Suggested comments for the Scottish Mental Health Law Review –

Deaths in detention reviews

The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") came into force in 2005 – how well does it work at the moment? In answering this it would be helpful to us if you could consider the following: • how well the Act helps people to get the right care, treatment and support • how well the Act protects people's human rights (Please see the start of the paper for the human rights we think are most relevant here) • how well the Act maximises a person's ability to make their own decisions and give effect to them • how things have changed since the Act came into force in 2005	• How well the Act protects people's human rights: The right to life The current Act does not comprehensively protect the right to life. Particularly for persons whose liberty is restricted, this right places duties on public authorities to protect life by ensuring the provision of a safe and respectful environment. This requires the following, of which some but not all required under current mental health law (link, part A): 1. Freedom from physical abuse by staff or other detainees 2. Freedom from bullying, threats and disrespectful treatment by staff and other detainees 3. Freedom from neglect by staff or external professionals 4. Freedom from unlawful use of physical restraint 5. An effective risk assessment by a qualified practitioner either before or as soon as reasonably practicable after initial detention 6. An effective review of that risk assessment at regular intervals thereafter 7. Dissemination of those assessments to relevant agencies within and outside of the setting 8. Access to timely and appropriate medical and mental health treatment and support 9. Access to appropriate social support, such as listeners, insiders and regular family contact 10. Information and advice in an appropriate format on how to access this treatment and support 11. Treatment for drug and alcohol abuse and protection from access to them 12. Proportionate individualised protection where the detainer knows or should know there is a real and immediate risk to life.

	The right to life also requires to investigation of deaths where the state may have had some responsibility for that death. Investigations are only adequate and effective when the investigation process (link, part B): 1. Is initiated by the state 2. Appoints an investigator independent of those implicated in the death 3. Begins promptly and concludes as quickly as is reasonable 4. Takes all reasonable steps to secure relevant evidence relating to the death 5. Takes all reasonable steps to uncover any discriminatory motive behind the death 6. Makes the investigation and its results open to public scrutiny 7. Involves the next of kin and ensures that their interests are protected 8. Holds to account anyone found to be at fault as a result of the investigation 9. Shares and puts into practice lessons learned from the investigation to ensure, so far as is possible, that steps are then taken to minimise the risk of similar deaths in the future. There is currently no legislative basis specific to investigations of deaths of persons under mental health law in Scotland. We have consistently made the case that there should not be mandatory fatal accident inquiries for all deaths under mental health law in Scotland, for reasons summarised here. We have instead proposed that case review by the Mental Welfare Commission should be combined with a discretionary power to hold an FAI (here, 5b). We have proposed a statutory requirement to notify any death of a patient subject to a compulsory order under the Mental Health (Care and Treatment) (Scotland) Act 2003 to the fiscal and the Mental Welfare Commission. Legislation within this function is in place in England and Wales but not in Scotland. We have proposed that the Mental Welfare Commission would keep the fiscal advised throughout the process, and would advise the fiscal if it believed there were grounds for an FAI, either instead of or following the review overseen by the Mental Welfare Commission.

	The Mental Welfare Commission is currently developing a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who had their detention suspended). This is at the request of Scottish Government (link). Our work is due to report at the end of June 2021. It is possible that we may make recommendations for future mental health law. It will be important for Scots law to ensure that the whole Scottish system of investigation of deaths promotes and protects the human rights of persons subject to these orders, and does not discriminate against persons in mental health detention in comparison with other detained persons. This perspective focuses on Article 2 ECHR / Article 10 CRPD. It is also relevant to Articles 3 and 14 ECHR, and a range of associated rights and duties found in UN treaties.
• Are there certain things that hinder the Act from working effectively? What would improve things?	There is no current legal requirement for health boards, local authorities or other bodies to act in response to findings and recommendations of reviews of deaths.
• Are there groups of people whose particular needs are not well served by the current legislation? What would improve things?	Our comments apply across all groups of persons with 'mental disorder' as defined in the 2003 Act.
• The Act has a set of legal tests to justify making someone subject to compulsion. Would you suggest any changes to these? In answering this, you may wish to think about how practical the tests are to apply and how fair they are to different groups, including people with different diagnoses.	
The Act requires a local authority to provide services for people with a mental disorder who are not in hospital,	Reviews of deaths, and of life-threatening serious adverse events, have the potential to determine whether these requirements are met in practice. Failure to provide these services has the potential to contribute to deaths. However,

which should be designed to minimise the effect of mental disorder on people and enable them to live as full a life as possible (sections 25 and 26 of the Act). • Do you think this requirement is currently met? • Does more need to be done to help people recover from mental disorder? You may wish to provide an example or examples.	these legal requirements may not be to be systematically considered in reviews of deaths.
• Does the law need to have more of a focus on promoting people's social, economic and cultural rights, such as rights relating to housing, education, work and standards of living and health? If so, how?	
• Do you think the law could do more to raise awareness of an encourage respect for the rights and dignity of people with mental health needs?	
The Review is also looking at the way people with a mental disorder are affected by the Adults with Incapacity (Scotland) Act 2003, and the Adult Support and Protection (Scotland) Act 2007. • Based on your experience, are there any difficulties with the way the 3 pieces of legislation work separately or the way they work together? What improvements might be made to overcome those difficulties?	Reviews of adverse events for persons who were subject orders under any of these Act may take place in different ways, for example, depending on whether a health board of local authority initiates the review. Current work by the Mental Welfare Commission and partner organisations has the potential to inform how review processes can become more coherent across services, for people who were subject to this range of legislation.
• Is there anything else you wish to tell the Review?	There may be some requirement for law reform around the relationship between the Mental Welfare Commission and other public authorities, such as the Crown Office and Procurator Fiscal Service. The future system for investigating deaths of persons subject to mental health law may require this foundation in law to ensure that the new system is non-discriminatory, in that is at least as effective in meeting human rights requirements as other

	systems of investigation such as mandatory Fatal Accident Inquiries for prisoners.