-stigma campaigns. This includes the work of See Me, which has conducted valuable work in addressing stigma. Forthcoming campaigns should be supported, but it is difficult to envisage how this could be done through legislation.
- **Attitudes towards working with people with a defined mental health condition** – Stigma around social care workers, third sector groups and clinicians who work with people with a defined mental health condition still exists. To secure the workforce of the future to meet the needs of this population, addressing this stigma within services, other settings and wider society should be an ambition.
- **Falling through the cracks** – People with defined mental health conditions have a range and variable sets of needs. They can be marginalised and disadvantaged in society. A purely universal ‘everyone’s the same’ approach to stigma, as suggested in the proposals, could inadvertently reduce the likelihood of support and recognition of that group’s needs.
- **Need for defined mental health conditions** – Identifying defined mental health conditions, describing them, diagnosing them, discussing related needs and outcomes, helps to facilitate discussions to target the stigma and

self-stigma surrounding them. Epilepsy is an example of a condition which, through concerted efforts, the stigma around the definition of the condition has been challenged while retaining the benefits of naming and subsequently targeting interventions and resources.

- **Societal Change –** Ultimately, society carries the greatest contribution and responsibility in stigmatising attitudes and behaviours and the consequent risk of self stigma. Addressing this, and the culture in services, extends beyond the boundaries of a mental health legislative framework. Anti-discriminatory approaches embedded across Scottish legislation and policy, addressing the particular stigma faced by those with a diagnosable defined mental health condition, would be a more appropriate approach.
- **Lived experience representation** – Meaningful lived experience input into local service development with co-design and co-production is an essential, and previously relatively overlooked area of work. This requires a culture change and the propagation of examples of good practice. It is difficult to see how it could be legislated for. It could however be included in other initiatives such as the Mental Health & Wellbeing Strategy.
- **Co-operation** – Protest, legislation, education are all key drivers to reduce stigma, but cooperation (co-production, co-development) with the voices of lived experience is the most effective of these. Enabling this may not be the place of legislation, but it can nonetheless be mainstreamed through greater emphasis on it in the principles.

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?

- **Preventative care in community settings** – Prevention includes the prevention of the relapse of a condition and/or the prevention of increased harm as a result of a defined mental health condition. Such support and care in community settings is missing or insufficient in many areas of Scotland, and the HRE framework and minimum obligations could provide opportunities to address deficits in preventative community care, with the right to life front and centre. This should include the provision of community services and day activities for people with learning disabilities, and access to a range of activities that support health, such as access to sport and social activities for this group.
- **Accessing care as a preventative act** – Access to specialist mental health care for those who would benefit from it at the right time before their condition worsens is a preventative act. It is essential that this care can be accessed in the right place at the right time. There are serious shortages of inpatient mental health beds and there needs to be learning and openness in those areas who have reduced their inpatient capacity to the point that the needs of people with a defined mental health condition can no longer be adequately met.

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

- **Benefits of effective care** – Effective mental health care including rehabilitation for those with long term conditions has been shown to have positive outcomes such as enabling a person to recover and to gain skills to support independent living, communication, and life skills so they can fully participate in society.

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

- **Evidence-based care** – There is a range of evidence in support of clinical interventions benefiting the person and their fulfilment of social, cultural and economic rights. Recognising this explicitly would reflect this and give specialist care its role as part of efforts to enhance a person's rights and improve outcomes.

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

- **Support for the overall direction** – We are supportive of the overall direction set out in the principles and purpose. There is inconsistency between the stated purpose and some of the later proposals, such as the removal of clinical diagnosis from mental health legislation, which would deny people additional protections and safeguards under the law.
- **Demand on specialist care** – The HRE framework, if enacted as proposed, would have substantial implications on services, in assessments, appeals and subsequent resources. This needs to be a factor which is considered when developing and operationalising how HRE would be delivered. Otherwise there is a risk that it would become unwieldy, impossible to deliver, or tokenistic.
- **Care that is matched, appropriate, and has evidence of benefit and efficacy** – In any system that sets out to deliver person-centred care, it should mean that the person is able to access the care which best matches their needs. This will be influenced by factors including the nature and severity of their condition, their preferences, and the evidence base for effective treatment.
- **Positive care settings** – All settings required by those with severe and enduring defined mental health conditions should be fit for purpose to meet a person's needs. There may be much to learn from the example of the link between legislation and subsequent improvements in the provision of Mother & Baby Units.

- **Inclusion of in-patient settings** – Positive care settings should include in-patient settings (looking to the 'Maggie's Centres' template for positive in-patient environments) and supported accommodation to enable community living. It is unacceptable that mental health inpatient services are sometimes inadequately maintained and do not always provide a welcoming and pleasant environment. We would also see this applying to those working to provide care for people with a learning disability, other relevant neurodevelopmental disorders, acquired brain injury and degenerative disorders such as dementia.

9. Cultural change in services?

- **More than monetary resource** – Monetary resource alone does not lead to a better culture of support and de-stigmatisation for those with a defined mental health condition. Sufficient staffing across health and social care settings is critical, as well as the time and structures for staff to deliver high quality care.
- **Staffing implications** – There is a challenge in recruitment and retention in mental health care. It is important that changes in mental health legislation to not have the adverse unintended consequence of making work within these settings burdensome, bureaucratic, and distanced from being able to provide direct care to patients. This means ensuring a culture of valuing staff at all levels, from our communities through to specialist in-patient settings challenging stigma towards those working with people with a defined mental health condition.
- **Evaluating workforce implications** – We would also urge that specific evaluations of the workforce implications of proposals from the Review are undertaken ahead of any legislative process.
- **Facilities** – There is also a need to ensure the facilities in which patients are cared for are modern and built with them in mind. The idea of aspiring to Maggie's Centres, which would reduce the stress of the environment and improve the mental wellbeing of patients and staff, should be considered.
- **Mental disability** – this term as defined under the Equality Act is cited as a means of accessing care. Many people, including those who present in specialist care settings, don't fall under this definition, and it ignores the ability to recover/ fluctuate in a condition. Such a framing would be stigmatising to people with a defined mental health condition.
- **Engaging wider pool of practitioners** – there will be many practitioners involved in mental health care who are not psychiatrists or working in specialist mental health care services eg general practitioners, social workers, nurses, Advanced Health Practitioners and physicians. Caution is needed to strike a balance between the undoubtedly important role of training and a

mandatory requirement which would act as a barrier to those practitioners engaging in delivering care.

Chapter 3: Supported Decision Making

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

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

- **Support the principle, subject to concerns** – Our members support wide-ranging reforms to promote supported decision making where possible and to maximise the expression for a person's will and preferences in decisions made with or about them. We nonetheless have concerns around the practical delivery of these proposals.
- **Evolution rather than revolution** – It should be appreciated that, while there is a new centrality to SDM in the proposals, and some novel ideas, the proposed model builds on and extends, rather than radically changes current law and practice.
- **Already enshrined in legislation** – Some aspects of the proposals are already enshrined in existing legislation. For example, the Adults with Incapacity (Scotland) Act 2000 states that account should be taken of *"the present and past wishes and feelings of the adult so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult"*. Additionally, in clinical practice it is routine to explore all avenues to enable a supported decision before recourse to statutory frameworks.
- **From benefit to the patient to their will and preferences** – The shift in emphasis from actions which are of *benefit* to the patient, to an approach solely determined by will and preferences is of raises concerns that it might lead to sub-optimal outcomes in some clinical situations. Examples include where:
    - it is complex and difficult to determine will and preferences clearly,
    - where there are conflicting preferences,
    - where conflicts of interest are possible but difficult to establish,
    - where the "stakes are high" and the certainty of will and preferences is not commensurate,
    - where benefit could not have been foreseen.
- **A person's rights, will, preferences and benefit –** in order to ensure such scenarios are minimised, we would urge that the considerations be broadened to recognise the person's rights, will, preferences and the aspiration to maximise benefit. This redefinition should recognise that these elements can

come into conflict, and a balance must be struck between recognising preferences while recognising what a clinician believes to be of clinical benefit. It would also recognise that a patient’s will and preferences could not be followed if it required a clinician to act in a harmful or illegal manner.

- **Change of preference** – There should also be a recognition that none of these will be static, and that a patient’s will and preferences may radically alter with time, and in changing circumstances. Legislative frameworks need to be able to account for the potential role a transient defined mental health condition may play in any change in will and preference. A pragmatic alternate approach in such situations particularly if there is a high level of risk, would be to provide treatment for a short period if impaired decision making is deemed temporary. This would come with the stipulation to revisit will and preferences throughout treatment, particularly when the person’s decision-making ability has improved.
- **Risk** – Our members seek to reduce risk, in partnership with lived experience and patients, regulatory bodies, health care organisations, safeguarding, scrutiny and improvement bodies, and carers. They also take account of their own ethics and the wish to provide good care, and society as a whole’s expectation of reducing risk for the wider population. Overriding this to focus on will and preferences could carry significant risk that the patient or another person will come to harm.
- **Patient’s voice and wishes** – In all of this, such factors have to be balanced by the patient voice, and enabling this to be heard through these procedures is critical.
- **Supporting a statement of preferences** – All efforts should be made to help individuals develop and state their preferences. This concept is already stated in the 2000 Act where a person is not considered incapable by means of communications difficulties “by reason only of a lack or deficiency in a faculty of communication if that lack or deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise)”. Colleagues in Learning Disability settings are familiar with the use of supplementary aids (e.g. Makaton, as Talking Mats) to enable communication. Our members recognise these efforts need to become routine and standard and would be supportive of efforts outwith legislation to improve the situation now.
- **Advance statements** – In order to make these more applicable and to address a lack of uptake, the College suggests the statements should meaningfully reflect what people *do not* want as well as do want to happen for them. When such a statement is overridden, there needs to be sufficient scrutiny, review and rights to appeal.
- **Independent advocacy** – Increased independent advocacy is strongly welcomed by the College. The fact it has not been adopted more widely

suggests underlying factors that needed to be addressed to ensure such mechanisms are accessible to all.

- **Named persons –** The unintended consequence of the removal of a default named person has left people who have a permanent lack of capacity with no named person. The need to increase uptake of this role should be balanced by ensuring the named person is appropriate for the role, as they potentially have access to a great deal of sensitive information.
- **Non-instructed advocacy –** Non-instructed advocacy, if undertaken by someone well trained and with experience working with people with a long-term cognitive impairment, can be very helpful in certain situations. It is particularly important where someone does not have family members to advocate for them. It needs clear parameters, though, to avoid the risk of spurious or vexatious actions supposedly on behalf of someone else.

1b. What do you consider would be the barriers to this?

- **Clarity** – There are common situations where a person's will and preferences are highly variable or inconsistent. This is exacerbated when there is more than one person or process involved. Thought needs to be given to how to address these issues.
- **Time as a resource** – It can take multiple meetings to build a positive relationship between a patient and a clinician, and to enable the patient's voice to be empowered to ask for what they need. This is time that is often not currently available to clinicians due staffing and resource issues and pressure of caseloads.
- **Accessibility of tribunals** – Elements like tribunal decisions not being available in accessible format significantly hamper a person's ability to engage with the system of appeals and redress. Such steps should be provided for as a matter of course.
- **Advocacy** – The resource required to deliver an uplift in advocacy would need to be driven by statutory duties to supply this resource. Funding for advocacy services should also be separate and distinct from wider mental health care funding.
- **Collective advocacy** – There is a need to consider collective as well as individual advocacy. More detail on how differences between collective advocacy groups would be managed would therefore be helpful (avoiding the presumption that any collective speaks for a whole group).
- **Forensic settings** – In forensic settings, significant barriers to deliver such a system included the risk and public protection measures required in this patient population.

- **Cultural barriers** – As suggested previously, such schemes and initiatives aimed at ensuring a patient's voice is at the heart of decision have faced adoption issues that are cultural, organisational and resource-based in nature. These would all need to be addressed for this scheme to move forward.

1c. How do you think the Supported Decision Making scheme should be taken forward?

- **SDM as part of new legislative framework** – If the SDM model, as described in the consultation document, is to be utilised as part of a revised legal framework in Scotland, then careful consideration must be given to its applicability to all areas of clinical practice, and to a broad range of clinical scenarios. Due attention should be given to disadvantages as well as advantages, and consideration of potential modifications and refinements in certain situations.
- **Interventions outwith legislation** – The Review has identified and described the need for SDM rather than proxy decision making to be the basis for clinical practice. We would urge that consideration be given to addressing these situations now, through initiatives undertaken by relevant authorities, rather than legislated for.
- **Access to advance statements for patients** – The opportunity of digitising advance statements so that they can be available to patients was highlighted, so they can be updated and available for staff to enable real time input. Examples of such care exist in diabetes care, dialysis care and maternity care. The equalising effect of both patients and staff having access to the same information is also important.
- **Appeals** - Provision for an ability to appeal decisions around supported decision making which is accessible, carries clear criteria and parameters around frequency is essential.

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

- **Challenges of undue influence** – Situations where undue influence is suspected to be present can be difficult for all parties. A clinician's knowledge of the person can be crucial in identifying undue influence, conflicts of interest and undue control. Clinicians with longitudinal knowledge of the person – such as General Practitioners – can be extremely useful, as can other professionals with knowledge of the person over longer periods of time. While very important, establishing will and preferences in these challenging cases can require even more expenditure of personnel and time.

- **Clinical guidance** – Such situations will need to be considered when developing clinical guidance and a code of practice, with specific guidance on recognition, consequences, information sharing, and directive advice.
- **Validity of views and wider appeals process** – When decisions are made which are not aligned to the will and preferences being put forward by a decision making supporter(s) then any oversight of this should include consideration of the validity of the views as well as the potential infringement of rights. Ultimately there needs to be an appeals or tribunal process where a decision making supporter could be removed if acting to the detriment of the person and not having regard to their genuine will and preferences.
- **Preventing harm** – As part of the wider preventative arc of the proposed legislation, minimising risk of harm/serious deterioration will be a critical consideration for clinicians on whether undue influence is present.
- **Welfare guardian disputes** – We would query whether clinicians should be able to contest decisions, as they can do with welfare guardians, if evidence suggests a negative interpretation of the person's will and preferences. In particular, the decision as to whether older age adults could return home is cited as a frequent scenario, as well as disputes with welfare guardians around who a person could engage with or where they live being reported in learning disability care settings.
- **Recruitment to provide supporters** - based on the negative experiences of Northern Ireland, recruitment for decision making supporters needs to be prioritised.

3. Should there be legal duties on public bodies to secure Supported Decision Making for people who need it?

● Agree ○ Disagree

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?

- **Enforceability and responsibility** – Like many of the proposals around statutory duties, the enforceability of these proposals and where responsibility lay for their delivery is critical. Without these elements established, it is unlikely legal duties, including around supporting advocacy, would have 'teeth' with regards to their prioritisation by public bodies.

4. Thoughts on a centre for excellence for supported decision making?

- **Existing organisations** – Scotland benefits from multiple organisations and structures for research and the development of good practice. These include, but are not limited to, the Mental Welfare Commission, the Mental Health Tribunal for Scotland, the Royal Colleges, the professional bodies, Universities, individual researchers, regulatory bodies, and Healthcare Improvement Scotland. These have the benefit of ongoing experience in the theory and practice of the current legislative frameworks.
- **Statutory basis unnecessary** – Currently existing organisations and structures supporting practice in this area should be supported and strengthened, and any new organisation focused on policy, practice and research in this area would not require statutory authority. We are also unclear why this specific area needs a centre of excellence to be legislated for, compared to other critical areas in mental health law such as minimising the need for non-consensual treatment.

Chapter 4: The Role and Rights of Carers

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

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

- **Role of carers –** We acknowledged the central role of carers in many patients' lives. We would urge an upscaling of recognition of their rights – including around their role in supporting someone with a defined mental health condition.
- **Training should not be specifically mandated by law** – We believe that legislation has many potential roles for advancing carer's rights, but training was an area that needed to be constantly evolving and adapting, rather than mandated and fixed to current understanding.
- **Carer's voices in services overall** – More important than any one training course is additional duties around ensuring carers are involved in wider service design. Current duties around engaging carers should also be strengthened, including around discharge from detention.

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

- **Consent and confidentiality** – The importance around whether there is consent to share information, even partially, needs to be made clear. The proposals do not focus on this point. There is also a need to consider the balance between obtaining consent for disclosure of information from the patient and the information families and carers needed to provide optimal care.
- **Need to acknowledge balances of rights** – While carers' rights to information and involvement needed to be reflected, it should nonetheless not be ordained that a person's wishes can be overridden on information sharing. There are situations where a patient would request their carers do not have knowledge and/or input into their care, and that this could, on occasions, place clinicians in a situation where it could not inform carers without breaching a person's wishes. Neurodegenerative conditions were said to present a particular difficulty around when and what to share, and with who, about a person's condition.
- **Clarity on 'leeway'** – Clarity on the balance clinicians face between obliging a patient's preferences and their wider health and right to life would be welcome. This would recognise there still needs to be information from the carers to the clinical team in many circumstances, that could be ascertained

while reflecting the patient's preference that information is not shared with the carer.

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

- **Engagement** – Young carers have particular support needs that require more intensive engagement by mental health services in order to enable them to fulfil their caring responsibilities. While this is unlikely to be legislated for, considering how this can be engendered across the mental health system would be a positive development.

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

- **Need for a role –** Unpaid carers has a critical role in the lives of many of our patients, and that they should be supported in this role and, if appropriate, have a voice in the care of the person they are supporting.

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

- **Value and renumeration –** We do not offer detailed comment on this question, beyond that unpaid carers needed to be adequately supported in their roles. This included with regards to renumeration beyond any monetary resource, but to the value they and their voice are held in by services and in the support provide for them to fulfil their caring duties.
- **Range of carers** – Many people would not consider themselves a carer, and outreach is needed to ensure their rights and available supports are understood.

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.

- **Named persons** – Carers who are parties to the tribunal process should have the tribunal documentation in an accessible format, including electronically if suitable

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

We do not have further comment.

Chapter 5: Human rights enablement

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

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

- **Endorse the centrality of human rights concerns** – We support the principles contained within the HRE framework to promote and protect human rights. We are in absolute agreement in relation to the centrality of human rights in mental health legislation and recognise the benefits these principles could bring to the care settings in which our members work and the patients they provide care for. Our following points centre not on the principles, but on the practicability of delivering this in the currently proposed framework, particularly in inpatient settings.
- **Continuity of care** – The proposal as outlined seems best suited to those with long term and enduring conditions, where there is time to compile a considered HRE assessment taking in the views of a range of relevant parties. There is less clarity on how this framework could work effectively for those presenting in crisis, for individuals involved with the criminal justice system or for individuals in physical health care settings who require non-voluntary interventions (eg managing agitation by someone presenting with delirium). It is unclear how professionals would access an existing HRE across a range of settings and how to avoid multiple HREs being in place for the same individual (which may contradict each other).
- **Waiting for assessments** – We have concerns HREs may inadvertently act as a barrier to care. Where an individual has a clear need (eg suitable housing), there should not be a requirement for a HRE to be compiled or updated before action can be taken. There is a risk that a HRE could become a prerequisite for service provision and add to the processes required to uphold a person's rights.
- **Appropriateness in clinical assessments** – Professionals already conduct a range of assessments, many of which are designed to facilitate holistic consideration of a person's needs and circumstances. We would suggest that, rather than introducing an additional form or evaluation, that the principles espoused by the HRE are incorporated into these current assessments. This will facilitate implementation and will avoid the introduction of additional barriers to care delivery.

- **Resource to deliver current assessments** – Current assessments can identify areas of unmet need, and being able to more clearly link these to specific human rights infringements may address areas of unmet need. At present, resource limitations act as a barrier to addressing these areas of unmet need rather than an inability to identify areas of unmet need.
- **Who this is for** – To uphold the human rights of those who are provided care under mental health legislation, it is important to clearly define to whom the legislation applies, and how it applies in a mental health context. Ensuring a focus on minimising any infringement of rights for those with a defined mental health condition should be a key consideration.
- **Clinical diagnosis** – For these evaluations to have a meaningful impact on improving outcomes for those with defined mental health conditions, it is important that they appropriately reflect the evidence-based care and treatment needs for the defined mental health condition. Ensuring people have the right to health (both physical and mental) is a key priority for the Review, and should extend to the provision of care that demonstrably can lead to optimal outcomes for any given defined mental health condition.
- **Link with outcomes** – Positive immediate outcomes for patients is critical in the uptake and delivery of this evaluation framework. If the HRE assessment does not address the current barriers to optimising rights, it is likely to be underutilised and to become a bureaucratic exercise that is seen as a burden by overstretched practitioners across a range of settings.
- **Practicalities** – The lack of detail on the practicalities of implementation in clinical practice is concerning. This includes different formats for the HRE to address urgent situations and to reflect different levels of complexity. There is lack of clarity on how HRE documentation will be accessed, how these will be shared with families/carers and how the HRE will be made easily accessible across a range of settings.
- **Balancing different rights** – In practice, our members are frequently faced with situations where different rights need to be weighed against each other. In situations where there is a conflict of rights and not all can be upheld, the HRE assessment needs to be able to reflect this. We would suggest that any appeals process also needs to incorporate consideration of conflicting rights and the risk posed (both to the individual and others) if certain rights are not infringed upon. As previously noted, any infringement of rights needs to be demonstrably justified, with appropriate safeguards.

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

- **Unintended outcomes** – We recognise the intention is for the HRE process not to be too burdensome. However, unless the process is clearly delineated, with tangible outcomes for patients, and with a realistic implementation process, our concern is that it will become so. Any implementation plan would need to be achievable based on available staffing and resources.

- **Delivering ambitions as principles across current safeguards and procedures** – As noted above, we are of the view that it would be more effective to embed the HRE assessment and its principles across existing assessments and processes. This would enable delivery of the benefits whilst avoiding the need for establishing a new process across a range of settings.
- **Dangers of not fusing into current processes** – Without delivering these in current tests, the danger of delays to care being provided by the requirement of additional tests and procedures is a concern. This would also reflect the wishes of clinicians, patients and families that assessments are minimised, and create scenarios where the procedures are not followed in emergency clinical situations.
- **Stress testing** – we would urge the incorporation of HRE principles be stress tested through clinical scenarios ahead of the development of any legislation.
- **Communicating across settings** – For HRE principles to be effective, the proposed actions to ensure human rights are met need to be communicated across settings. This is particularly important for those with the most severe need. Ensuring the specific needs of people with a defined mental health condition are acted on regardless of where they are engaged should be a key consideration.
- **Remedy and appeal** – Any appeal process needs to ensure that the organisation identified as not meeting a specific need is held to account for doing so, rather than an individual clinician, practitioner or team.
- **Appeals process** – To avoid the appeals process becoming overwhelmed or excessive resource needing to be available for the appeals process, it would be helpful to have clear criteria for the basis of any appeal. Without this, our members believe there is a danger of the system being overwhelmed by the volume of appeals.
- **Uptake of provisions** – across different settings, it is uncertain the extent to which we will see take up of these provisions if they are impracticable or do not bring meaningful benefit to people receiving care. Wider efforts to embed a human rights culture across settings is therefore essential.
- **Patient's refusal to complete a HRE** – There is a lack of clarity in the proposals on the effect of patient refusal to engage with an HRE. There appears to be a presumption that with support most people will eventually agree. However for a right of refusal to be meaningful, we cannot support a position where a HRE is completed even if a person competently refuses to engage (eg with the input of professionals and family/carers but not the individual themselves). What effect this would then have on access to care and ability to challenge

service provision needs further clarification. This point also reinforces why embedding in current practice would be the most practicable solution.

- **Access to HRE for patients** – The opportunity of digitising a HRE so that they can be available to patients and updated and available for staff to enable real time inputs was said to be critical.

2b. What barriers do you see to its operation in practice?

- **Links to minimum obligations** – The HRE framework is unlikely to have the intended outcome in the absence of appropriate resources being available to meet the identified needs. The minimum core obligations may help to clarify realistic expectations of resource allocation to meet specific rights.
- **Limited resources** – Unless embedded within current processes, there is a risk that the HRE framework will require additional resourcing, which comes with an opportunity cost. At present, it is unclear by which mechanisms resource allocation will be made available when a need is identified.
- **Purpose of annual reviews** – The proposal outlines a range of events that should trigger a review of the HRE. We do not think an annual review, in the absence of a specific triggering event, would lead to improved outcomes, and would be concerned that such a 'routine' review would be resource intensive to little benefit.
- **Duplication and lack of clarity** – Unless there is a central record of HREs and considerably improved IT systems that communicate with each other across agencies, it is likely that individuals will have multiple HREs drawn up in different settings at different times with different outcomes proposed. This is compounded by the difficulties in record systems in Scotland, with a lack of links between health care, social care, criminal justice, boards and primary and secondary care.
- **Family and carer objections** – There is a lack of clarity within the proposal as to how conflicts between the individual, their family/carer and professionals as to the outcome of an HRE would be resolved. There also needs to be borne in mind that minimising assessments rather than expanding their number, is the continued preference of many patients and their families, to ensure a system that is clear on when and how their rights are being upheld.

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

- **Role, competencies, responsibilities –** The person most appropriate to initiate an HRE will vary by circumstance and settings. In general, we would suggest it should be someone who already knows the individual and/or has a significant role in their future care. It should be someone who has the competencies to conduct an HRE, an understanding of the person's condition, circumstances and needs, an understanding of a human rights framework, and an understanding of resources available.

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

- **Incorporating into current assessments** – We would reiterate our view that it would be preferable to incorporate the principles of the HRE into current assessments.
- **Currently proposed triggers** – The triggers proposed are appropriate in principle. The caveats to this would be the degree of change considered sufficient to require an update to the HRE. At present "a change of mind" is listed. As this could be a relatively frequent event, guidance on thresholds for reviewing the HRE would be of assistance.

4b. Is there anything not included which should form a trigger?

- **Delayed discharges** – Delayed discharges from hospital, particularly for people with intellectual disability and dementia, are cited as a clear trigger point for such an evaluation. The effectiveness of the HRE principles in addressing delayed discharges should be the key test of their ability to address infringements of human rights.

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

- **Responsibility without power** – Individual clinicians, practitioners and teams often do not have the power or access to resources to deliver aspects of care they consider would be beneficial. It is essential that if an HRE assessment identifies a need for care or interventions then this does not leave individual clinicians placed in a position of responsibility for the failure to deliver rights or services out with their scope or auspices, including community settings.
- **Lack of 'teeth'** – While there is an expectation this would drive a focus on meeting the patient's rights, the lack of 'teeth' in the process give sus concerns over whether this would be an effective remedy. In doing so, a lengthy appeals process will be unlikely to address fundamental issues with regards to resourcing, whilst requiring professionals to engage with lengthy reviews that may not result in any additional resource becoming available to meet the identified need.
- **Timelines** – The potential administrative pressures if there is a set timeline for the delivery of these should be considered. While recognising the need to respond to patient concerns in a timely manner, the additional pressures this would place on clinicians would need to be managed effectively, with space and time to engage in the appeals process.

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

○ Agree ● Disagree

Please tell us why you feel this way

- **Systemic resolutions** – Wider, systemic issues, would need a different mechanism of resolution.
- **Basis for request for review** – Numbers alone should not be the basis for a collective review. Guidance on what basis any collective review would be considered would be required, with clear mechanisms to consider conflicting views/needs between different groups. Central data collection and systemic analysis of complaints can help identify issues relevant to a group, and monitoring of this nature can help guide collective reviews. Avoiding resource allocation to vocal groups, to the detriment of more vulnerable groups unable to raise their concerns, would require explicit consideration.
- **Responsibility** – Unmet need for a collective group is likely to reflect systemic deficiencies at an organisational/government level. Mechanisms to address these deficiencies will need to be directed at the appropriate level, with remedies requiring those responsible for a given area to act.

Chapter 6: Autonomous decision-making test

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

1. Capacity and SIDMA

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

More information

Option 1: Are you in favour of the current capacity and SIDMA tests remaining – unchanged?

○ Agree ● Disagree

- **Advancements in understanding of role of human rights** – Since the introduction of the 2003 Act, consideration of human rights issues has become much more central in evaluating and justifying interventions under mental health and incapacity law. The 'gateway test' for interventions must take explicit account of human rights issues, and we believe the SIDMA test, introduced in the 2003 Act, is no longer fit for purpose.
- **Case for single test** – While these questions do not directly relate to whether the Review will eventually recommend a fusion act, it seems likely that, even without fusion, there is a case to be made for a single gateway test under two aligned acts (covering mental health and incapacity law). In this case, the more widely applicable and understood incapacity test, perhaps with modifications as suggested below, would be a clear choice.
- **Lack of understanding of SIDMA** – While the incapacity test is widely understood and regularly applied by medical practitioners across the specialities and by other professional groups, the SIDMA test is much less well understood and used. It is applied only to patients treated under the 2003 Act and even among mental health professionals, can be poorly and inconsistently applied. This is highlighted in MWC research suggesting only 12% of professionals correctly filled in the SIDMA box on treatment forms.
- **Multiple tests did not ensure equity** – The current system of people undergoing different 'gateway tests' and then receiving different protections and safeguards depending what legislation is used is not equitable and could be seen as discriminatory.
- **Review in light of using case law** – In making changes, there is a need for proposals to be cognisant of the extensive case law that exists in relation to

capacity and medical treatment, which would need to be considered in any legislative proposals.

- **Recognise beneficial elements of current legislation** – While supportive of efforts to replace SIDMA, we would also urge that positive elements from the current legislative tests are carried forward. In particular, the useful clarifying guidance by the MWC on use of SIDMA in challenging cases should be reviewed to see how any alternative test might be made more clinically useful and applicable to a range of presentations.

Option 2: Are you in favour of the current tests remaining, distinctly – but with one, or both, reframed, if possible, to address the current problems articulated above?

○ Agree ● Disagree

If you would prefer a reframed definition, please feel free to comment on what you would wish to see adjusted.

- **SIDMA no longer fit for purpose –** As highlighted in the previous question, we believe that SIDMA is no longer fit for purpose and support a single 'gateway test' in either fusion or aligned legislation. We support the Review's call for a new test.

Option 3: Are you in favour of the current tests remaining but reframed as a single test?

○ Agree ● Disagree

If so, please comment to let us know if would this include additional matters, or be a reworking to conjoin the current tests?

- **Need for a single new test –** A single 'new' gateway test would undoubtedly take in elements of the two current tests. Instead, we should take this opportunity not to simply conjoin the current tests but to update our view as to the purpose, basis, considerations, and content of such a test. The most important 'new' elements would the need to maximise autonomous decision making, to consider the effects of defined mental health conditions as 'controlling influences', and to maximise individual will and preferences while giving due consideration to competing rights.

- **Fluctuating capacity** – any future test has to take into account fluctuating capacity. This would explicitly acknowledge SIDMA's greatest strength, to account explicitly for this and what someone's behaviour indicates over a period of time rather than in a single capacity assessment.

Option 4: Do you see little value in the current tests, preferring to see one, or both, of them replaced?

○ Agree ● Disagree

- **Value in current tests** – While we support the replacement of SIDMA, we would suggest that there is and will remain significant value in the current tests in providing protections and safeguards while legislation to replace it progresses. We would support replacement in the context of more broad-based legal reform in this area.
- **Disadvantages of change** – There are limitations to all approaches to determining someone's decision making ability. The current construct of impaired decision-making is a pragmatic conceptualisation. It is well established and well understood by clinicians. To completely step away from this is brings risks as well as potential benefits. Its use extends beyond mental health and across all aspects of health and social care and any replacement needs to be applicable and usable in all of these settings.

Option 5: You may prefer an option not mentioned, please feel free to comment.

Please let us know your thoughts on any options not mentioned

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

We have deliberately not asked specific questions; we wish to leave this open for you to offer any comments on its workability for different categories of persons and to make any suggestions for improvement.

Please share your views on the concept of autonomous decision making

- **The role and purpose of the ADM test** – In considering the ADM test as described, we are primarily considering it as a replacement for the SIDMA test in the 2003 Act. A framework where there is a single gateway test, based on the ADM test would raise additional questions.

- **Need for more clarity before final decision** – To allow for full consideration of the ADM in clinical practice, there would be a need for more clarity as to the exact details of the tests, its criteria, and its application. It is not possible without such detail to consider how the proposals would work in practice and make suggestions accordingly. These would then need to be supplemented by stress testing through clinical scenarios prior to legislation.
- **Guidance** - We welcome the intention of the review to produce further guidance regarding autonomous decision making. It is a complex area which is core to new legislation. We will seek to participate in the process to develop an understanding of ADM and guidance regarding its use.
- **Undue influence** – We strongly support the inclusion and recognition of the undue influence of a defined mental health condition on a person's will and preferences.
- **Harm –** Point 7 of the ADM test concepts states "*Where a person is judged not to be able to make an autonomous decision, there would always be an assumption in favour of respecting their will and preferences unless this will result in a 'harm' being caused.*" We consider that the definition of harm must be explicitly construed in such a way that the person should retain their rights to life, health, welfare, and dignity. It is also important to retain the importance of preventing deterioration in condition, alleviating serious suffering and the prevention of harm to others.
- **Specific as opposed to global view of decision making** – We recognise the importance that the ability to make decisions is specific to a particular decision. We therefore fully agree that an autonomous decision-making test which determined that someone did not have decision making ability in respect to one aspect of their life or treatment does not indicate that they lack ability in another.
- **Balancing conflicting rights –** We are in agreement with point 9: "*A decision to intervene without giving full effect to the person's will and preferences is permitted only if this will demonstrably lead to more respect, protection, and fulfilment of the person's rights overall, or to prevent harm to another person or other persons. Intervention must only be to the extent required to achieve these protections*". Further details as to how this balancing of competing rights should be made, and how this would involve any pre-existing HRE document, or any urgent HRE process would be welcome.
- **Distinguishing 'bad' decisions and inability to make autonomous decisions –** The need to clearly distinguish between a decision being made autonomously by a person that others considered unwise, and a decision which is due to lack of autonomous decision making ability is critical and must continue to be reflect in the test and in guidance. In the 2003 Act, s.328(2) states (in part): *"a person is not mentally disordered by reason only of any of the following … behaviour that causes, or is likely to cause, harassment, alarm*

or distress to any other person … acting as no prudent person would act". This clarification is important and we would support its retention. It is essential that people retain the right to make decisions that others may consider unwise, if they have the decision-making ability to do so. It will remain important that the decision or behaviour is not the sole determinant of a lack of capacity. The role of a defined mental health condition is therefore of paramount importance in considerations around assessments of decision-making ability.

- **Urgent situations** - "Urgent situations" is a widely understood term that should be used in relation to the provision of care, and we recommend this is used, and could encompass any decision on care which has to be made before the complete process outlined could be completed. We consider that even if it is not possible to conduct a full ADM test as proposed, some assessment of decision making needs to take place proportionate to the urgency of action, and if it could not be completed it should be revisited at the earliest opportunity. We agree that even in an urgent situation, efforts should be made to support decision making, and consideration must be given to any expressed advance wishes.
- **Excess complexity and practical applicability** – There is a danger that an excessively complex process for assessments of decision making would become impracticable, and add to, rather than remove, confusion particularly among non-mental health clinicians. There will remain a need to test how proposals would work in practice through consultation and application to clinical scenarios and make alterations accordingly.
- **Consider replacing or refining the term 'crisis' –** The term 'crisis' means different things to different people. For example, a situation of distress would be considered by some to be a 'crisis', while some may view 'crisis' as only indicating 'life or death' situations. Additionally, situations where the acute problem relates to physical health (e.g. injuries sustained in a car accident) are seldom referred to as crisis. It therefore has the potential to be misunderstood and potentially discriminatory.
- **Mature minors** – In order for this test to be applicable to children and young people, it needs to be cognisant of the Age of Capacity (Scotland) Act 1991 s2(4): *"A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment".* With this stipulation in mind, consideration will need to be given to the use of the ADM test for those under 16 years, as well as the stipulation for a qualified medical practitioner.
- **Relational aspects** – the 'relational aspects' being brought in, and incorporating the views of families and carers, may have unintended consequences if not clarified in guidance. This included broadening to such a point that the test becomes undeliverable in emergency situations, and that

an individual's choices are compromised by considerations from their wider social network overriding their views, will and preferences. At times families and carers may be extremely concerned by the autonomous decision a person is making and consider it is indicative that their defined mental health condition is leading to impaired decision-making ability when this may not be the case.

In a worst-case scenario, this would take us back to situations where families become the 'de facto MHO'. Many or most families and carers want to promote the person's health and welfare. This is usually positive, however may at times conflict with the person's will and preferences and associated autonomous decisions. Alternatively, they may consider that the person has autonomous decision making ability despite evidence to the contrary. '*Taking reasonable account of their views*', as does happen now, is appropriate.

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?

- **Competencies of assessor** – The skills and experience required to deliver these assessments will vary depending on the clinical situation and the intervention to which the decision pertains. There will be a range of clinical situations in which a test of autonomous decision making is required. It is enshrined in medical practice – including in the GMC guidance 'Decision Making and Consent' – that the practitioner giving care and treatment to be satisfied that the patient has consented to it. In many cases, in additional to medical staff, other health staff, including Allied Health Professionals and Nurses, as well as Social Workers would be required to carry out assessments. The basis for carrying out assessments competently will be: knowledge of the ADM test via appropriate professional training; knowledge of the nature and purpose of the intervention required; knowledge of the consequences of refusal; availability of peer support and senior review in more challenging or atypical cases.
- **Training** – Training and engagement will be critical in broadening out who could undertake these tests. A clearer understanding of the available resources and the ability of other clinicians enabling them to conduct an initial assessment under this decision-making test is seen as essential.
- **Regulation** – We recommend that the person conducting the ADM assessment is a member of a health or social care regulatory body.
- **Understanding and Experience** – The practitioner conducting the assessment must have a clear, comprehensive understanding of the proposed interventions and their risks and benefits, as well as an understanding of the consequences of not undertaking an intervention. They must have an

understanding of the conditions and symptoms that could impact on autonomous decision making.

- **Availability of senior review** – There will be more complex situations where specialist expertise is desirable. An escalation process to access specialist input will be required. An example of this includes someone with depression wanting to stop dialysis which would result in death, who may or may not have decision making capacity for that decision. It is likely the assessment would require input from a physician, a mental health professional, family and carers, all information available on the patient’s will and preferences, and a supported decision making process.
- **Weight of these decisions** – Decisions around capacity are profound and critical, carrying significant weight in their impact and implications. This needs to be borne in mind when setting out who can take these decisions and the need for them to be as highly trained and skilled as possible. We believe the principle that the professional making the decision around the application of the test should hold responsibility for the intervention needs to be retained.
- **Relationship with HRE framework** – The functions of the ADM test and HRE assessment are different. We do not agree with the suggestions that the person completing the HRE assessment should necessarily perform the ADM test or that the person responsible for the intervention would do the ADM test and update the HRE. An example where this would be inappropriate is as follows; the HRE may be completed by a social care professional with a clear, appropriate focus on the fulfilment of the person’s social, cultural, and economic rights. If the person then required surgery the surgeon, potentially with specialist input from a mental health clinician, would be the appropriate person to conduct the ADM test. It would be both inappropriate for the ADM test to be done by the social care professional or for the surgeon to make material changes to the HRE.

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

Things you may wish to consider are:

- *What qualities should the appeal have? – for example it needs to be accessible and speedy.*
- *Who can trigger an appeal? – the person themselves or any other party with an interest?*
- *Should it have escalation, e.g. commence with an internal review before secondary or external review?*
- *Who should conduct an external review?*

  - *Should there be easy access to an independent second opinion – how might this be obtained?*
  - *Should there be any limit on the frequency of which one dispute an ADM outcome?*
  - *Should there be access to a judicial process?*

- **All options needed** – All options around appeals should be included, proportionate to the different severity of individual cases. This should include a judicial process. Clear communication around this, such as the section 47 flow chart used for AWI assessments, is needed.
- **Mental Health Tribunal for Scotland –** The MHTS is the appropriate forum for appeals in the first instance. It is more accessible to people with a defined mental health condition than the Sheriff Courts, has an inquisitorial process suited to the purpose, and is less stigmatising.
- **Appeals process in emergency scenarios** – How the appeals process is to apply in emergency situations is a concern. There will be scenarios where the appeals process is not possible until after a clinical intervention is carried out - e.g. intubation for a patient who has stopped breathing, or emergency sedation in a situation of high risk. New legislation needs to encompass this within the provisions for urgent situations. In addition, a retrospective review or appeal needs to consider the context and information available at the time an ADM assessment is made.
- **Who can trigger an appeal** – Our suggestions would be the person themselves, the named person, main carer, power of attorney, mental welfare commission and MHTS.
- **Frequency –** There needs to be a limit on the frequency of appeals or the use of the act will become impracticable and impact on the care that can be delivered to all patients due to limited resources.
- **Streamlining processes across different parts of the act –** We consider it very important there is a right of appeal and review. We consider the MHTS or equivalent would be the proper place for any hearings to be conducted. Processes of appeal and review in the legislation as a whole need to be streamlined. For example, appeals against HRE, SDM and ADM in the case of the same person should be dealt with together, rather than through separate concurrent or consecutive processes.

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

- **Recording the ADM test –** The proposals state the recording of the ADM *"should be stored in the records alongside the HRE"*. This is impracticable in Scotland where there is no unitary health and social care record and no ability to easily access records across health boards, primary or secondary care. This would also make it difficult to implement an appeals process. We suggest that a record of the ADM test should be made alongside the intervention proposed similar to a Section 47 AWIA certificate and this should be lodged with MWC, with a copy in the clinical or social care records relevant to the intervention or interventions being conducted.

Chapter 7: Reduction of Coercion

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

Please share your views on how the Review understands coercion

- **Rights-based approach –** When utilised appropriately, compulsive, non-consensual treatment can preserve life, improve health, and serve to uphold key human rights principles such as dignity and the ability to fulfil social, economic, and cultural rights. Compulsion is also broader than detention and the use of force. Our members have seen the damage defined mental health conditions can cause to people's safety, dignity, relationships, and health. Compulsion is an infringement of rights which must be justified, and should only occur to promote conflicting rights such as the right to life in a situation where the person is unable to act autonomously with capacity. Wherever possible, decisions regarding treatment should be made by the person themselves.
- **Terminology** – The use of language is important. As has been discussed elsewhere in the review, it can be unhelpful and stigmatising. We consider that the term "coercion" is stigmatising and carries connotations of nefarious motivations and malpractice. It should not apply to the use of compulsion to deliver essential, potentially lifesaving care and treatment in the context of conflicting rights and impaired decision-making capacity. It should also be noted that coercion implies a person has been persuaded. This disregards scenarios where a person is not able to express a view or their actions or views are being overridden in the context of the stipulations and safeguards of mental health legislation.
- **Clearer definition** – While broadening the understanding of compulsion and non-consensual practice across settings is welcomed, a clearer definition of what it constitutes would be helpful when in engaging with future proposals. Clear definitions pertaining to compulsory/coercive actions in mental health settings would be very helpful to target interventions to reduce particular practices and address variations. A potential example would be staff being stationed outside a patient door is seen as coercive in some health boards, but not in others.
- **Extension to physical settings** – Compulsion does not occur solely in mental health settings. The broadened scope of coercion/compulsion including in physical health settings is endorsed by members. Safeguards must be accorded to people who are subject to compulsion or non-consensual treatment wherever this occurs. The review provides the opportunity to potentially drive efforts across health and social care settings to improve

practice and ensure that compulsion is only used in a way which promotes rights or balances conflicting rights.

- **A national register of restraint** – Measures such as restraint and seclusion require scrutiny, oversight, and data to facilitate research and review. A register of restraint extending to other treatments which need specific safeguards would be welcome. It is important that this is not excessively bureaucratic.
- **Reducing compulsory care** – We value the importance of minimising the use of compulsory care and treatment of all types to only those situations where it is absolutely necessary. This is already the aim of good practice. The College supports work that would improve care, with an aim of reducing those situations. We seek to ensure that the reduction or avoidance of compulsion does not result in a failure to meet needs, or is driven by a presumption against treatment. While preferring the term compulsion rather than coercion (as previously stated), we agree with the position stated in the review that *"in many situations, some use of coercion can be necessary and proportionate as part of promoting and protecting all of a person's relevant human rights"*.

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

- **Psychological support** – Psychological, trauma-informed support following compulsory care, recognising how traumatising this can be, is compulsory care and treatment is addressed, and better meet the needs of those who had received compulsory treatment. The additional resources required to deliver this are needed.
- **Importance of reciprocity** – Reciprocity should remain as a core principle interlinked to the provision of rights. It would be of benefit in efforts to reduce non-consensual practices. Reciprocity directly addresses the responsibility of only infringing rights when this is balanced with the delivery of interventions which fulfil needs and rights.
- **Additional approaches** – we make comment on additional approaches in response to question 4.

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 "coercion" should be the term used ● I think some other word(s) should be used

Please give reasons for your answer and any suggestions of other word(s) that should be used

- **Alternative terms** – We believe that not all compulsory care, non-consensual treatment or restrictive practice is coercion. Coercion implies malign intent and definitions of it include the use of threats. Coercion also suggests a lesser infringement of rights at times than compulsion as it encompasses the concept that the person subject to it is ultimately persuaded. The terms compulsion, compulsory treatment, and non-consensual treatment are considered more appropriate, as well as restrictive practice. We are open to exploring other suggestions about terms arising from this consultation.
- **Marginalisation of mental health care** – Terms which equate coercion and harm with mental health services alone and treatments delivered by them further stigmatise and marginalise those who call on, work in, and interface with such services in comparison with physical health care services for example.
- **Use of force –** We recognise that "use of force" may not be a discriminator as to whether a treatment is compulsory or not. We are absolutely clear that use of force should be limited to the most extreme situations, while noting there are situations were fundamental rights, such as the right to life, can only be upheld by the considered, justifiable and proportionate use of an intervention which involves physical force.

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

Changes might include: changes to physical environments; changes to resourcing and better valuing of staff; addressing attitudes and culture; and acceptance, participation and activities on wards, for example.

- **Support to reduce coercion** – Efforts to reduce compulsive practice are absolutely supported by members. We support the recognition that much more than simply increasing the proportion of preventative care is required.
- **Measurement, monitoring and safeguards** – These would have an important role in assisting change and legislation should enable these measures.
- **Using evidence** – There is already a strong evidence base around reducing restrictive practice. Mainstreaming and resourcing the delivery of care in keeping with this evidence base is far likelier to be able to achieve a reduction in coercive practice than law reform. We would welcome the approach of the Scottish Patient Safety Programme and HIS in utilising a strong evidence base to enable local areas in Scotland to attempt to identify best practice in reducing restrictive practices.
- **Resourcing** – We recognise that improved resourcing can lead to significant improvements of care and thereby potentially reduce restrictive practice. Clinicians share concerns that they can be in unwanted positions where restrictive practice and situations such as delayed discharge are more

frequent than they wish due to limitations on resources. Resourcing is a problem across settings where mental health care is delivered. We welcome acknowledgement of this.

- **Environments** – The physical, psychological, and cultural aspects of environments where care is delivered are fundamental to its quality. It has major impacts on the experiences of patients. Improvements, in line with our aspiration for Maggie's Centre-esque care settings could foreseeably reduce the use of non-consensual or restrictive practice.
- **Alternate practices to compulsory care** – We disagree with an obligation, however well intentioned, to automatically attempt alternate practices to compulsory care. This could leave patients suffering without the care and treatment they need while alternate options known to have less benefit for them are attempted. To stipulate this at every turn would override a clinician's duty to promote a person's rights to health and their right to life.
- **Specifying interventions** – Interventions should be tailored to needs and appropriate to the person. While recognising the potential benefits of having tools like 'Open Dialogues' available for some patients, assuming everyone would benefit from this would lead to unintended harms for other patients. It would also ignore the 'least restrictive option' stipulation currently in place. It is also unhelpful and inappropriate for legislation to mandate any specific intervention whether this be pharmacological, psychosocial or psychological. We hope that the mental health law developed as a consequence of this Review is in place for a considerable time to come. Any interventions which are too specific may not stand the test of time and evolving evidence in practice.
- **Long term 'fixed' versus fluctuating conditions** – In general, the proposals in this section appeared to be built around particular types of patients with longer-term, systemic or static conditions who needed support to fulfil their rights, In doing so, it made the proposals less applicable to the wider patient population in mental health care with fluctuating conditions, and made it less likely their outcomes would be as improved by it. We recommend further "stress testing" with clinical scenarios as proposals are being refined.

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

Including the current responsibilities of the Mental Welfare Commission and 'Designated Medical Practitioner', and ways in which the patient or their supporters might challenge particular interventions.

● Agree ○ Disagree

Please give reasons for your answer

- **Need to improve** – Throughout this process, we have taken the view that current practice can and must improve to ensure we are compliant with international human rights standards. This extends to strengthening safeguards. We fully support the role of independent reviews of compulsory treatment.
- **Work with the Commission** – The work by DMPs and the MWC has been shown to influence care plans in a collaborative way with clinicians. That process needs to be continued through strengthening these safeguards.
- **Scope of safeguards** – The current part 16 safeguards and parameters of tribunal scrutiny are relatively narrow. This should be extended to encompass a broader range of interventions that are given under compulsory measures. As in current legislation, a balance will need to be struck around urgent situations where interventions should be proportionate to manage time sensitive needs with associated risks with DMP or equivalent review occurring at a practicable point. Reciprocity would be a critical principle to uphold within the application of safeguards.

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.

- **Expansion of MWC role** – The expansion of the Commission's role is generally welcomed, viewing it as a key body to fulfil many of the aspirations of the review.
- **Section 47 Adults With Incapacity (Scotland) Act** – We consider that the current oversight of the use of the Adults With Incapacity Act is disproportionately low in comparison with the Mental Health (Care and Treatment) Act and yet the level of compulsion and non-consensual treatment can be extremely high. Clearer oversight is required. We consider that the Mental Welfare Commission and Mental Health Tribunal for Scotland should have roles in this regard. Section 47 certificates should be available and for interventions and situations that involve restrictive practice, subject to monitoring.
- **Avoid compromising current role** – An increase in roles and responsibilities, should not be at the cost of the Mental Welfare Commission's ability to engage and influence clinicians, supporting them to deliver best practice and rights-based approaches. This aspect of the Commission's work has been highlighted by many members. The Commission should not become a purely regulatory body.
- **Mental Health Tribunal for Scotland –** The Mental Health Tribunal for Scotland also has an important role in the oversight of the use of compulsion

and non-consensual treatment. We consider that the Tribunal's role in this regard should be widened strengthened. For example, applications for guardianship (or equivalent), and appeals in relation to AWIA should be held in a mental health tribunal setting.

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

Please let us know if you have any further suggestions for understanding rising rates of detention and people on community-based CTOs

- **Need for further consultation –** The planned targeted consultation in relation to community-based CTOs is necessary to enable us to fully engage with this question. We look forward to this consultation which covers an extremely important area of practice. We wish to be an active participant, and would urge the Review to consult widely on its proposals in this area.
- **Utilisation of community CTOs –** Community CTOs can be a preventative measure. They can enable a reflection of the balancing of rights, with the infringement of rights inherent in the order balanced against the likelihood of a greater infringement of rights, such as hospital admission or harm to the patient themselves or others if no order are in place. Well-resourced services will have some impact on reducing the need for community CTOs but will not reduce it entirely.

Chapter 8: Accountability

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

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?

- **Support in principle** – We support proposals that the Tribunal should have increased powers to order that services and provisions, specified in the RMO's care plan be provided. However, concerns around the operation of such powers, as described below, need to be addressed.
- **Responsibility for planning treatment** – The Consultation document states: *"We do not intend this power to be used to require professionals to deliver care which they do not believe can be clinically justified*". We strongly agree with this principle. We support increasing the Tribunal's powers to order that all elements of the care plan be carried out, but it is inappropriate for the Tribunal to become involved in stipulating treatments or treatment types. Choice of the most appropriate treatment in any particular case is to be a matter for the clinical team in discussion with the patient and with consideration of their individual needs.
- **Resource issues** – Members expressed a number of concerns around the resource implications of the proposal. While a legal mechanism to ensure care specified in an order is delivered could be critical to ensuring a patient could realise their rights, without wider increase in resources available to services, it is unlikely to be effective. In the context of limited resources, services directed to meet the needs of one patient by a Tribunal stipulation might also lead to diversion of resources from other areas of service provision. Provision of a route to 'guaranteed' service provision for detained patients, if not available to voluntary patients, could also provide a 'perverse incentive' to encourage patients to place themselves under formal measures.
- **Broadened duties** – Broadening the scope of the Tribunal will "require NHS boards, local authorities and integration authorities to provide such care and support as may be required". This would also extend the scope of the RMO's role to issues wider than detention, such as housing and social support. While this might well be a useful means of ensuring full realisation of rights it remained fundamentally tied to the availability of resources. both financial and staffing-related.
- **Responsibility for compliance and enforcement** – Beyond the resource issues, we need clarification as to where the responsibility for non-compliance with the Tribunal's orders would lie. The RMO was often directly 'in front of' the

Tribunal, but the power to authorise and many interventions lies elsewhere – with NHS Boards, IJBs, Local Authorities, or with local or national government – the process by which the Tribunal could directly compel these agencies to action was questioned. Additionally, clarity on the process envisaged when where patients appealed to the Tribunal because of non-delivery of their care plan is needed.

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?

Please share your thoughts about the ways we want to extend current excessive security appeals to anyone subject to unjustified restrictions

- **Our support** – We absolutely support this in principle, recognising this is a positive recommendation from the Barron Review.
- **Resource issues** – This proposal gave rise to many of the same resource issues as described above, in particular the risk that in the context of limited resources, services directed for one patient by an excessive security appeal might simply lead to diversion of resources from other areas of service provision.
- **Defining excessive security** – Excessive security needs to be defined, and the framework for reviewing what constituted excessive practice within the suggested examples needs to be established. Without this, there is a danger of services being overwhelmed by appeals, regardless of their relevance or merit.
- **Inappropriate settings** – The potential benefits include driving service developments to the benefit of patients. In particular, concerns from the Barron Review, of people being placed in inappropriate forensic settings, could be addressed, including for those in low security settings who could be cared for in the community.
- **Ensuring the proposal has meaning** – The success of this proposal was absolutely tied to the availability of sufficient resource and that further consideration of enforcement mechanisms was required.

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

- **Improve what we have** – There are a number of routes by which people can raise concerns in the mental health system currently. While not always effective, it is improving upon these mechanisms, rather than starting from scratch, which would be the most effective way of ensuring the complaints system work better for patients.

- **Purpose** – It was added improvements to a complaints system needed to keep focused on the purpose and scope of mental health legislation. By expanding the scope of the complaints system beyond those who access care provided under mental health legislation, the system could become potentially overwhelmed and less effective for those in need of redress.
- **Complaints legislation for wider NHS** – Current patient complaints legislation for the health service would be the better place for many of the issues raised.

3b. Do you have any other ideas to make this process more effective and equitable?

- **Support those with severe needs** – The complaints system was underused by particular groups, including those with the most severe needs who lacked the support and confidence to raise complaints. Efforts to support those with most severe needs were felt to be needed.
- **Identifying systemic issues** – A means of identifying continuing or recurrent complaints by locality or nationally could help to establish more systemic issues in the provision of care. Having such a monitoring system would enable those issues to be addressed.

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

- **Uncertain if in scope** – The positive fulfilment of rights will require such court actions to be available when necessary. Nonetheless, legislating for such collective advocacy may lie outwith the scope of mental health specific legislation. These proposals, which should be applicable beyond mental health, should be adapted into human rights legislation more widely.
- **Defining collective advocacy groups** – It would be important to establish the definitions for collective advocacy groups, and provide mechanisms by which they could be confirmed to be truly representative of their individual communities. We would suggest monitoring for systemic issues as a likely precursor for collective advocacy to be taken to address these.

4b. What are your thoughts about creating a way for collective advocacy groups to alternatively escalate unresolved human rights issues to an identified scrutiny body?

Our members did not take a view on this question.

4c. Please let us know of any existing organisation that you feel should take on that role?

Our members did not take a view on this question.

4d. Should these proposals also cover individual advocacy organisations?

○ Agree ○ Disagree

Please tell us why you feel this way.

Our members did not take a view on this question.

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

- **Defining these groups** – Potential ways of defining these groups, and setting clear expectations of how representative they are, should be established. Such stipulations are necessary for strengthening these groups and the esteem in which they were held by services.
- **Engagement with other parties** – Engagements by Health Boards and other public bodies should take place, to ensure they were aware of what constituted these groups and how best to engage with them.

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

- **Duties of government** – The scrutiny landscape also needs to recognise the duties of government to enable better care.
- **Delayed discharges** – Delayed discharges was seen as an area where greater scrutiny would be very beneficial for patients. In doing so, it could help address a fundamental breach of a person's rights in not getting care at the right time.
- **Tribunal's role** – the role of the Tribunal should extend to highlighting to the Commission systemic deficiencies in the delivery of care or promotion of human rights, including through specific referrals.
- **Referral to Tribunal** – Where the Commission identifies a major imbalance in the fulfilment of the human rights of a person and have failed to achieve resolution, they should have the power to refer this to a Tribunal. This should come with the power to create individual statutory duties to address significant human rights imbalances.

- **Tribunal’s membership** – We strongly advocate for the expertise and experiences of psychiatrists to be retained as members of the Tribunal. We also wish to increase and support greater participation from general members of the tribunal, including lived experience representatives.

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

- **Support expansion** – We would support the expansion of the Commission’s role and would urge it be given more substantive powers when it comes to compelling responses to its findings.
- **Wider scrutiny review** – Any changes to its role needed to be alongside a wider review of the scrutiny and assurance landscape, ensuring the resources available across organisations like HIS were utilised.
- **Independent of government** – The Commission must be able to highlight flaws in government policy which result in failures to deliver care in a rights-based manner. To ensure for this, we would urge that the Commission report to parliament instead of government.
- **Court of session** – where there are major ambiguities in terms of the law, the Commission should be able to take these to the Court of Session.

Chapter 9: Children and Young People

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

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

Please choose one of these responses:

● The current 2003 Act principle for children is still needed

Please explain below

Answer to question

- **A version will be needed** – a principle around meeting the needs of the child is still essential. Regardless of the wording, it can draw particular attention to the needs of children and young people as patients, young carers, and dependants of patients, as well as the risk to themselves and to others. Meeting their needs should be recognised through a core overarching principle, as in place now.
- **The core purpose** – The application of mental health law to children and young people is in a very specific confine of mental health care and treatment. While recognising the broadening out of its application generally, there are fears that without a core principle recognising the child's welfare in accessing care for defined mental health conditions, that population would lose out on additional safeguards they can and should be able to call on.
- **Implementing the UNCRC** – The implications of the UNCRC and how this would be delivered in mental health settings needs consideration. Clinical guidance, in particular for children with communication/ intellectual difficulties, would be essential to the delivery of ambitious extensions of the consideration of rights in clinical practice, if full incorporation of the UNCRC is to be achieved. With this in mind, the current principle is more applicable to mental health care and treatment than wider UNCRC principles,
- **Balance of rights** – There is a need to recognise the different 'weighing' of rights in clinical situations (including right to health and right to life). The deployment of mental health legislation implicitly calls for this, and a continued principle directly relating to mental health care and treatment needed to reflect this.
- **Risk** – the risk for individuals and others is a critical factor in the decision making around clinical care and treatment. With the continued guiding principle of meeting a person's care needs, risk will remain a very present

factor when it comes to the protections and safeguards available to a young person.

- **Parental rights and responsibilities** – the rights of the parent need to be more explicitly considered. This consideration should extend to current tensions where the rights of the child come into conflict with the rights of a parent/carer to exercise their responsibilities to the child.

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?

- **Responsibility** – Who responsibility fell to and how they would have the power to leverage this is a concern. Adding such levels of additional responsibility, including in systemic areas such as child poverty, could end up raising expectations on clinicians without the subsequent power to enact change. The statutory duty of mental health and care agencies must remain the provision of treatment for defined mental health conditions, and ensuring children's rights are secured within this sphere of responsibility.
- **Renumeration** – Capacity issues mean that, in trying to meet all these obligations, the core work of CAMHS would be diluted in the process. In doing so, it would create expectations currently impossible to meet for patients.
- **Giving additional assessments teeth** – Expecting clinicians in emergency situations to justify the full range of rights being assessed is difficult to achieve meaningfully in practice, amidst the pressure of meeting the fundamental rights to health and life.
- **Current duties** – Co-ordinated Support Plans and other mechanisms already impose duties on services to meet children's mental health needs, but that these duties do not have sufficient teeth to be enforced. The duties under GIRFEC and the Child's Plan are also said to be relevant in this regard.
- **Key blockages** – It is uncertain whether these duties would address the core issue preventing the fulfilment of rights in CAMHS, of in-patient units getting 'blocked up' by young people waiting on social care supports. A statutory duty on IJBs and other authorities to address such specific gaps would be much more meaningful that overarching responsibilities not directly linked to clearly present issues.
- **Out of hours care** – There are fears that, as a result of a reduction in emergency care placements, increasing emergency detentions of under 18 year olds under the Mental Health Act is taking place, often to unsuitable settings 'out of hours'.

- **Accountability** – Clarity on who has these responsibilities and how they would discharge them is needed. Fundamentally, accountability as the primary concern around the delivery of this, the gap between government rhetoric, communication and reality on the ground.
- **Changes in age range** – there are already variations as to what legislation or care setting applies by age. This present difficulties for the implementation of any proposals in this area.

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

- **Review in 24 hours** – Such a review could disadvantage a young person, leaving them waiting on broader care and treatment. This is already being reflected in current efforts to boost out of hours access to care, with insufficient trained clinicians specialising in children and young people to be able to do this.
- **Who is undertaking the review** – Detained patients would typically be reviewed by a senior clinician as soon as possible after admission. Children's rights would be better served if the reviews carried out on behalf of the Chief Social Worker, such as by an MHO or child/family social worker. Their key role would be to consider and provide where appropriate, a meaningful alternative to hospital detention (such as enhanced family support or an alternative social care placement).
- **Who made these reviews** – There is vagueness as to who would conduct wider reviews, and how they could be empowered to secure resource to meet the full care and support needs of the young person. MHOs are suggested as an option, but they would need greater resourced and clinical support to discharge to a more appropriate placement.
- **Appropriateness of tribunal** – Having such a review, involving a tribunal, could be an additionally traumatic and intimidating experience if not appropriately handled.
- **Alternative to admission** – This ambition is supported in principle, but we are concerned at the notion that clinicians could deliver on this principle in crisis situations. There are a number of examples of clinicians who have been unable to seek, under the current MHA and sections 25-27, housing and other supports for patients due to a lack of resource and availability.
- **Delivering appropriate, rights-based access** – Utilising the principle of reciprocity, which we believe should be retained, an expectation that an MHO be made available 24/7 to all children being considered for detention in Scotland would be an appropriate application of said principle. This should be a minimum standard under any new legislation and drive appropriate training and recruitment.

3b. What are your views on the safeguards for emergency detention?

- **Realistic demands** – The notion mental health officers could be able to confirm an EDC 24 hours a day is unrealistic based on current staffing provision. MHO authorisation will lead to young people waiting on interventions they need.
- **Differentiation** – While recognising crisis situations can and do take place, the notion of crisis situations requiring 'lesser' safeguards is concerning. Setting an expectation to do all you can to abide by assessments and the young person's wishes and maximising their rights in these situations is the much better option.

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?

- **Transitions** – The perspective from generalist adult services highlighted difficulties around referrals as young people are 'bumped' up the adult waiting list having already waited on the CAMHS list, while an adult waiting on the service falls further down the list. This leads to people being disadvantaged.
- **Engagement between settings** – The dialogue between CAMHS and generalist adult services around transitions vary widely, between 6-month forward planning and a 'trapdoor' between the two settings from one day to the next. A wider cultural change is needed to fulfil a young person's rights, recognising that person's needs and preferences which can include preferring engagement from adult services. Adopting the principle of the service that best meets their needs is where they are engaged would be a better option. This will require training, resource and closer working of services.
- **Service availability** – We would question whether it is the place of the law to specify what services should be available. The CAMHS service specificationis being implemented, and making these legally binding would have potentially unintended consequences.
- **Different standards** – Further difficulties around the different demands between children and young people with neurodevelopmental disorders and those with defined mental health conditions would emerge, with different service specifications and range of waiting times for both. These set out minimum obligations of the kind this Review are seeking to establish.

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

- **Choice of named persons** – We support young people under 16 should be able to choose their named person. A young person deemed to have capacity to make certain decisions, such as medication, should in principle have a say on who their named person is.
- **Impact on accessing care** – Young people want their parents involved when they feel they need them involved, and should be trusted that to make that judgement. The current system, where people potentially avoid care because they know their parents will be notified, is not acceptable.
- **Involvement of family** – Wider issues around the involvement of a family in a person's care need considered. The tension of a child being able to potentially 'disenfranchise' parents places clinicians in a difficult position of potentially disenfranchising family members. This is further exacerbated by the acknowledgement that, on critical issues such as health history and what medication a young person may react adversely to, information from parents may be needed.
- **Robust alternatives** – In order to make the switching of a named person work, robust alternatives needed to be available, to ensure the young person isn't disadvantaged by not having a named person at all.

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?

- **Defining and justifying** – A stronger definition and what these added in addition to current tests is essential, as it is hard to engage with the proposals as they stand.
- **Ensuring young people get the care they need** – to ensure young people get the care and support they need, the tests as designed could add further complexity to the process.
- **Relevance to children** – These tests also appear to be much more explicitly drawn towards adults rather than children and young people. In doing so, these tests would go against ICD 11 and the 'lifelong' nature of support it calls for those with a defined mental health condition.
- **Capacity** – A wider definition of capacity and its cognitive focus raises concerns. 'Bright' children and young people can appear cognitively capacitous but potentially still have impaired decision making due to the effects of conditions such as an eating disorder.

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

- **Restraint and seclusion** – Expanding additional authorisations around monitoring of restraint and seclusion is to be welcomed to ensure when and how often these practices are used is recorded. All usage of restraint and seclusion should fall under this.
- **Different types of seclusion** – Different types of seclusion, such as bed rest for young people with anorexia, needed to be considered as part of wider care and treatment.
- **Expert second opinion** – There may be scope to extend the Act to consider a second opinion around the extensive use of restraint and seclusion, and professionals should input to this. There is support for reviews of ward level management, but whether this need to be legislated for is questionable.
- **Restrictive practices and staffing** – Additional monitoring and safeguards may not address the fundamental issues in providing care (particularly around staffing) that led to restrictive practices, such as the lack of an alternative option.
- **Experience on learning disability wards** – The experience in learning disability wards is that the Commission focused on the clinical team when considering inappropriate provision. The Commission must have the teeth to demand service change beyond clinical practice in response to inadequate provision.

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

- **Universal application –** As previously highlighted, additional support and safeguards are provided for in mental health legislation need to continue to be available to children and young people. This includes those with learning disabilities, autism and neurodiversity.

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

- **Role of parent** – We recognise the parental issues and tension on a clinician making decisions around named persons, but shifting this to the young person may not be of benefit either, placing them with a traumatic decision to make.
- **Specialist MHO** – We would propose that a MHO role specialising in engaging with children and young people be developed as an additional role.

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?

- **Lifespan approach** – As a College, we support and endorse efforts to provide support and care for defined mental health conditions across the lifespan universally, recognising the different needs of age groups.
- **Cannot support what is proposed** – Separating young people from mental health law cannot be reconciled with this ambition, and as a College we would strongly oppose this move.
- **Parity of esteem** – Children can suffer from severe and enduring defined mental health conditions, often with poorer prognosis than adults. A robust framework for the timely provision of effective treatment is necessary for these children, as it would be for physical health conditions.
- **Accessing safeguards** – Disenfranchising children and young people from the specific protections of the mental health act would severely disadvantage our most vulnerable children and young people. The protections and safeguards of mental health legislation must be in place when they are accessing mental health care.
- **Loss of protections** – the arguments for mental health provisions to fall under future children's legislation is not sufficiently justified, and would harm the care and treatment outcomes of children and young people. The potential removal of the technical and detailed safeguards in mental health settings would be the likely result. Overarching legislation would be much more generalist and less able to recognise the particular provisions needed to provide mental health care and treatment to young people.
- **Enforcing other acts** – The lack of teeth in current legislation outwith mental health to secure better support for a young person is a greater issue than the support and safeguards provided for under mental health law. The reason many children and young people require the protections under mental health legislation is as a result of failures to deliver other safeguards, and there is no real sense that combining mental health law with these would change this.
- **In limbo** – Bringing to together all these pieces of legislation would be an incredibly complex piece of work and leave children and young people waiting on legislative change for years, while adults access new safeguards and protections. This would be a fundamental breach of the College's universalism approach to how the rights and safeguards of mental health law should apply.
- **Transitions** – Transitions between children and adult mental health services would be further harmed by different legislation, adding further complexity to this process.

- **Adjusting –** Adjustments in lifespan mental health law for children and young people is the much greater preference. In doing so there would be scope to recognise the particular needs of children and young people while ensuring the wider ambitions and focus of mental health law, on providing for care and treatment, are retained.
- **Not delivering a GIRFEC approach** – Proposals around the National Care Service are much more likely to bring different professions and perspectives together to meet the needs of a young person in a GIRFEC approach.
- **Delivering rights for all requiring particular safeguards** – The gap between recognising people have particular needs as a result of their defined mental health condition. It is again reflected in pursuing generalist children's legislation that would not reflect the particular needs of children and young people with a defined mental health condition.
- **Mature minors** – we would again cite, in this context, the Age of Capacity (Scotland) Act 1991 s2(4): *"A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment"*.

Chapter 10, Part 1: Guardianship – What are your views on what's proposed?

- **Need to address problems with current system** – The current Review and the preceding 2018 AWI consultation identified problems with the current Guardianship system, which had been noted by practitioners for some time. These included:
    - the issue where a Welfare Power of Attorney is not accepted, in current Scottish practice, as having powers to place a person against their currently stated wishes, leading to a need for guardianship application even if the powers granted by the adult included placement powers;
    - the lack of any form of emergency powers leading to either periods of lack of proper legal oversight or inappropriate use of MHA powers, and;
    - most significantly of all the lengthy delays between application for guardianship and orders being granted. This last is the most significant clinically, typically leading to delays of 6 to 10 months, during which times an individual can be 'trapped' in an inappropriate and at times detrimental placement, without any legal authority to move on to a more appropriate setting. Given the age-profile of the individuals concerned, this can often represent a significant proportion of their remaining lifespan. Any proposal which fails to address this central issue must be seen as a failure.
- **Timescales and judicial forum** – The described process is legalistic in focus than rather clinical. As such, the timescales being discussed are framed in legal timescales rather than clinical ones. While there is a need for proper scrutiny, due consideration must be given to immediate patient needs and the need to avoid lengthy period, where there is no oversight whatsoever. We suggest a clear route to resolve the acknowledged current difficulties is a move to statutorily defined and enforceable timescales and to move the judicial forum to the Tribunal. While we accept the issues with this that the Tribunal themselves have highlighted, our members believe that the Sheriff Court is a less appropriate place to consider these than the Tribunal and to deliver to a statutory timetable.
- **Proposals for 'graded guardianship'** – The idea of 'graded guardianship' has been much discussed over the last decade in Scotland. The proposals related to a series of roles 'below' full welfare guardianship, which could be accessed more quickly, via simplified process, where full guardianship was not required. The current proposals are for three tiers: 'full guardianship', powers of attorney, and a new 'supporter' role given a statutory basis. Whether the 'powers of attorney' role is of any additional value beyond currently will depend on whether any more clarity can be added to power of a PoA as regards placement issues. The supporter role is merely a codification of a role which is already a part of clinical practice. While its formalisation might aid recognition

and ease of involvement, our members did not feel that it would move any cases from the guardianship backlog.

- **Nomenclature** – It is not clear to us the reason for moving from the well-understood term ‘guardianship’ to ‘decision making representative’ when the function and powers are broadly the same. One motivation might well be the UN CRPD general comment 1: “substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment … must be abolished”. Since the substitute term would clearly be included in the meaning of this statement, it is not clear that the substitution is of any value. We propose that the well understood current terminology is retained.

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

- **Support its omission** – We believe the role of co-decision maker should not be reinserted into the proposals. While a potentially useful role in a narrow range of circumstances, there were insurmountable problems in the context of disagreement between the person and the co-decision maker. If the person’s views had primacy then the co-decision maker had no more powers than that of a supporter; if co-decision maker’s views have primacy, then they became a guardian without judicial process

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

○ Agree ● Disagree

- **Timescales and forum** – As stated above, the key issues are those of timescales and a forum working to clinical timescales but with the potential for adequate oversight. Without clarification of those in the proposals, there can be no confidence that current issues will be addressed.

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

- **Application in real cases** – The application model in appendix A in the context of a range of clinical situations would suggest a number of areas where the model does indeed seem to allow for ‘streamlining’ of an application. Firstly, a ‘pro forma application’, presumably describing a less bureaucratic process might bring some time benefits. Secondly, the scope for the Court to consider granting emergency powers might be of real benefit in allowing for judicial oversight of emergency interventions while then preceding to a full application on the same process – rather than duplication of effort. And thirdly, the ability to ‘upgrade’ a supporter or attorney would potentially also bring time-savings if information from the previous application could be used directly.

Unfortunately, there are a number of areas where the ‘streamlined’ process could still lead to lengthy delays. Firstly, the HRE/SDM/ADM process, if not provided in an emergency form in legislation and alongside specific guidance to this effect will provide a ’roadblock’ to intervention. Members reported frequent situations where a request for a clinician to provide a ‘formal capacity assessment’ appeared to provide an insuperable obstacle to further intervention and there was concern that the HRE process could provide a similar ‘pinch point’. More seriously, our members reflected the delays in the system were not so much about individual processes taking a long time but rather lengthy delays between processes: in allocating a social worker, in allocating an MHA, in delaying Local Authority intervention to allow a family member to be identified, in getting a court date. The lack of statutorily enforceable time scales and the lack of an immediately available judicial forum represented the reasons behind most of the reported delays and that unless these two issues are resolved in legislation, said delays would remain intractable.

- **Suggestions** – The need for statutorily enforceable time scales and a judicial forum available in good time is critical. Other ways of streamlining include a legally nominated a ‘point person’ who ‘drives’ the process of application. Secondly, factoring in the cost of delays to an individual, including in accessing appropriate care to challenge presumptions that a lengthy and thorough process is automatically considered of benefit.

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

○ Agree ● Disagree

Please explain

- **Need for ‘urgent’ as well as ‘emergency’ order** – Acknowledgement of the need for an emergency process to allow the delivery of essential care provided in a timely manner is welcome. However, even this process is ‘downstream’ from a judicial application, which is not completable within true clinical timescales in emergency situations. We suggest consideration of an initial order for use in urgent situations, which could be retrospectively reviewed as part of the emergency or full application.

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

● Agree ○ Disagree

Please explain

- **In line with principles –** A principle of the 2000 Act was that interventions be least restrictive on the adult's rights. In this context, an order allowing for a single intervention only, rather than for multiple interventions in an ongoing way could in some circumstances be most in line with these principles. This needs balanced by the lengthy and cumbersome guardianship process being no shorter or easier for intervention orders. Given the potential need for further interventions, there will remain a rationale to consider guardianship rather than intervention order.
- **Remains potentially useful and could be more so if process delays improved –** A non-recurring power authorising a single intervention is clearly in line with the 'least restrictive' principle. It is likely that if delays in the guardianship / intervention order process were addressed, it could be fully utilised. A 'time limited guardianship with a single authorised power' could also achieve the same purpose with less potential confusion

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

● Agree ○ Disagree

If so, will the model allow for this?

- **Single system for monetary interventions** – This is a potentially complex area: firstly, because personal finances now include electronic and online spending, and secondly, because appointeeships involve DWP interventions and are not currently devolved. We would support bringing all interventions in the affairs of an adult under a single devolved system with similar protections and scrutiny for all individuals regardless of their financial means

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

○ **Agree**○ Disagree

If so, will the model allow for this?

We would refer to our response to question 7.

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

Our members made no comment for this process.

Chapter 10: Adults with Incapacity proposals: Part 2 Power of Attorney

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

- **Unsure of significant issues** – Beyond issues around deprivation of liberty and timescales for appointment, we don't see issues with how PoAs conducted themselves under current guidance.
- **Deprivation of liberty** – The Review recommends: *"That clarity is offered on the powers of a welfare attorney to deprive a person of their liberty"*. Over the last decade, it has become accepted across the Sheriff Courts and the Local Authorities that a welfare PoA cannot exercise powers to place a person against their currently expressed wishes, even if they have lost capacity. This has had the result that guardianship has had to be sought to place such a person even if there is a PoA in existence. This is debatably not the intent of the original Act. We note that the in 'Continuing and welfare attorneys: code of practice' , at 2:19 it states that powers could include the power to: *"decide where you should live"*. We welcome clarity on this point, but wonder how it would survive the legal scepticism which has affected the current use of PoA powers in this situation.

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

- **Support across process** – Situations could be envisaged across the whole process of an attorney's existence. This would range from the period of seeing the need and looking into the process, through application, to the period when the adult lost capacity, and through the challenges of placement, perhaps against the adult's wishes. A form of support would seem to be required in all of them. Although overstretched, the Local Authority and then the MHO seemed the most likely place where an individual would look for help. Clear guidance available online and regularly updated seemed crucial as a backup to in-person advice.

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

- **Concern without clear proposal** – The Review notes concern about how to, and where to, report concerns with regarding an attorney. There are no clear proposals about how this is to change. The fragmented nature of the reporting structure seems the most obvious area for improvement, with a single reporting and oversight body a possible solution.
- **Misuse of powers** – A concern in the practical application of this is how the system would proceed if a PoA holder was found to have misused powers. This includes what sanction would be available and, if the sanction included removal of powers, how decisions about the adult would proceed from that point.

4. What are your thoughts on the investigations structure?

- **English system ineffective** – In developing any potential investigations system, colleagues in England reported to us the DoLS process they use is not seen as an effective solution in relation to investigations.

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

Our members did not offer a comment.

6. 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)?

- **Delays in appointing powers of attorney** – The timely appointment process which led to well qualified individuals having to wait months to be appointed is a concern. This leads to a delay in the realisation of a person's rights when they are becoming incapacitous.

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

Our members did not offer a comment.

Chapter 10: Adults with Incapacity proposals: Part 3 Medical Treatment and Research

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

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

- **Refinement of effective current process** – We agree with the Review's view that the current Part 5 of the 2000 Act *"provides a pragmatic and fair process to authorise medical treatment"*. Accordingly, minor clarifications and alignments are what is required. We are in broad agreement with this approach.
- **Priority needed for clarification of powers of force and detention** – The main deficiency in the current process is the lack of any powers to authorise and appropriately oversee use of force and detention. Currently, the use of force and detention is authorised under the 2000 Act but only when *"immediately necessary and only for so long as is necessary in the circumstances"*. This leads to significant ambiguities in the law with need for use of the 2003 Act EDC and STDO powers. Clarity in this area and intervention powers clearly stated in one statute is desirable.

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?

- **Importance of guidance or clarity in statute** – The current law allows for force and detention only when *"immediately necessary and only for so long as is necessary in the circumstances"*. There is the potential for considerable ambiguity and debate about the extent of common law emergency authorisation, what interventions involving force were permissible under the 2000 Act, and which required the use of the 2003 Act (in the absence of other alternatives available in clinical timescales). The need to resolve this issue via statute or guidance was a major concern for practitioners.
- **Reviews and scrutiny** – A key issue for any revised process is the availability of external review and scrutiny. A balance needs to be struck in this area between rapid access to powers (which might be required very urgently) and the need for meaningful scrutiny, which should include right of appeal.
- **Primarily responsible clinician** – We would advocate the retention of the principle within current AwI legislation that the primarily responsible clinician is charged with responsibility for the use of these provisions.

- **Resource needs to meet aspirations** – The implications of *Cheshire West* in relation to continuous supervision has made robust legislation in this area imperative. Alongside the development of appropriate law, there is a need to consider the clear resource implications of expanding oversight.

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

- **Support for current system** – We support the current system. It is hoped there will be significant improvements and innovations in treatments in the coming years and the process by which treatments are added to, and removed from, the list needed to be responsive. It should also be borne in mind that 'adults' under the 2000 act included those aged 16 and 17, who had special protections for certain interventions

3b. Please share your views on Transcranial Magnetic Stimulation (TMS) being added to the list of special treatments requiring additional safeguards in section 48.

- **Evidence base** – There have been concerns as to the evidence base for TMS. These would need to be fully scrutinised and considered further before being introduced as a special treatment.

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

○ Agree ○ **Disagree**

Please give details of the changes you think are needed

Members noted that the procedure was infrequently used but expressed no concerns about its operation in principle.

Chapter 11: Deprivation of Liberty

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

1. Please share your views on our proposals.

- **Recognise the deficiency in current law** – These proposals seek to address a long-acknowledged deficiency in Scottish law, of an individual being subject to ongoing oversight and not being free to leave. If they cannot consent (whether or not they apparently object), there must be a judicial process with right of review and appeal, in order for the deprivation of liberty to be lawful.
- **Progressive alignment** – As part of our 'progressive alignment' model, some lawful authorisation for deprivation of liberty must be subsumed within the revamped guardianship processes, with the same timescales as provided for under the Mental Health Act.
- **Concerns for separate proposal** – There are a number of concerns around the clinical application, practicality and potential lawfulness of this proposal, which would require consideration if working this proposal into useful law. These concerns include: the range of individuals potentially subject to such an order and the siting of the associated clinical responsibility; the judicial forum for oversight and the capacity of the judicial system to timeously process such orders; and the need to ensure that any new legal instrument really does fully address the current gap in legislation. We expand on these below.
- **Range of individuals subject to such an order** – While improvements in the use of Supported Decision Making will hopefully make it *"possible for more people to be considered able to consent to their living arrangements, even where they are subject to continuous supervision"* the proposals acknowledge that many people will still require a lawful process to authorise their care. Although necessary in law, these proposals will certainly expand hugely the numbers of persons dealt with under some kind of legal instrument.

  One part of the 'gateway test' for such an order would presumably be triggered by a deprivation of liberty to which the person could not consent. Our members sought clarity on the clinical test, analogous to the current incapacity test, which would be applied. While a key part would be the ADM test, continued consideration of and the specification of, the causative defined mental health condition, would remain crucial – both for clarity of the clinical basis of the order to the judicial body and as a way of allowing clear challenge to the basis for the order. It would be helpful to also have details on the application of what is proposed to mental health settings and on whether and how these orders would apply to children and young people.
- **Clinical responsibility** – The detailed proposals must clarify who would have authority and clinical responsibility to apply for such an order. Given the potential numbers of cases the proposals should address, the resulting

staffing and resource implications and avoiding the point of application for an order becoming an undesirable ‘bottleneck’ to care needs to be a priority.

- **Judicial body for scrutiny** – Our members suggested the MHTS would be the best forum for scrutinising these orders, given their experience and structure. In delivering this, the resource and capacity implications would need considered.
- **Need for clear timescales** – We would urge that both the ‘routine’ and the ‘urgent’ orders have clear statutory timescales, as already exist for orders under the 2003 Act. Lack of clear and enforceable timescales could lead to a continuation of potentially lengthy periods of unauthorised deprivations of liberty for some individuals.
- **Scrutiny for all orders** – The safeguards should be in place for all orders, regardless of perceived consent. This includes those in domestic settings, recognising the additional resources that would be required. The notion of universal safeguards is important to ensure equity under the law.
- **‘Perceived consent’** – The idea a person who cannot make an autonomous decision can nonetheless have their lack of objection construed as expressing a will and preference to remain in their current arrangements is concerning. We are instead in favour of the broad ‘acid test’ of deprivation of liberty set out in *Cheshire West* which includes non-coercive care and support but to which the person cannot consent, their lack of objection notwithstanding.

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

- **Use of and sequencing of urgent and standard orders** – The model as stated discusses standard orders first, giving the example of: *“a person in a care home is expressing a clear preference and significant will to leave the care home but the impact of their illness makes them unaware of the dangers of the main road outside”*. The proposed approach suggests use of application for standard order in this situation. However, there would clearly be a delay between the professional becoming aware of this situation and the application being made, and then a further delay between the application being made and the granting of any standard order. Our members questioned the authorisation for deprivation of liberty for this period.

  One option would be to allow for use of an urgent order to provide authorisation for this period. However, the urgent order as described notes: *“an application should be made to a court or tribunal”*. It therefore also would have a delay between its clinical necessity becoming apparent and the judicial authorisation becoming available. There will be a need to consider the authorisation for deprivation of liberty in urgent situation *before* judicial authority can be sought, and also consideration of how the two orders will lead into each other and what statutory timescales will apply. This will be necessary to avoid the situation, otherwise foreseeable, where the urgent authorisation expires before the standard order case has been heard.

- **Need for automatic review** – Both members and lived experience representatives recognised the potential usefulness of urgent orders in enabling more prompt care to be provided with deprivation of liberty, but with appropriate safeguards. Both groups are concerned about the potential for individuals without capacity, but who are unobjecting, to attract less scrutiny. There is a need for an automatic review of urgent cases even where there is no objection or appeal.
- **Who should make the application** – The individual making the urgent order should be the professional most involved in the situation and with most knowledge of the person and the risks. The range of professional groups who could lead on an order, and who might be involved to support and order, or to develop the rationale for such an order, will depend on the precise application mechanism developed. Medical doctors (including General Practitioners, Psychiatrists, Old Age Physicians, Advance Nurse Practitioners and others) would potentially be appropriate clinicians. Social Workers (including MHO or equivalent role) might appropriately have a leading role in making applications. Other groups might well also be practically legitimately involved, but we would suggest these groups should be members of a regulated professional body to ensure oversight.

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?

- **Automatic and timely review** – Any model should prioritise a standardised review process that does not require an individual to ‘trigger’ it. This would ensure the burden is not placed on the person receiving care and support to access a process to uphold their rights. A ‘real and accessible’ right to challenge the lawfulness of any order also requires statutory timescales for orders with review and hearings within prescribed periods.
- **Detail of appeals process** – The appeals process lacked sufficient detail, in particular around the provision of appeals processes and the criteria that would be drawn up for assessing which appeals could go forward. This would recognise that no such criteria would see bodies like the Tribunal quickly overwhelmed.
- **Protections applying across settings** – On safeguards more widely, the extensive protections provided under mental health law should be extended

to other settings, reflecting that mental health law offers best practice in many cases around scrutiny and review of care and access to advocacy.

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

- **Staffing, resources and availability of tribunal time** – The proposals relate to extending judicial protections to a group currently falling into a 'gap' in the law. This is welcome and overdue, but carries clear additional staffing and resource implications. In the absence of additional resources, specifically tied to the proposal, there is concern about diversion of resource from other vulnerable groups. The other major area of resource concern is the need for expansion of available court/tribunal time to enable timely reviews and authorisations to be carried out. The resource available to deliver appeals needed to be considered. The balance between ensuring the right to appeal is there and not overwhelming the system to the stage where none are processed in a timely manner is critical in the practical delivery of the proposals.

4b. What else may you wish to see included?

- **Children and young people** – There is a need to consider children and young people explicitly to make the proposals fully competent for all those who might be affected by them.

Chapter 12: Mental Disorder

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

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

● Agree ○ Disagree

why do you agree or disagree?

- **Of fundamental importance** – It is fundamentally important to retain a gateway to mental health and incapacity law which, as one component, includes reference to diagnostic criteria. Members made reference to a number of issues in support of this position including: the need to define the purpose of the law(s); the need for a diagnosis to access appropriate care; the role of diagnosis in establishing and guiding safeguards; the need to delineate exclusions under the law(s); the desirability of common understanding of scope of the law between clinicians, individuals affected by the law and legal bodies; the need for compliance with existing international jurisprudence; and the need for diagnostic consistency to enable valid international comparisons. We expand on these below.
- **Purpose of the law** – While legal reform should be ambitious in its aspirations, it should be clear in its scope. Mental health legislation should be explicitly directed to, and tailored for, overseeing the care and of, and optimising the rights of, those with conditions affecting their mental health or their capacity. This implies retaining the focus of the law by means of some form of diagnostic criteria.
- **Role of diagnosis –** Someone should not be subject to mental health legislation by virtue solely of having a diagnosis. It is the effects of the condition on a person's functioning, symptoms, decision making and needs which may or may not make legal frameworks necessary and appropriate. The use of a diagnostic component in the gateway allows clarity that these effects, for example the impairment of decision making capacity, relate to a defined mental health condition and therefore enables the utilisation of mental health legislation to provide care with sufficient safeguards and protections.
- **Diagnosis as a gateway to appropriate care** – In clinical settings, establishing and communicating a diagnosis allows for appropriate treatment planning, communication of prognosis, consideration of prophylactic interventions, as well as explanation to the patient and their carers as to the nature of their experiences. Clinical diagnosis can additionally act as a critical gateway to a person accessing appropriate care and support, given that such services are very often diagnosis-based. Conversely, failure to apply accurate diagnosis can lead to catastrophic misplacement, such as individuals with defined mental health conditions being inappropriately placed in the prison system.

- **Establishing and guiding safeguards** – As well as delineating the core purpose of the laws, diagnosis allows for the identification of those to whom the laws do, and do not, apply. This is felt to be imperative to ensure that legal powers are not mis-applied and that those subject to compulsory care and treatment under mental health law have access to appropriate safeguards, including challenging the diagnostic basis of, and proportionality of, their compulsory treatment.
- **Appropriate exclusions under the law** – Diagnostic categorisation defines, in a predictable and understandable way, those to whom the law applies. Equally important is clarity on those to whom the law *does not* apply. The current mental health law in Scotland includes, at s.328(2) seven exclusions to categorisation within 'mental disorder'. The first four of these (sexual orientation, sexual deviancy, transsexualism, and transvestism) have been removed from diagnostic categorisation, which we absolutely welcome. We believe the remaining three exclusions should remain under any future revision.

  The proposed remaining exclusions would be as follows: (1) "Dependence on, or use of, alcohol or drugs". It would be clinically inappropriate to make this category of 'disorders' subject to compulsory treatment as longer-term abstinence is contingent upon voluntary cooperation. (2) "Behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person". This should be retained to avoid inappropriately bringing criminal activities, without attendant mental disorder, under the purview of mental health law. (3) "Acting as no prudent person would act". This protects against the situation of people being subject to compulsion purely for making what others consider to be ill-judged or unwise decisions.
- **Common understanding and accountability** – A clear advantage of diagnostic classification in practice is that individuals affected by the law, their advocates and legal representatives, and the judicial bodies dealing with their cases, have access to common diagnostic classification systems. This means that clinicians who assert that a particular diagnosis is present can be asked to clarify the symptomatic basis for this assertion. Removal of a diagnostic test could render the law over-inclusive and ill-defined and reduce the accountability on clinicians in applying mental health legislation and reduce the burden of proof for the application of mental health law.
- **Consistency** – There must be consistency in terminology across different settings and statutes, including in the context of forensic settings.
- **International treaty compliance** – A key objective of the Review is to increase alignment between Scots law in this area and international treaty obligations, including Council of Europe and UN treaties. The consultation document notes that "ECHR caselaw (the Winterwerp ruling) has established that lawful psychiatric detention requires objective medical evidence of a true mental disorder"

- **International comparisons** – A key goal of our College is to advance effective treatment of those with defined mental health conditions. Scotland is very well placed to contribute to this worldwide effort with many world class universities, an enviable biotechnology sector, and robust data via Public Health Scotland. Medical research on 'mental disorder' requires common understanding of diagnostic groupings. Abandonment of international diagnostic classification in Scotland, at least for legal purposes, risks diminishing Scotland's role in the international effort to understand and more effectively provide treatment for defined mental health conditions.

1b. If you agree, please share your thoughts on what that gateway should be

- **Impaired decision-making as a result of a specified condition** – Our members are broadly supportive of a gateway test based on the suggested Autonomous Decision Making (ADM) test which would explicitly retain consideration of specified defined mental health conditions. These conditions would not be the starting point for interventions, but, as stated in the ADM test outline, would be "important in determining the nature of support and interventions that are required" and would be considered as a factor which could "impact on the authenticity, or voluntariness, of their decision-making".
- **Retaining current range of conditions** – The current conditions considered as 'mental disorder' under Scots law, including personality disorder, learning disability and autism, should remain under the mental health legislation. While recognising the recommendations of the Rome Review, we believe removing people with learning disabilities will adversely impact their access to care and support and lead to inadvertent harm. Examples of removing people with learning disabilities from mental health legislation include New Zealand. Evidence suggests removal led to higher rates of imprisonment and a decline in specialist clinical skills. This has since led to retrospective legislation that, in many aspects, is less rights-based than what was in place previously. Our view is that the legislation should be designed to be applicable across a range of defined mental health conditions, and that excluding any specific diagnosis leads to poorer outcomes.

1c. What terminology should we use?

- **Addressing stigma is wider issue than change of terminology** – A key goal for our College is reduction and elimination of stigma experienced by those with defined mental health conditions. While we understand the motivation behind changing the terms used, our members expressed concern that stigma is related to wider issues then simply terminology, and that changing terminology without addressing these issues risked a "euphemism treadmill". Members also noted how other conditions such as epilepsy and HIV were once associated with much higher rates of stigma, but which reduced as these conditions have become better understood, and better treatments have become available. Whose with these conditions are now more integrated with society, and this occurred without changing the name of the conditions or moving away from the principle of these being a diagnosable condition.

- **Destigmatising recognised as critical** – While changing language alone does not in itself remove stigma, our members support the need to move to a term or set of terms which enjoy widespread acceptance.
- **Suggestion of: ‘defined mental health condition’** – Our suggestion for an alternative term in mental health law in place of ‘mental disorder’ is ‘*defined mental health condition*’. We believe retention of ‘mental health’ is crucial for clarity and specificity. We believe that the term ‘condition’ is more neutral than the alternatives such as ‘illness’, ‘disorder’, or ‘disability’, while being specific enough to be clinically viable. We think that the adjective ‘defined’ is important in order to make clear that the conditions potentially subject to legal intervention are not arbitrarily chosen but relate to accepted clinical practice and to potential statutory exclusions. We suggest that the UN World Health Organisation’s International Classification of Diseases 11 (ICD-11) would be a suitable basis for the definitions of defined mental health conditions.

Chapter 13: Fusion or alignment?

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

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?

○ Agree ● Disagree

Please provide an explanation for your answer

- **Clear theoretical advantages of single statute** – We can see clear benefits to fusion of mental health and incapacity law in principle. The concept of a fusion law, including a singular test, set of criteria for interventions, set of principles, and set of interventions and safeguards is attractive. This could enable non-discrimination and equal protection for all groups subject to intervention under the law. It could also avoid the problem inherent in separate pieces of legislation containing similar interventions. Where the protections are the same for the intervention, there is needless duplication and complexity, while where they are different, there is hard-to-justify discrimination. A single statute would also allow for greater clarity both for those treated under the act and those professionals and groups using the act.
- **Problems of fusion approach** – Alongside the recognition of the clear potential advantages of fusion, our members expressed a number of practical concerns about the scope, drafting, and operation of such a single act. In particular, concerns were raised about whether the scope of a single act would include those under 16 years; whether a single test involving capacity could be applicable to those in forensic settings; and whether a single act involving both mental health and incapacity would come to be seen (inappropriately) as primarily a matter for clinicians based in psychiatry. We expand on these in the paragraphs below.
- **Children and young people** – Current incapacity law in Scotland is applicable to those 16 years and over and presumes capacity as a starting point. For this reason, those framing any fusion legislation would need to give careful consideration to whether and how it would be applied to those under the age of 16. The issues around a presumed lack of capacity and parental consent mean children and young people could not access these protections under fused legislation as it stands. Individuals in this age range can present with severe defined mental health conditions, and require the protections provided within current mental health legislation, with any amended legislation ideally building on these. This would also be required by our responsibilities under UNCRC. In Northern Ireland, where fusion law is already on the statute book, the full enactment of the Mental Capacity (Northern Ireland) Act 2016, will

potentially apply the new procedures and protections to adult patients, while continuing to apply the outdated Mental Health (Northern Ireland) Order 1986 to children.

- **Universalism over fusion** – Our members strongly advocated the principle of the universal application of mental health law across the lifespan, including children and young people, as a foundational test for any proposals around fusing metal health legislation – expressing a preference for ’universalism ahead of fusion’.
- **Forensic patients** – Current mental health law in Scotland is applicable to those in forensic settings. In these cases, there is modification of the criteria to omit the ‘significantly impairment decision-making ability’ (SIDMA) criterion. For this reason, those framing fusion legislation would need to explicitly consider the coverage of forensic patients and whether any modification of the single test was required in such cases.
- **Clinical responsibility** – In current incapacity law in Scotland, authority for medical treatment is given to “the medical practitioner primarily responsible for the medical treatment of the adult”, or to a member of other professional groups, where they satisfy “such requirements as may be so prescribed and who is primarily responsible for medical treatment of the kind in question”. Our members expressed concerns that, unless carefully managed in legalisation and associated guidance and codes of practice, a fused law, and in particular a fused entry test, could come to be seen (inappropriately) as primarily a matter for clinicians based in psychiatry, creating an unwelcome ‘pinch point’ for individuals accessing care waiting on a specific profession to conduct such an assessment.
- **Learning from experience elsewhere** – Similar legislative reform has been, or is being considered, by the other two jurisdictions within the United Kingdom. We would urge that the Review pay cognisance to the tests for implementing fused mental health and capacity legislation proposed in ‘Modernising the Mental Health Act: Increasing choice, reducing compulsion: Final report of the Independent Review of the Mental Health Act 1983’ (the Wessely Review) at page 222 - Future Direction Of Travel – Fusion Of The MHA And MCA. We would also suggest close consideration of experiences in Northern Ireland. Our discussions with colleagues there have highlighted difficulties which have been seen in delivering a fused mental health legislation. Additional bureaucracy with limited additional benefits in delivering rights, and prior legislation from 1986 continuing to apply to children and young people, creates a double standard in safeguards.
- **An eventual destination** – Our ‘disagree’ in this response section is to the question of fusion being the ‘best way forward’ with the Review proposals as currently formulated. Recognising there are fundamental issues that need addressed, in particular around universalism, we believe fusion is a positive destination to which we should eventually aspire.

1b. Do you consider that 2 or 3 pieces of law would be preferred, each dealing with specific issues across mental health, incapacity and adult protection law.

Please let us know why

- **Universalism ahead of fusion** – As stated above, our members' clear preference was for a reformed mental health law applicable across the age range, ahead of fusion of mental health and incapacity law for adults, and ahead of fusion of both with adult protection law.

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

Please let us know why

- **Support as most pragmatic way forward** – The option with the strongest current support among our membership is for close as possible alignment between mental health and incapacity law, while retaining children within the scope of mental health law. This would allow many of the theoretical benefits of fusion to be attained with fewer attendant complexities and risks.
- **Issues with 'gateway test'** – An implication of close alignment of mental health and incapacity law, even without outright fusion, is having a single 'gateway test' of decision-making, such as the proposed ADM test in the review consultation. This means children and young people with incapacity due to physical immaturity would need careful consideration as to the required modification of the 'gateway test'. Our members suggested consideration of an age-triggered omission of the presumption of capacity and alignment at that point with s.2(4) of the Age of Legal Capacity (Scotland) Act 1991.
- **Additional consideration of UNCRC** – Our members with specialist experience in the care of children and young people urge that, ahead of future work on legislation, there be careful examination of the interaction of the UNCRC and the UNCRPD, and how the requirements of the former would be delivered through aligned mental health law.
- **Potential complexity of statute** – A potential benefit of fusion would be that test, intervention, and safeguards are described in a single statute to which professionals and individuals can refer. Alignment, while desirable in some ways, carried the risk of producing a third amending statute, amending the two existing statutes in complex ways. If considering the process of alignment it is critical that the new legislation achieves its aims in a clear and understandable manner.

2b. Which aspects of the law should be aligned and which should be left within standalone law?

- **Acts suitable for alignment** – Current mental health and incapacity law (the 2000 Act and the 2003 Act) would benefit most from alignment – and in particular by alignment of their gateway tests, deprivation of liberty interventions, and judicial forum. The 2007 Act has a much wider ‘gateway test’ and applicability and is to best sit as a standalone law.

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

● Yes ○ No

If you answered with 'yes', please let us know more by answering the following questions.

	Agree	Disagree
Should that forum be the sheriff court?	○	●
Should that forum be a tribunal?	●	○
Should there be a single forum only in the event of fused legislation?	○	●
Is a single forum your preferred way forward regardless of wider changes to the legislation	●	○

	Agree	**Disagree**
If you consider aligned legislation is preferred, should a single judicial forum be part of that alignment?	●	○

Please share any reasons for your answers

- **Tribunal as single judicial forum for aligned legislation** – The College is supportive of an expanded remit for the current Mental Health Tribunal for Scotland to deal with all mental health, incapacity, and potentially adult protection cases. Members believed that the Tribunal was the main judicial repository around these matters and contained the most expertise around how best to properly engage and support individuals going through these procedures. Members noted that subsequent resource and staffing to the Tribunal to meet this additional demand would be essential.
- **Need for legislation to support rapid access to judicial review** – The rapid access to judicial review for CTO applications under the Tribunal has been a welcome development, especially when compared to the slower pace of review in the Sheriff Court. Some of this rapid access, though, flows from time limits for review specified in the 2003 Act, rather than being specific to the Tribunal as such.