

The Royal College of Psychiatrists in Scotland Response to the Independent Review of Learning Disability and Autism in the Mental Health Act: Stage 3

Initial Comments

The Royal College of Psychiatrists in Scotland welcomes the work that the Independent Review team has conducted in this area over the last year. Like the Review team, the College wants to ensure that those with Intellectual Disabilities (ID) and Autism receive the best care and services possible in Scotland and that legislation upholds human rights and provide safeguards in terms of access to appropriate services and protection of vulnerable groups. The College recognises that the Review and its recommendations to that extent are human rights focused, however we are gravely concerned that this particular interpretation of the requirement under UNCRPD will have serious unintended consequences which will undermine the very human rights we are all committed to deliver. Before the recommendations are given to the Scottish Government, the College would like to share its concerns and offer alternative solutions which we hope even at this late stage the Review team will consider. We would be grateful if all of our concerns and alternative suggestions are addressed in the final report to Government.

Overarching concerns:

Having examined the Review recommendations document for Stage 3, the College has grave concerns regarding how the recommendations would adversely affect the care and treatment of vulnerable adults and undermine their human rights.

Of particular concern to the College membership is the perceived lack of consultation around the development of the recommendations. The Review has heard from some of those with lived experience, mental health groups and professionals over the last year, however, the input that these groups - or from the Review's subgroups - have had into the development of recommendations appears to have been very limited. An example of this is the recommendation regarding a new role for Multi-Agency Public Protection Arrangements (MAPPA) mentioned in the recommendation paper (p.94). It is our understanding that MAPPA were unaware of the Review and have not been contacted by the Review team regarding the suggestion that non-clinical professionals might assess risk, until the College highlighted this comment to them. We are also unaware of any consultation with the Risk Management Authority. Until we reached out to them, the GMC were also unaware of the Review and the fundamental changes proposed on the approach to consent to treatment.

We welcome that the Review worked to include people with lived experience views on this topic. However, the College has concerns that the accessible wording used for the Stage 3 easy read document may have unintendedly created bias toward particular outcomes, and there appears to be a marked lack of critical analysis / counter-argument to the recommendations, either on the website or in the recommendation report. The way the statements are framed made certain concepts and interpretations of UNCRPD hard to challenge and thus missed much of the detail and nuance required for a considered consultation. This lack of accessible balanced information could fundamentally affect responses and undermines the contribution of those with lived experience. We are also concerned that by the very nature of their condition, the most vulnerable and the most in need of legal protections were unfortunately unable to take part, which once again undermines the validity of the report to produce balanced recommendations. Special strategies would have been needed to appreciate the lived experience of this group of individuals.

The Review contains a number of statements throughout that appear not to be substantiated by critical analysis of the evidence. These were of particular concern when they appeared to be dismissive of the protections existing in current practice and legal frameworks. There is a general lack of critical analysis of existing practice and legislative arrangements. We will highlight examples in our response to the Stage 3 Sections (below). Without this evidence, it is hard to argue that these statements have taken due consideration of the current system and appropriately considered its strengths and weaknesses. On a similar note, the Review recommendations do not address certain topics that are necessary to appreciate the current landscape of provisions and services in place for those with ID and Autism. There is no discussion within the review on the current shortages of ID psychiatrists, nor on the anticipated impact that the recommended changes could have on carers or on victims of offences committed by individuals with ID or Autism. The protocol for risk management, and the impact on those with dual diagnosis, or those with substance misuse concerns have also not been highlighted in the Review, and their respective requirements are left unevaluated.

An average of thirty people with a single diagnosis of ID are detained each year in Scotland ¹. The recommendations proposed, if implemented, would have implications for all mental health and wider decision-making processes for adults. The proposals fundamentally undermine the concept of informed consent for all medical treatment, the validity of the Adults with Incapacity (Scotland) Act 2000 (AWI), the safeguards contained within the Adult Support and Protection Scotland Act 2007, the definitions and protections in Disability Discrimination Legislation, protections in the Criminal Justice and Licencing Scotland Act 2010, and all civil contract law. The ability to vote, to marry, to consent to sexual activity, all would be subject to change. An impact assessment of how these recommendations would impact these major areas must be conducted before the implementation of such recommendations can be considered. As the

¹ Mental Welfare Commission for Scotland, [MHA Monitoring Report 2018-19](#), 2019, P.30.

report itself acknowledges in its conclusion on p.150, there could be a rise in suicides and imprisonment if these proposals were adopted.

The College supports the fundamental importance of human rights for individuals that the Review proposes. However, the Review needs to critically appraise what human rights processes are currently in place within legislation. Frontline clinicians, including psychiatrists, are aware of the need to comply with existing human rights legislation - including in emergency situations - as it is core to training, professional guidelines and standards of practice. We would also suggest that the human rights of other groups such as carers or victims of offences committed by individuals with ID or Autism be recognised as part of the Review's conclusions and should be considered for the population as a whole. Should the Scott Review also consider a human rights approach for its review, the College will advocate that human rights should be inclusive for all.

The recommendation report appears to offer no clearly defined answers in regard to what would happen next and the impact these recommendations could have. We recognise that this is work for Scottish Government to analyse should they consider the recommendations, but the Review team must make this a clause of their recommendations for the sake of accountability and transparency. Similar analysis should also be conducted on what alternatives to the recommendations could be, for those same reasons.

The recommendation to move the Responsible Medical Officer (RMO) role to a wider responsible clinician role including psychologists is not supported by the College. There is no substantial evidence that this approach has benefited patients in England. The College does support psychologists having a greater role within the Mental Health Tribunal for Scotland (MHTS) system, such as a statutory duty (in cases where psychological treatment is the main component of the patient's care) for a responsible psychologist to be appointed and a requirement for them to submit up-to-date evidence and appear before MHTS. We do not support taking away the protection of Psychiatrists as RMOs.

Legal and clinical constructs of capacity:

Throughout the report the Review introduces and makes use of the terms "legal capacity" and "mental capacity", as used in the UNCRPD. However, the term "legal capacity" is not used in Scots Law or clinical practice in the same way. "Legal capacity" in Scots law is with regard to decision-making capability. The Review's use of the term "mental capacity" is similar to the Scottish Law concept of "legal capacity". "Mental capacity" to our knowledge does not appear as a term anywhere else in Scots Law. Scots Law uses the term "Adults with Incapacity". In the clinical context, the medicolegal construct of capacity is decision specific not global. We would ask that the Review team adds to their recommendations a glossary of terms to define how the Review uses these terms and avoid confusion.

UNCRPD:

We recognise the ambition and reasoning behind the Review team’s initial choice in taking a particular interpretation of the UNCRPD. However, the College has concerns that this is not the best way to implement UNCRPD concepts, demonstrated by the fact that no other legislative area has been able to find a practical way to implement a purist interpretation. The UN model, given that it must suit the wide variations in worldwide health services, is not nuanced to the situation in Scotland. The Independent Review of the Mental Health Act, led by Professor Simon Wessely, has shared this view that the UNCRPD as an entity is not compatible with health systems².

One example of difficulty in interpreting UNCRPD is the position which the UNCRPD takes against substitute decision making and a preference for supported decision-making process instead³. We note the Review accepts this view that everyone has capacity and that substitute decision making should be abolished. In a Scottish setting this is very problematic when it comes to what are known as hard cases, as capacity is decision-specific, and is assessed on this basis (rather than an individual having capacity or not). While the UN convention does discuss hard cases as a potential workaround for issues, we note that the alternative suggested is very similar to the substitute model, which then makes the change to supportive model redundant. In this area the UNCRPD would appear to be somewhat inconsistent in its approach which leads to considerable confusion and needs to be critically examined by the Review: it is inconsistent to make a blanket ban on substitute decision making when in essence, substitute decision making appears to be advocated by UNCRPD in cases identified as “hard cases. The College would suggest that the majority of those in most need of the legal protections provided by the current legislation undermined by the proposals are “hard cases”.

The UNCRPD, as applied by the review, also conflicts with the fundamental principle of informed consent that universally underpins the practice of medicine within Scotland.

As we will highlight in our response to Section 2, the use of the UNCRPD in its purist form and in particular the removal of LD and Autism from the legal definition of ‘Mental Disorder’ will lead to significant issues with wider Scottish legislation. One such piece of legislation is the Not Guilty by Reason of Mental Disorder provision, which would no longer be applicable and would inevitably increase the number of ID and autistic persons in Prison. This concern towards wider legislation has been practically demonstrated through New Zealand’s own review⁴.

The College would also like to highlight a concern regarding the tone of the report, which frequently comes across as anti-health service, anti-doctor, and anti-psychiatry. The College accepts that this may not have been the intention of the Review team, and it may be that the

² Independent Review of the Mental Health Act, [Modernising the Mental Health Act](#), 2018.

³ United Nations, [Convention on the rights of Persons with Disabilities](#), 2008.

⁴ McCarthy, J, & Duff, M., [Services for adults with intellectual disability in Aotearoa New Zealand](#), British Journal of Psychiatry International, 2018:16(3), 71-73.

tone in the review's report is derived from the UNCRPD approach against using a particular interpretation of the medical model. It is unfortunate however that the report appears to overlook that the Scottish model is one which is progressive, embraces the best of multi-professional working, listens to lived experience, embraces the principles of 'realistic medicine, and has the principles of medical ethics, GMC guidance and ECHR at its core. Both the AWI and Mental Health Care and Treatment Scotland Act 2003 (MHA) are ECHR compliant; a human rights framework is already in existence to protect individuals using services. It would have been useful for the team to critically appraise the success of the section 1 principles of the MHA. What are the non-compliance aspects of human rights the Review is concerned about and where is the evidence to demonstrate this?

The concept that all people have legal agency with support, while commendable, is unfortunately unworkable for many. Our members work with people who have no communication skills whatsoever or those who are unable to take in sufficient information as to be able to be considered to have been adequately informed to make a decision. This would leave any medical professional in a difficult position as to how they could consider that a person can consent to something if they cannot be considered as having met the good practice guidance regarding informed consent, which is current practice. Patient and carer participation is clearly established in the current MHA and AWI legislation and there is a statutory duty within both Acts to promote decision making ability and to take full account of any current or previously expressed wishes of the adult. These processes and principles should continue to be built upon. We note that the recommendations have insufficient discussion regarding how the AWI and Adult Support and Protection Acts will be affected by the proposed changes.

Our members' experience with the AWI act is that it is regularly used to ensure the health and wellbeing of a group of individuals who are unable to safeguard themselves, and the removal of the legislative powers underpinning the multi-disciplinary care and treatment provided to this group would be of great concern. Indeed, individuals who are under Welfare Guardianship currently are more likely to have a range of supports, as there is far greater professional involvement and oversight in comparison to that which is proposed by the Review. The safeguards that are currently in place for those with ID and Autism must be appraised, should the Review wish to obtain a true understanding of the positives and negatives of the current system.

Proposed separate structures provisions for people who have ID and Autism:

From the evidence provided and through the experience of working with those who have ID and Autism in a Mental Health environment, the College does not believe that a valid case has been made for ID and Autism to be dealt with differently from other conditions. Instead we believe that everyone in Scotland should have appropriate and timely interventions for their mental health conditions.

Section 1 - What Scotland needs to do

Having reviewed the recommendations put forward by the Review, the College does not believe that a sufficient case has been made for individuals with Autism and ID to be treated under separate provisions from those provided by the Mental Health Act (MHA) and other supporting legislation.

With regards to the proposed incorporation of UNCRPD within the recommendations, we note that there has been no critical appraisal or recognition of the variations in how the UNCRPD is viewed when proposing to be added to legislation⁵. The College would seek clarity on why the Review wishes to change the law to comply with UNCRPD, when it is legally non-binding. It should be noted that no nation state has managed to implement the UNCRPD in its full provisions. Does the Review see this change as fixing gaps within the current provisions or do they believe a system-wide overhaul is required? The College cannot see how the Review team could seek to accomplish this without any critical assessment of current provisions being conducted. It would therefore be beneficial to understand how the Review team envisages this.

It is our belief that the Review 's report has failed to provide a critical assessment of the current system or of why current provisions need to change; this absence of the overall picture thereby denying readers the opportunity to make an informed decision when responding to the recommendations. The College is concerned by the absence of recognition for the fact that there has been a human rights framework in place since 1990, which underpins all existing mental health legislation. Furthermore, there is a lack of recognition of the existing checks and balances of the system, which is vital to understanding the current system and its positives and negatives.

We believe that a better approach would be to consider how to take the better aspects of the UNCRPD and apply them to Scottish legislation, and we welcome the opportunity that the Scott Review provides to look towards fusion legislation, which could aspire to produce a stronger ethical basis than current legislation. A useful study of this approach can be found in Scholten and Gather's paper on the adverse consequences of article 12 of the UNCRPD⁶.

Section 2 - How we understand autism, learning disability and mental health

The College was concerned by the absence of recognition or appraisal of the current human rights culture within the mental health framework, which is based on the European Convention

⁵ Scholten M, & Gather J., [Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward](#), Journal of Medical Ethics 2018:44, 226-233.

⁶ Scholten M, & Gather J., [Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward](#), Journal of Medical Ethics 2018:44, 226-233.

of Human Rights (ECHR). On p.17 of the Stage 3 consultation document, it is suggested that current provisions for those with ID and Autism do not recognise ECHR standards. We feel it is pertinent to reassure the Review that this is not the case, and provisions are currently in place to support the human rights of individuals receiving treatment. Frontline clinicians are well aware of the need to comply with existing human rights legislation, which is core to all training, professional guidelines and standards of practice.

When considering any changes to terminology, it is important to consider the wider repercussions across all legislation and the risk of a diminution of rights. As an example, should individuals with ID or autism no longer be categorised within the term mental disorder, they would lose the protections of Not Guilty by Reason of Mental Disorder and Capacity to Participate in a Trial, both of which exist to provide much needed protections for vulnerable people. Furthermore, mental disorder as considered within the existing legislative framework is a necessarily diverse group that includes a wide range of disparate conditions, disorders and illnesses, and recognises that any person in the population may need specialist provision of care and treatment at times when they are suffering from a range of ill health that impacts on their ability to keep themselves safe. This would be another safeguard which would be lost should this group be removed from the protections of the act, which would be discriminatory towards such individuals. We have significant concerns that these recommendations, whilst undeniably well-meaning, may have the unintended consequence of make vulnerable people more vulnerable. The real-world consequences of similar legislative change in New Zealand has demonstrated this⁷, and we would draw attention to the following: *“Once the patient no longer required management as a special patient, no legal framework existed to offer ongoing compulsory supervision in the community”*.

We also wish to note that the Review’s suggestion that medicine offers no cure is not in line with current thinking regarding the modern recovery model used for those with ID and Autism. Across medicine, for example in patients with advanced malignancy, the concept of ‘cure’ has shifted to one of maximising function and potential. We believe the Review should consider the recovery model before making any conclusions.

Our concerns regarding the definition and usage of capacity have been raised at the beginning of our submission, however, it is relevant to note this once again, as the issues raised have caused some confusion throughout the report and if implemented, would involve a wholesale overhaul of the medicolegal system in Scotland and an entirely new legal framework across medicine.

⁷ McCarthy, J, & Duff, M., [Services for adults with intellectual disability in Aotearoa New Zealand](#), British Journal of Psychiatry International, 2018:16(3), 71-73.

Section 3 - Support for decision making

The UNCRPD purist interpretation suggests that everyone should be equal and treated as such. The College agrees whole-heartily with the statement that '*Scotland has to make sure that the rights, will and preferences of autistic people and people with learning disability are respected at all times*'. This requirement to protect and respect the rights and wills of the individual is already enshrined under the Equalities Act 2010.

As referenced in Section 1, Scholten & Gather's paper outlines six significant issues arising from article 12 of the UNCRPD. Of particular concern is the potential for misconduct and mistreatment of vulnerable people, should the existing tried and tested safeguards be replaced with an inadequate alternative. The College finds this of considerable concern, as the recommendations made do not appear to have any basis on an evaluation of the strengths and weaknesses of the existing safeguards, which have been developed over time to provide an exhaustive protective framework for the most vulnerable.

Furthermore, we note that the Review offers no appraisal of T2 and T3 provisions for psychotropic medication, despite citing concerns regarding the usage of psychotropic medication for patients with ID. Medical treatment is diverse and there is good clinical evidence that psychotropic medication is of benefit to people with ID who present dual diagnosis or complex issues. This relates to the fact that people with neurodevelopmental disorders are at greater risk of mental illness. There are no existing studies of the subject in Scotland, the Review refers to the English equivalent. The College would welcome a review of the situation in Scotland; where better social supports are in place. There may be incidences where psychotropic medication would not be required, however without this support available, the absence of such medication would likely cause greater distress.

The College recognises the vital role that independent advocates have in relation to the MHA. However, the suggestion on p.27 of the recommendations that an independent and non-instructed advocate would have to authorise medical treatment on a compulsory order, is deeply concerning. This recommendation would result in substitute decision-making being made by someone with less knowledge of the situation or the individual. Community Treatment Orders afford patients and carers the provision for regular statutory reviews of treatment and in addition the opportunity to appeal. Patients, carers, curators and lawyers have access to non-means tested legal representation which includes the option for an independent psychiatric report, which includes independent reports. The tribunal system includes the independent review by a panel consisting of legal, psychiatric and general members. This provides extensive input from clinical and legal practitioners who have a level of training, continuous professional development and knowledge of the case which enables full scrutiny of treatment. The current system is therefore independent, has checks and balances, and a high level of oversight. Adopting the Review's recommendation would require considerable up-skilling and increase in number of advocates and will likely result in confusion regarding the role. At present the independent advocate is neutral, conveying the person's views to the clinical team. Should this

recommendation be implemented, the neutrality of the advocate would be lost and impact negatively towards the patient's care. This recommendation also increases the chances of harm towards the individual and takes power away from a family member or someone known well to the individual. Both of these consequences will likely subject the individual to additional distress.

With regard to the current Best Interest approach, carers and professionals should not feel alienated from the conversation and a balance of best care and inclusion in conversation is required for the sake of the individual. Unpaid carers should always be involved in decision making unless the individual concerned has asked for them not to be included and has the capacity to do so. It is not clear to the College why the Review believes the best interest model is not working, and what evidence this is based on.

We welcome the Review's positive comments regarding the Millan Report, p.88 of the Review paper, and how the report is still relevant to the Scottish mental health sector⁸. The College would also welcome a review into current provisions of residual capacity, another area which does not appear to have been critically assessed to examine for improvements.

Section 4 - Support, care and treatment

With regard to support, care and treatment rights, the Review has shown particular interest in some groups, especially women, children and offenders. At present in Scotland there is a national lack of child and adolescent specialist services for those with autism and ID, and some evidence locally that young people with autism and ID are not accessing these services in the numbers that would be expected given the high levels of mental illness and co-morbidity. This means longer periods of morbidity, potentially higher mortality and people transitioning to adult services without having been able to access the appropriate assessment and treatment services and without adequate future planning - leading to further mental ill health and morbidity. We strongly agree with the Review's statement that it is never acceptable for people with an ID or Autism to be rejected from support, care or treatment because they have ID or Autism; this is already illegal under the Equality Act. It is important to note here that in order to address the issues noted above, support to tackle the current shortages of ID and CAMHS psychiatrists must be given priority by Scottish Government.

The College also agrees with the Review's position that patients should not be trapped for years in the hospital system. We suggest that the current statutory appeal mechanism to a tribunal for patients detained in hospital who could be in the community (the revocation of a hospital compulsory treatment order, which can result in a community order) should be strengthened. We also support the Review's recommendation that Tribunals should have a statutory right to act and would recommend they have the ability to place statutory duties on local authorities to

⁸ Millan, B., [Review of the Mental Health \(Scotland\) Act 1984](#), SE/2001/56, 2001.

provide and fund suitable provision in the community would address current failings in this area. We believe that patients deserve better than the current system can provide, and we hope to work closely with the Scott Review on entrapped patients in order to address this matter.

Section 5 - Where support, care and treatment happens

The Review's recommendations regarding a move away from a hospital model and toward secure social care services in the community are of some concern and appear to once again demonstrate an anti-medical bias without providing adequate evidence for why it believes this to be the case. At present there are protective legislation and regulations which dictate exactly what a hospital is and provides; no such provisions exist for community-based secure centres. The Review does not appear to have considered the governance nor the regulatory protections the community secure centres would need to have in order to operate safely.

Furthermore, social care services do not have the skills or experience to support individuals with autism and ID when they are at their most unwell, and any legislation that considers the needs of people with autism and learning disability as different from the general population will only act to discriminate against such groups and prevent their access to specialist services when they are most needed.

Putting people in secure settings risks a situation where they may be victims of others in that setting. Established health approach, governance and trauma informed care helps minimise this in the existing hospital-based setting. There is no mention of how this would operate in community services. Furthermore, the Review fails to consider those with dual diagnosis and the impact the recommendations would have on their care and treatment. Our members often work with individuals with ID or Autism who require additional treatment for other diagnoses such as personality disorder, psychosis and dementia. It is unclear where such individuals would fall in the proposed new system. The College does agree that a new model for inpatient services should be considered, as the inflexibility of current arrangements can cause stress for some individuals. We would welcome the opportunity to support this work.

For emergency admissions, the College believes that there should be sufficient access to ID services for all who require it. Provisions should be put in place to ensure adequate services are available, to avoid situations of individuals with ID or Autism having to be admitted to general adult beds, due to a lack of availability of suitable ID beds. This is a regular issue within mental health services and the College believes better reporting should be put in place to identify and address the problem.

We are greatly concerned by the comments made on p.72, that *'there may be some autistic people or people with learning disability who prefer to use general mental health services, with adaptations, and based on informed choice'*. This suggests the removal of the requirement for

ID specialists - instead offering more general services - and appears to lack understanding of the extremely specialised, skilled and important role such specialists have in supporting the most vulnerable, particularly in times of crisis. We would suggest that the Review instead calls upon Scottish Government to increase the number of ID psychiatry training places at core and specialty trainee levels, thus allowing consultant expansion, to ensure that there are enough consultants to give individuals the best support, care and treatment possible. We also call for an increase in ID beds to meet demand.

It should be noted that in some situations, seclusion should be considered a medical treatment when appropriately prescribed and overseen, offering clear benefits and being of preference for some individuals when compared to alternatives such as the use of medication or restraint. The Mental Welfare Commission Guidance on Restrictive Interventions, which informs best practice, is to be published shortly. We would ask the Review team to clarify in their recommendations the evidence they have on the overuse of compulsory treatment and care in hospitals. There are current provisions in place to ensure this does not happen, through the oversight that both the Mental Health Tribunal and the Mental Welfare Commission provide.

Section 6 - How professionals make decisions

When discussing Section 1 principles, the Review has used introduced the term “unsound mind”. Whilst this term has been used within the ECHR, it is not generally recognised in Scotland nor is one which we would wish to use, due to the negative connotations attached.

P.94 of the recommendations suggests that a non-clinical professional should do risk assessments rather than a psychiatrist or psychologist. Adopting this recommendation would require considerable up skilling of non-clinical professionals in how to deal with such cases and raises the questions of where accountability would lie for adverse outcomes and what regulatory body would oversee these professionals and decisions. Furthermore, it does not address the current risk assessment model utilised by clinicians which is entwined with all aspects of the person’s care; a complex approach integral to clinical professionals’ many years of training. Furthermore, it would mean that individuals with ID and Autism be separated from all other assessment procedures (how would this impact those with dual diagnosis?). The Review makes no reference to how risk would be managed in this new system or by whom. The model used in the United States of America separates the risk assessment from the treating clinician, but it is important to note that it is still a clinician who provides the assessment.

Section 7 - How decisions are monitored

As highlighted in our answers to sections 1, 2 and 6, we believe that there is no recognition or appraisal of the current provisions regarding human rights for those with ID and Autism and this absence has a significantly detrimental impact on the recommendations.

We note that the Mental Welfare Commission may also have concerns regarding the ramifications of this recommendation, which would drastically change the Commission's remit to the equivalent of the Care Quality Commission and Health Improvement Scotland. We would suggest instead that mechanisms to ensure consideration of Section 1 principles should be strengthened with explicit inclusion of them when considering detentions under the MHA. This could be done by including them in proforma documentation and requiring tribunals to review the principles and comment upon them in judgements. There should be a strengthening of recorded matters and a mechanism whereby tribunals can refer any significant concerns to the Commission. We see this as a more practical counterproposal to the Review's suggestion of the Commission and the MHTS being given increased authority to protect the rights of autistic people and people with learning disability.

Section 8 - Offenders

The College has serious concerns with the suggestions made in the recommendations regarding offenders. The well-meant intentions would have the repercussions of making the system less fair and inequitable for those with ID and Autism, due to its removal of existing protective rights.

As a direct result of this loss of rights, many more individuals with ID or Autism will be sent to prison rather than diverted to health care settings, as is currently the case⁹. At present, those with ID make up no more than 5% of the prison population, and people with Autism are an even smaller percentage. Should a specialist environment be provided (as suggested by the recommendations), practicality dictates that all of these individuals would need to be accommodated in a single prison, thereby resulting in longer distances from social supports and family, a recognised factor which causes significant distress amongst vulnerable individuals. Should the Review examine current provisions, it would note the difficulties in providing specialist services in each prison due to the low numbers of qualifying cases.

The Review makes reference to the Northern Ireland Act, but as this legislation has not yet commenced, been applied or tested, it cannot be used as a practical example of the application of a mental capacity act.

The recommendations do not provide information regarding how their suggestions would impact victims in the justice system, focusing solely on offenders. Clarity is therefore required on how such recommendations would affect fair trials for victims.

On p.127 of the report, there is mention of limiting terms. We believe that the comparison between a forensic health system "term" and the prison system is grossly misleading. It is comparing treatment to punishment, which are two entirely separate entities. Therefore, the

⁹ McCarthy, J, & Duff, M., [Services for adults with intellectual disability in Aotearoa New Zealand](#), British Journal of Psychiatry International, 2018:16(3), 71-73.

recommendations to limit the 'term' will have the unintended consequences of limiting the duration and benefit of treatment provided.

We support the Review's emphasis on reducing offending in the future. We would suggest that the use of appropriate adult models, as used in England, could be used to protect vulnerable adults in Scotland when it comes to offenders and trials.

Section 9 - Where support, care and treatment happens for offenders

The recommendation that community rehabilitation be provided - whilst focused on ID and Autism in this instance - could be argued for all offenders who require treatment for mental illness. Therefore, we believe that this recommendation would need to be inclusive for all.

We note that the Review recommends using rehabilitation centres instead of hospitals and that the wording used once again appears to suggest a negative attitude towards hospital care. Without providing evidence to support this conclusion, it is difficult to understand why human rights are considered to be enhanced by the notion of an adapted prison rather than a specially designed healthcare system. It would leave individuals with ID and Autism unable to access appropriate clinical care for mental disorder, with physical disorder treated as a completely separate issue. The inequity between physical and mental health appears to reinforce a detrimental lack of parity and stigmatising attitudes to people who have mental health needs.

There are aspects of support and treatment for individuals with ID and Autism which cannot be successfully undertaken within the prison setting. The Scottish prison system is a punitive model which has not been designed with the intention of being a therapeutic place for vulnerable individuals. We therefore cannot support this recommendation due to significant concerns that it will leave vulnerable people exposed and deny them access to treatment. Reduced access to treatment is a known contributor to an increased rate of recidivism with ultimately longer durations of incarceration and loss of liberty. A further concern is the higher rate of substance misuse in prison than in secure hospitals. As a direct result, individuals with ID and Autism could be vulnerable to being targeted and bullied by other prison occupants regarding their medication.

Section 10 - What this means for the law

In conclusion, the College believes that ID and Autism should remain under the protections of the MHA, as the removal of such safeguards would inevitably create more harm than good.

The Review's summary, as outline on p.150, sums up many of our concerns.

'We have not suggested that detention and compulsory treatment on the basis of disability should end at this time for autistic people and people with learning disability. With the current

level of development of mental health and criminal justice services in Scotland, we think that if the law did not allow professionals to restrict liberty or to give compulsory treatment to autistic people or people with learning disability on the basis of disability, this could lead to more lives lost to suicide. We also think that more people could be brought within the criminal justice system inappropriately'.

Like the Review team, the College fully supports the notion that Scottish Government work towards the goals mentioned above, which should be clear from our comments throughout this response. We look forward to supporting the Scott Review and its aspirations of addressing the challenge of creating workable and appropriate fusion legislation for Scotland.

RECOMMENDATIONS

The College would like to make the following recommendations, which we believe offer a more practical approach to promoting human rights for individuals with ID and Autism.

1. Intellectual Disability and Autism should not be separated from other conditions, and instead should be together considered by the Scott Review with a view to fusing mental health and incapacity legislation.
2. The principles of mental health legislation should be strengthened by the inclusion of supported decision making as an essential aspect of “having regard to” present wishes. This could be an enhanced aspect of advocacy. The training and professional registration of advocates should be reviewed accordingly.
3. Mechanisms to ensure consideration of Section 1 principles should be strengthened with explicit inclusion of them when considering detentions under the Act. This could be done by including them in proforma documentation and requiring tribunals to review the principles and comment upon them in judgements. There should be a strengthening of recorded matters and a mechanism whereby MHTs can refer cases to the Mental Welfare Commission (MWC) for review. The MWC should include more reference to the Section 1 principles in their visits. Scottish Ministers should explicitly address and be subject to the Section 1 Principles in any decision or position in relation to restricted patients.
4. The statutory appeal mechanism to tribunals for patients detained in hospital who could be in the community should be strengthened and monitored, along with the ability to place a statutory duty on local authorities to provide and fund suitable provision in the community, similar to the appeals against excessive security.
5. All individuals with ID who are detained should have a responsible psychologist appointed with statutory duties to report on the up-to-date psychological treatment needs and intellectual functioning to tribunals, alongside a responsible psychiatrist with specialist training in ID.
6. We suggest that patients subject to criminal procedures who have their diagnostic category changed by a tribunal, for example from ID to Personality Disorder, should be referred back to the sentencing court for consideration of the suitability and appropriateness of the disposal.
7. Arrangements for patients subject to a Compulsion Order and Restriction Order and conditional discharge should be on a clearer statutory footing. There should be greater clarity regarding the process of derestriction and the Memorandum of Procedure

updated to remove any suggestion that if the 'significant harm test' to others in the compulsion order is satisfied then the ongoing "necessity" test in the restriction order is met.

8. There should be greater monitoring of ID and Autism within the criminal justice system, monitoring of the Appropriate Adult arrangements, and adapted offender programmes and improvements in training for all staff.
9. Recruitment to ID psychiatry posts should be identified by the Cabinet Secretary for Health as a priority. Civil servants in NHS Workforce Planning at Scottish Government should be directed to work with Royal College of Psychiatrists in Scotland and NHS Education Scotland to provide targeted incentives to improve the fill rate of ID training posts and consultant vacancies.

Suggested Further Reading:

Academic Papers

Craigie, J., [Against a Singular Understanding of Legal Capacity: Criminal Responsibility and the Convention on the Rights of Persons with Disabilities](#), *International Journal of Law and Psychiatry*, 2015:40

Stavert, J., [The Exercise of Legal Capacity, Supported Decision-Making and Scotland's Mental Health and Incapacity Legislation: Working with CRPD Challenges](#), *Laws* 2015:4(2), 296-313

Stavert, J., [Paradigm Shift or Paradigm Paralysis? National Mental Health and Capacity Law and Implementing the CRPD in Scotland](#), *Laws* 2018:7(26)

New Zealand Legislation

[A Guide to the Intellectual Disability \(Compulsory Care and Rehabilitation\) Act 2003](#)

[Intellectual Disability \(Compulsory Care and Rehabilitation\) Act 2003](#)

[MHA \(Act\) 1992](#)

Scotland and UK Legislation

[An introduction to Scottish adult incapacity law](#)

[The British Academy report on What is Legal Capacity?](#)

[The Essex Autonomy project report on Towards Compliance with UNCRPD Art. 12 in Capacity/Incapacity Legislation across the UK](#)