

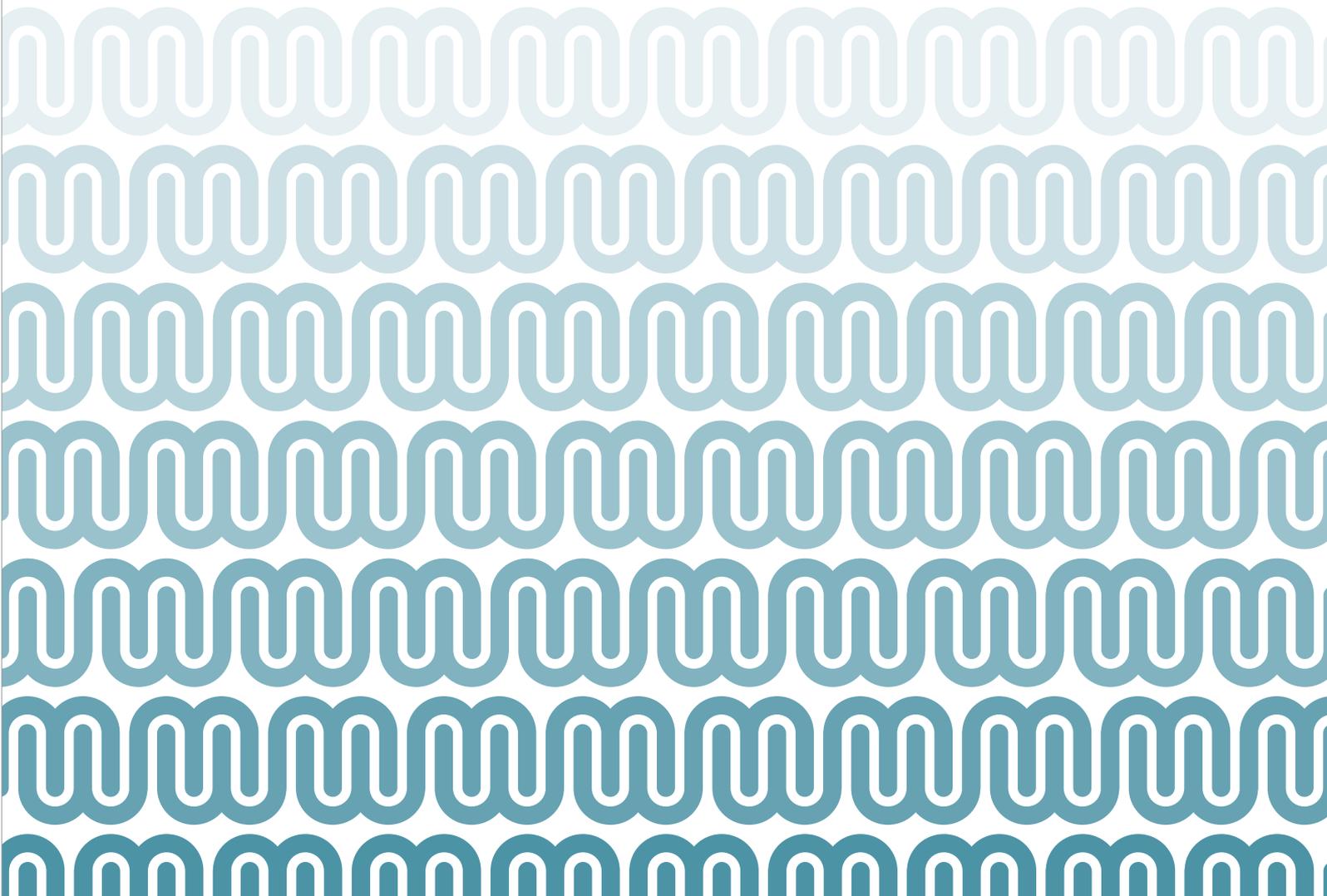


mental welfare
commission for scotland

Response to Phase 1 Consultation of the Scottish Mental Health Law Review

Corporate reports

29 May 2020



Our mission and purpose

Our Mission

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

Our Purpose

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

Our Priorities

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

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

Our Activity

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

Contents

Response to Phase 1 Consultation of the Scottish Mental Health Law Review	5
A. The Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) came into force in 2005 – how well does it work at the moment?.....	6
B. How well does the Act help people to get the right care, treatment and support?	7
C. 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)	9
Proportionality	15
Emergency Detentions	15
Short Term Detention Certificates	18
Compulsory Treatment Orders.....	23
Designated Medical Practitioner Safeguard.....	27
The Mental Welfare Commission.....	29
Social Circumstances Report	31
D. How well the Act maximises a person’s ability to make their own decisions and give effect to them?.....	33
Advance Statements	33
Advocacy availability.....	34
E. How have things changed since the Act came into force in 2005?.....	36
F. Are there certain things that hinder the Act from working effectively? What would improve things?	37
G. Are there groups of people whose particular needs are not well served by the current legislation? What would improve things?	39
Learning disability	39
Offender mental health	39
Children and young people	40
Perinatal	40
Personality Disorder	41
People with suspected mental disorder who are in a public place	42
H. The Act has a set of legal tests to justify making someone subject to compulsion. Would you suggest any changes to these?	43
I. The Act requires a local authority to provide services for people with a mental disorder who are not in hospital, 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.	45
J. 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?.....	48
K. 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?	50

L. 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 (ASP). Based on your experience, are there any difficulties with the way the three pieces of legislation work separately or the way they work together? What improvements might be made to overcome those difficulties?	51
M. Is there anything else that you wish to tell the review?	54
Appendices.....	56
Appendix A:.....	56
Death in Detention project – information for the Review	56
Appendix B:.....	56
Will and preference and the Mental Health Act - The views of 86 people with lived experience of mental illness or as carers of people with a mental illness	56

Response to Phase 1 Consultation of the Scottish Mental Health Law Review

1. The Mental Welfare Commission for Scotland (The Commission) welcomes the opportunity to respond to the phase 1 consultation of the Scottish Mental Health Law Review (the Review).
2. Our response is informed by the Commission's experience of meeting its duties and responsibilities including those under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act). The Commission occupies a unique place in the landscape of mental health and social care. It has a statutory duty to monitor the use of the Act and has a duty to provide advice on the use of the Act. Commission staff visit people in hospitals and in community teams and in their own homes, identify deficiencies of care and treatment and seek to remedy these.
3. The Commission is keen to ensure that the lived experience of service users, patients and carers fully informs the Commission's approach to this response. We have appended a report by the Commission's Engagement and Participation Officer (lived experience) exploring service user and carer views on a key aspect of mental health law reform- the UNCRPD challenge of ensuring that the will and preference of people is considered alongside their rights. This work is currently unpublished (May 2020).
4. We welcome the Review's aim 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 remove barriers to those caring for their health and welfare; the Human Rights approach that the Review is taking to this task; and the participation of people with lived experience in the 'core' group.
5. The Commission suggests that the voice and professional experience of practitioners should be represented in the Review core group.
6. The Commission suggests considerations of sustainability and the climate emergency should inform the approach to the review, recommendations on legislative reform and its practical implementation. It may be helpful for the Review to consider appointing a 'champion' for sustainability.
7. Key Messages from this Response: The Commission considers that principles of **Proportionality and Reciprocity** are not currently met under the Act and that these are particularly important to deliver a Human Rights approach that will have meaning for people with mental disorder, service users and the people who matter to them; and for the professionals who work with them. We have used a data-driven response for the Review to demonstrate how these principles are not currently met.

A. The Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) came into force in 2005 – how well does it work at the moment?

8. The Commission believes that some aspects of the Act work well but there are aspects of the Act that do not work well. In this section we outline our considerations to determine how well the Act ‘works’.
9. The UN Convention on the Rights of Persons with Disabilities (CRPD) UNCRPD came into force in 2008. The Convention sets out a wide range of rights including, among others, civil and political rights, the right to live in the community, participation and inclusion, education, health, employment and social protection. The Act was written and implemented before the CRPD was ratified. Scottish Government is committed to progressive realisation of the CRPD. In this response we highlight some immediate issues that this poses but we are not attempting to assess the Act- that was written before the CRPD came into effect- against this.
10. Another framework against which the Act might be assessed against is the World Health Organisation (WHO) Resource Book (WHO-RB) on mental health, human rights and legislation- that was first published in 2005 and includes a checklist of 175 specific items to be addressed in mental health legislation or policy in individual countries. This framework has now been withdrawn as it is not concordant with UNCRPD however researchers working in international mental health law comparisons still regard the WHO-RB as the most comprehensive checklist for mental health legislation available, rooted in UN and WHO documents and providing the most systematic, detailed framework for human rights analysis of mental health legislation (Kelly, 2017). The Act has never been assessed against this framework.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5563026/> (accessed 19 May 2020)
11. The health and social care system in which the Act operates in is also substantially different from the systems that were in place when the Act was passed and first implemented. The terminology used in the Act does not reflect the roles of Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs) The specific effects of IJBs on e.g., the independence of the MHO may have impacts on how well the Act functions in an altered delivery landscape.

B. How well does the Act help people to get the right care, treatment and support?

The Commission's Engagement and Participation Officer (Carer) has commented on this question based on their work gathering the views of carers. These comments have informed the approach taken to the response.

12. In terms of compulsory treatment, the Act is clear about the rights an individual has, provides specific guidelines and has safeguards in place. A clear process exists and professionals are aware of their roles under the Act.
13. However, the Act does not help everyone who has a mental illness, learning disability, dementia, or an associated condition, as many of them will never be subject to the Act and therefore some of the protections the Act affords to ensure that people get care, treatment and support are not available to them.
14. There is a duty under the Act that everyone regardless of detention status has a right to advocacy. We discuss this further in a section on advocacy below
15. It is not widely recognised that individuals in the community who have a mental illness but are not subject to the Act have rights under section 25 – 28.
16. The Social Work (Scotland) Act 1968 gives local authorities a legal duty to provide assessments of needs for individuals and section 25 of the Act places a duty on them to provide care and support to those with mental health issues whether they have been in hospital or not. Under section 26 of the Act local authorities have a duty to provide or secure the provision of services to promote wellbeing and social development, including the provision of social, cultural and recreational activities; training; and assistance with obtaining and undertaking employment for those over school age. Section 27 provides for travel assistance to facilitate accessing services.
17. Too often the reduction of symptoms or discharge from hospital for an individual is seen as the end of the journey rather than the beginning. Symptom control does not indicate recovery.
18. The Act doesn't work in a vacuum. It is important that services are adequately resourced to reflect the needs. The following sections illustrate some of the service constraints that the Act works within, particularly for those with mental illness.
19. Resources are scarce and that, in addition to poor staffing levels often leads to individuals left to their own devices when trying to reintegrate into society. The provision of Community Psychiatric Nurses or Occupations Therapists to facilitate this is not universal. Individuals can easily relapse and require further admission or intensive treatment.
20. CAMHS services are stretched to their limits and communication between them and schools can be difficult. Support from schools is also not a guarantee. A lot of work is being done in education around mental health and well-being. However the system for supporting a young person with a serious mental illness is unwieldy and inefficient.
21. Think Positive (who are mentioned in the mental health strategy) have a remit to support young people in colleges and universities however it is very variable how much input they have.
22. Accessing employment is something that most people would need support with which again is often not available within restricted resources. Self-Directed Support payments are available to some with various caveats but are often viewed in distinct

silos for people. More creative use of this matching services to the person rather than vice versa would be welcome.

23. Having meaningful activity leading to positive outcomes for someone trying to recover seems like an obvious route for someone to take but is rarely available.
24. This lack of community support often leaves families trying to support the individual with limited knowledge and resources of their own. 'Confidentiality', rather than being a protection for individuals becomes a barrier to families and carers trying to provide support and adversely affects the relationship between families and services. Too many families are caring for and supporting individuals in their own homes but are still excluded from relevant information about their care and treatment. It seems ironic that when an individual is detained with SIDMA they lose their right to liberty and their right to refuse medication but their decision to exclude family from being involved in their care is accepted without question and upheld.
25. One example is a family whose adult child, through illness, had declined to have them involved in her care. However when she absconded from hospital the police visited them to ask about her whereabouts. The worried family searched for several days contacting relatives abroad before finding out she had returned to hospital the same day. The reason given for not telling them was it would have breached patient confidentiality. The 'Triangle of Care' model has had some success in hospital settings in improving communication but its use varies widely in community settings.
26. Having an advance statement is of course an effective way of ensuring family/carer involvement even if an individual becomes too unwell to grant consent. Unfortunately, advance statements are still not widely used despite the obvious benefits for everyone.
27. Those individuals in the community who remain on compulsory orders can also struggle to get adequate support. Carers often find these barriers and that their concerns and opinions are dismissed. This can then lead to deterioration of the situation leading to crisis and possibly detention under the Act. As we are aware detention rates are rising listening to families/carers could be a first, low- cost step in addressing this by prevention.
28. Having a named person is one way to have family/carer support for an individual. Changes to the Act in 2015 have made this process a bit more complicated however and, of course, it only comes into force when an individual is detained.
29. Supported Decision Making (SDM) as advocated by CRPD is admirable. However, as with the detention rates, this is going to be much more difficult to implement without the involvement of families and carers. SDM is only ever going to be possible with a trusted person available to help facilitate discussions. This will often be a family member. Even more importantly, listening to families who are flagging up concerns early is vital to allow this to happen. Ignoring these concerns, as so often happens, allows a person's condition to deteriorate to the point where this is no longer possible and leads to inevitable detention.
30. GPs sometimes struggle to get help for individuals with mental health issues often because of the lack of resource available to CMHTs and not all GP practices have access to primary care worker
31. Better communication between primary and secondary care and more seamless access to assessment would greatly improve the management of these individuals in the community.

C. 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)

32. Mental health legislation can restrict and deprive a person of their liberty and can impose treatment that they do not want or cannot consent to. Traditionally the purpose of legislation was to ensure that people who are unwell are treated to restore them to health and reduce any risks that the altered state of health might pose to their safety and that of others and; to ensure that when someone is made subject to detention or treatment that they cannot or do not consent to, that there is a mechanism for this detention to be reviewed and safeguards are in place to ensure that people are treated in accordance with their human rights.
33. Developments in International law would suggest that a Mental Health Act ought to go further and focus on the restoration of other rights that are impinged on by the presence of disability (there is debate about at what point a mental illness or abnormal mental state is considered a disability but most commentators and those in practice would accept that a severe enduring mental illness is a disability.)
34. Section 1 of the Act refers to principles that anyone discharging functions under the Act must have regard for. They have widespread support. The principles underpin ethical decision making, particularly when protecting the Rights of a person is not straightforward as Rights conflict e.g., the Right to health and the Right to Liberty.
35. However, the Act was created before the UK ratified the CRPD. It does not incorporate all of the rights referred to within UNCRPD.
36. Although the Millan Committee proposed principles for the current Act which broadly reflected European Convention on Human Rights (ECHR) requirements, those proposals did not translate comprehensively into the current Act. The Commission believes that the principle of reciprocity ought to be strengthened to include a duty on the State to progressively realise the needs of people who use mental health services, both in inpatient and community settings.
https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf
37. Reciprocity was seen as key by many consultees, including RCPsych, SAMH, the Law Society of Scotland and others. That principle (reciprocity) could have embodied the crucial ECHR requirement of proportionality, but the current Act does not provide a principle of proportionality, nor statutory mechanisms to ensure proportionality in professional or judicial decision making.
38. The Millan principles are listed below (in bold) along with specific concerns about whether they are realised in practice:
 - **Non Discrimination, Equality, Respect for diversity**
 - There are concerns about whether the Act and its implementation adequately addresses concerns about equality and respect for diversity.
 - Work in progress, a paper on ethnicity and mental health, co-written with Commission staff (currently in draft) - considers issues with regards ethnicity and mental health. It comments on the incomplete returns of ethnicity paperwork (that is part of the Act paperwork): around 82% completed across Scotland with variation between areas. It is therefore difficult to determine whether rates of detention for BAME groups are higher.
 - However, using the incomplete data set, the Commission noted in last year's monitoring report that 5.8% of detentions were for BAME groups and yet the

BAME community makes up 4% of Scotland's population. (The Commission monitoring report 2018/19: https://www.mwcscot.org.uk/sites/default/files/2019-10/MHA-MonitoringReport-2019_0.pdf)

- There are concerns that other groups such as:
 - young people (the monitoring report mentioned above suggests rising rates of detention);
 - people with a learning disability (independent review of Learning Disability in the Act <https://www.irmha.scot/>);
 - offenders with mental health difficulties and;
 - people with severe enduring mental illness may not be well served by the Act and its implementation

(Our concerns for these groups discussed in the section on least restrictive alternative below).

- LGBTQ people are known to experience higher levels of mental ill health and suicide. However data is not routinely collected on this group, and it is not clear, for example, whether they may be over or under-represented with regards detention. This 'invisibility' is a significant barrier to addressing the mental health needs of this group and to ensuring that they are well served by the Act.

(LGBTI Populations and Mental Health Inequality (2018) LGBT Health & Wellbeing, Scottish Trans Alliance, Equality Network, LGBT Youth Scotland, Stonewall Scotland:

<https://www.lgbthealth.org.uk/wp-content/uploads/2018/08/LGBTI-Populations-and-Mental-Health-Inequality-May-2018.pdf>)

- **Reciprocity**

- The Act asks the person discharging functions within the Act to have regard for reciprocity. The Commission has specific concerns about whether, when the state has imposed an obligation on an individual to comply with a programme of treatment and care, whether a parallel obligation on the state to provide safe and appropriate services, including and particularly, in the community after discharge from hospital, is realised. We discuss this in further detail below.

- **Informal care where possible**

- There is a concern that this may not always happen. For instance there has been a suggestion that at times due to bed pressures someone may be made subject to the Act in order to ensure that they are prioritised for a bed. The Commission has anecdotal evidence that this is happening and suggests the Review consider this formally in an evidence session.
- Equally, it has been suggested that clinicians may continue compulsion in community settings in order to ensure that their patient continues to receive input from other services. Again, we have anecdotal evidence that this is happening but would ask the Review to consider asking for evidence on this, particularly from colleagues in forensic community settings.

- **Participation**

- This is discussed in sections below, particularly in sections on advance statements & advocacy.
- **Respect for carers**
 - There are concerns that their voice is not always heard. Please see Commission carer engagement & participation officer's comments in the opening question.
- **Least Restrictive Alternative**
 - This principle that does not find full expression in the situation where detention is the only option deemed suitable- it becomes the least restrictive alternative by default. In this situation there is a concern that the Act is used to legitimise a lack of resource or failure to ensure progression along a pathway.
 - The recent independent review of learning disability and autism in the Mental Health Act, drawing in part from Commission data, concluded that this is true of the Act in relation to people with a learning disability. For example, a person with learning disability can in effect be detained in hospital for very long periods of time, not due to clinical need for hospital but due to extremely delayed discharge awaiting community care provision.
 - Iatrogenic effects (problems that arise because of treatment, including loss of skills of independent livings) and the damaging effects on mental health of inappropriate placement of people in hospital are not recognised within the current Act, which may reflect the absence of a wider view on reciprocity and proportionality in the Act.
 - The following reports all make reference to the delays in discharge from more restrictive environments than the person should have been in (although not all the patients in these reports were detained, many were):
 - *No Through Road* – 1/3 of people in LD hospital units delayed discharge, often for many months
https://www.mwscot.org.uk/sites/default/files/2019-06/no_through_road.pdf
 - Forensic themed visit – 61 patients in low secure awaiting community or rehab places
https://www.mwscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf
 - *Autism and complex needs* – almost half in hospital awaiting community place
https://www.mwscot.org.uk/sites/default/files/2019-10/ASD_ThemeVisitReport-20191030.pdf
 - Rehabilitation wards – over a third delayed discharge
https://www.mwscot.org.uk/sites/default/files/2020-01/20200130_ScotlandsMHRehabWards_ThemedVisitReport_0.pdf
- **Benefit**
 - The Commission believes that practitioners work with this principle in mind.
- **Child welfare**
 - This principle requires that the welfare of the Child with mental disorder should be paramount in any interventions imposed on the child under the Act. The

aspirations of the United Nations Convention on the Rights of the Child that young people are treated in specialist settings due to their particular needs and stages of development are not met here.

- The Commission continues to report on the numbers of children and young people who are admitted inappropriately on wards designed for adults. Despite the principle of the welfare of the child and the duty on Health Boards (to use the term within the current Act) to provide services and accommodation that meet the particular needs of the child or young person the CAMHS waiting lists are huge and subject to regular media attention and the Commission's reports on placements in adult wards had led to little action. This year we reported that 101 children and young people were admitted to inappropriate settings (mostly adult wards) for their mental health needs.

https://www.mwscot.org.uk/sites/default/files/2020-03/YoungPeopleMonitoringReport_2018-19.pdf

Within this report we also comment on the difficulties of meeting the need of children and young people who require inpatient provision in more specialist settings such as intensive psychiatric care units (IPCU) or those who have associated needs due to Learning Disability or those who require specialist care and treatment because of offending due to mental disorder. Scottish Government intends to incorporate CRC principles into Scots law. The MHA may require some reform for full compatibility with the CRC.

39. It is helpful that the review states the human rights that it considers most important in considering how well the Act protects the Human Rights of people with mental illness. These are listed here.

- The rights to life and to health
- The right not to be subjected to torture or cruel, inhuman or degrading treatment, including the right to respect for physical and mental integrity
- The right to liberty and security
- The rights to a fair hearing or trial in decisions about civil rights or criminal charges, and equality before the law
- The right to private and family life
- The right to not being discriminated against in claiming or getting your rights
- The right to an effective remedy
- The rights to participate in society and live independently in the community
- The right to an adequate standard of living, food and housing
- The right to social security

40. However, there are other rights and principles that are not reflected in this list. This response isn't the place to consider the full range of rights that might need safeguards or duties in an Act to promote -for people with a mental disorder, however the Commission suggests that principles of Reciprocity from Millan are not given full effect and the principle of proportionality is not mentioned specifically at all and is a key principle that should be considered.

<https://eachother.org.uk/proportionality-margin-appreciation-human-rights-plain-english/>

41. For qualified Rights, or when Rights need to be balanced and curtailed in order to ensure the safety and health of an individual or for the protection of others, the

curtailment of Rights must be proportionate under both European Convention on Human Rights (ECHR) and CRPD frameworks

42. Although some of the duties that flow from observing the least restrictive alternative might follow the principle of proportionality, this might not be interpreted in this way. The Commission data set will demonstrate issues with regards to this below.
43. A key debate that will inform the progression of the Review is the tension between interpretations of the CRPD, particularly the views of the UN Committee on the Convention of the Rights of Persons with Disabilities. The Committee issues general comments, of which general comment 1 was contentious (on Article 12) as were the Committee's comment on Article 14.

Text box 1: Text of Article 12.

Article 12 – Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

44. An interpretation of Article 12(4) is that when there are measures taken that curtail the full expression of legal capacity- this is only done once appropriate measures have been taken to support the exercise of this; and are subject to the safeguards that are mentioned in 12(4). A key issue is proportionality and; that nothing is done excessively for any one group more than any other.
45. The UN Committee on CRPD has gone further with its recommendations to the UK government in 2016 that state parties should:
 - Incorporate the Convention (Recommendation 7)
 - Abolish all forms of substituted decision-making. (R.35a)
 - Repeal legislation and practices that authorize non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment; (R41)

- <https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhspCUnZhK1jU66fLQJyHIkqMIT3RDaLiqzhH8tVNxhro6S657eVNwuqlzu0xvsQUehREyYEQD%2BldQaLP31QDpRcmG35KYFtgGyAN%2BaB7cyky7>

46. However, there are voices of dissent from this e.g., the UK government 'strongly disagreed' with earlier findings of this Committee (other States hold similar position on aspects of CRPD).
<https://commonslibrary.parliament.uk/research-briefings/cdp-2018-0148/>
47. The Independent Review of the Mental Health Act (1983) in England (The Wessely Review) stated in its final report and recommendations that the review did not feel that it was right to follow the Committee's interpretation of CRPD that supported decision making is the only safeguard available to those who lack capacity stating clearly: '*we do not think we are compelled to follow this interpretation and we will not*'. (p13)
<https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>
48. Another article that's interpretation by the Committee has been contentious is Article 14.

Text box 2. Text of Article 14

Article 14

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - a) Enjoy the right to liberty and security of person;
 - b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

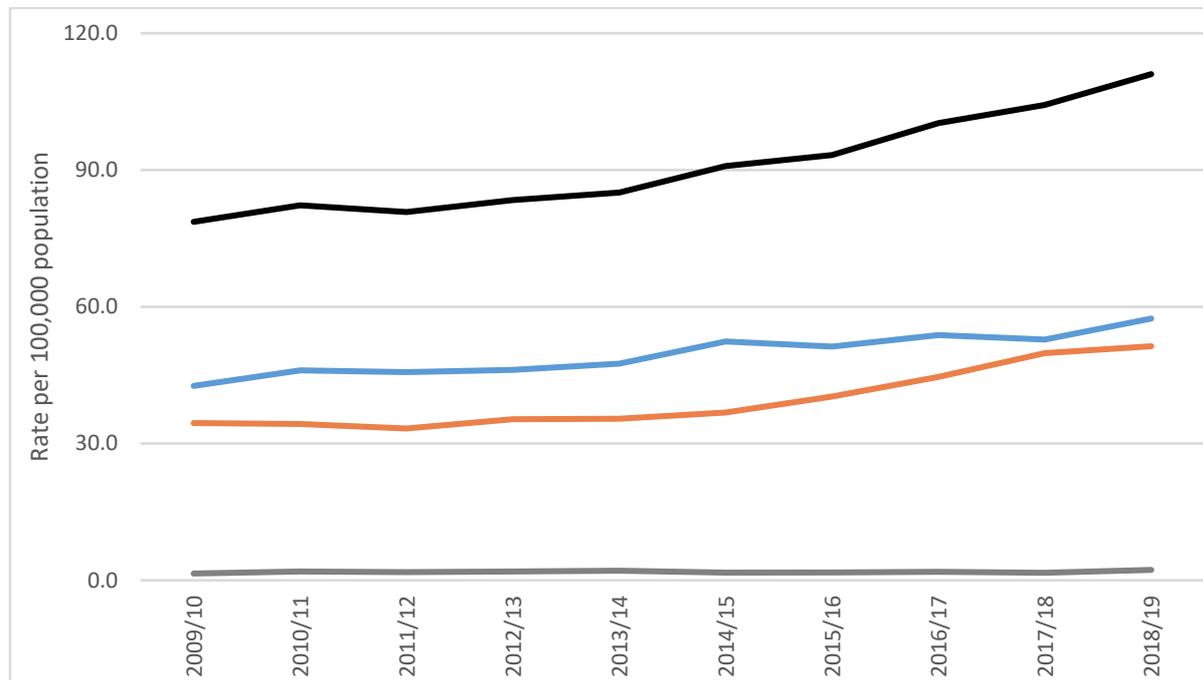
49. The Committee on CRPD has argued that 'the existence of a disability shall in no case justify a deprivation of a liberty' implies that a diagnosis or disability should not even be a criterion that needs to be met in order to justify a detention. Most current mental health acts have a diagnosis (as well as other criteria as conditions of detention).
50. Formulations of reasons for involuntary treatment that do not have diagnosis as a criteria would seek to rely on the 'lack or absence of capacity' as a criteria (this is one of the justifications offered for the so called 'fusion' of capacity based legislation and mental health acts) but there are commentators who would argue that even using this (the lack of capacity) is also discriminatory and therefore even the 'fusion' acts would fall foul of this interpretation of the CRPD.
51. Article 5(e) of the ECHR allows for the lawful detention of people of unsound mind.
52. The interpretation of CRPD that has no regard for diagnosis is at odds with Article 5(e) of the ECHR. Under the current Act it would already not be possible or legal for the detention of any person with a mental disorder to proceed on the basis of a diagnosis alone.

53. A case can be made that compliance with the CRPD requires limitation on rights in certain conditions.
<https://autonomy.essex.ac.uk/resources/eap-three-jurisdictions-report/>
54. The Commission considers the debate around interpretations of the convention to be an unhelpful distraction from the helpful steer it provides in advancing the rights of people with disabilities and ensuring proportionality when will and preference must be balanced with other Rights.

Proportionality

55. In the sections that follow we look at civil detentions and explore issues related to these that would suggest that the principles of the Act are not being met and the safeguards currently present are under-utilised.
56. The Review’s terms of reference indicate that the rising rates of detention is an area that it intends to focus on. The Commission has a statutory duty to monitor the use of the Act. The number of people subject to detention increases each year. In 2018/19 the Commission was notified of 6038 new episodes of compulsory treatment during the year. This is the highest number of episodes recorded since the 2003 Act was implemented.

Figure 1. Rates of detention across Scotland for EDCs, STDCs, CTOs
https://www.mwscot.org.uk/sites/default/files/2019-10/MHA-MonitoringReport-2019_0.pdf



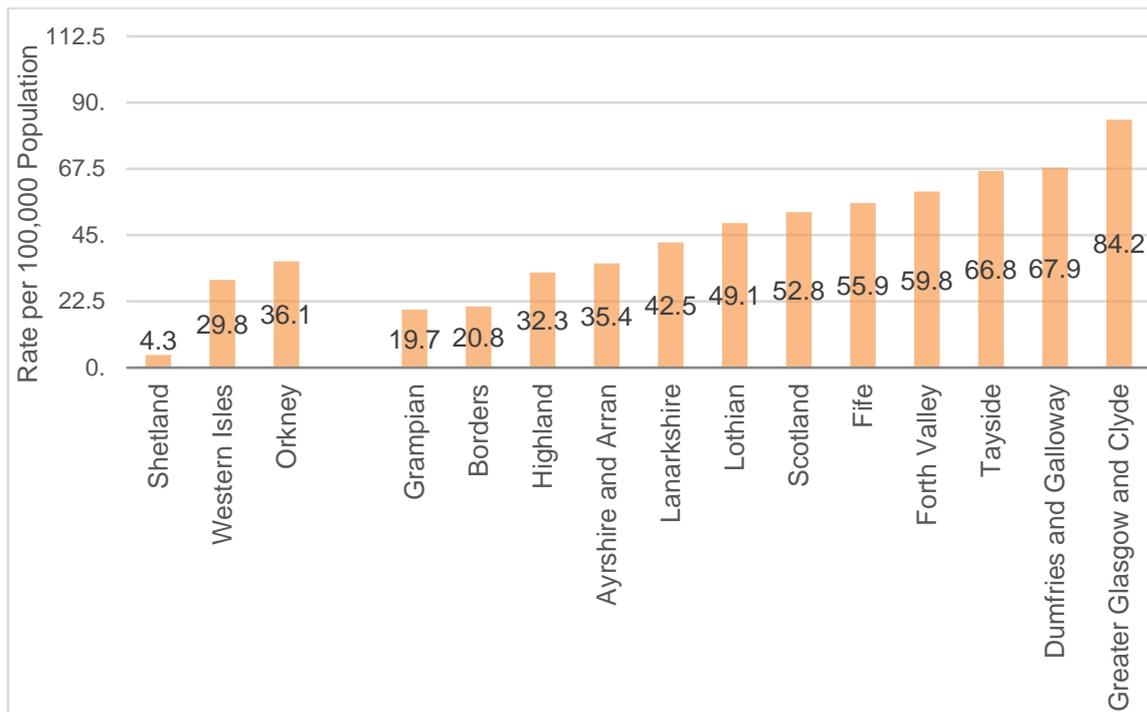
Emergency Detentions

57. Emergency detention certificates (EDCs) are designed to be used only in crisis situations to detain a person who needs urgent care or treatment for mental ill health.

They can be issued by any doctor, with the input of a mental health officer (MHO) and allow someone to be kept in hospital for up to 72 hours. There are no appeal mechanisms for EDC so therefore vitally important that the power is used appropriately and sufficiently safeguarded.

58. Key aspects of the Human Rights considerations of EDCs is the extent to which they are used by services (this has been rising); to what extent the safeguard of MHO consent is used (this is inconsistent - see graph below); whether they are used consistently across Scotland (there is considerable variation - please see graph below); and whether treatment safeguards are adequate (please see section on treatment safeguards below).
59. The concerns with regards the extent to which they are used is highlighted in SG quality indicators for mental health services as they suggest that the number of EDCs per 100,000 population is an inverse marker of the quality of the therapeutic relationship with patients (Eq2- SG QI markers).
<https://www.gov.scot/publications/mental-health-quality-indicators-background-secondary-definitions/>

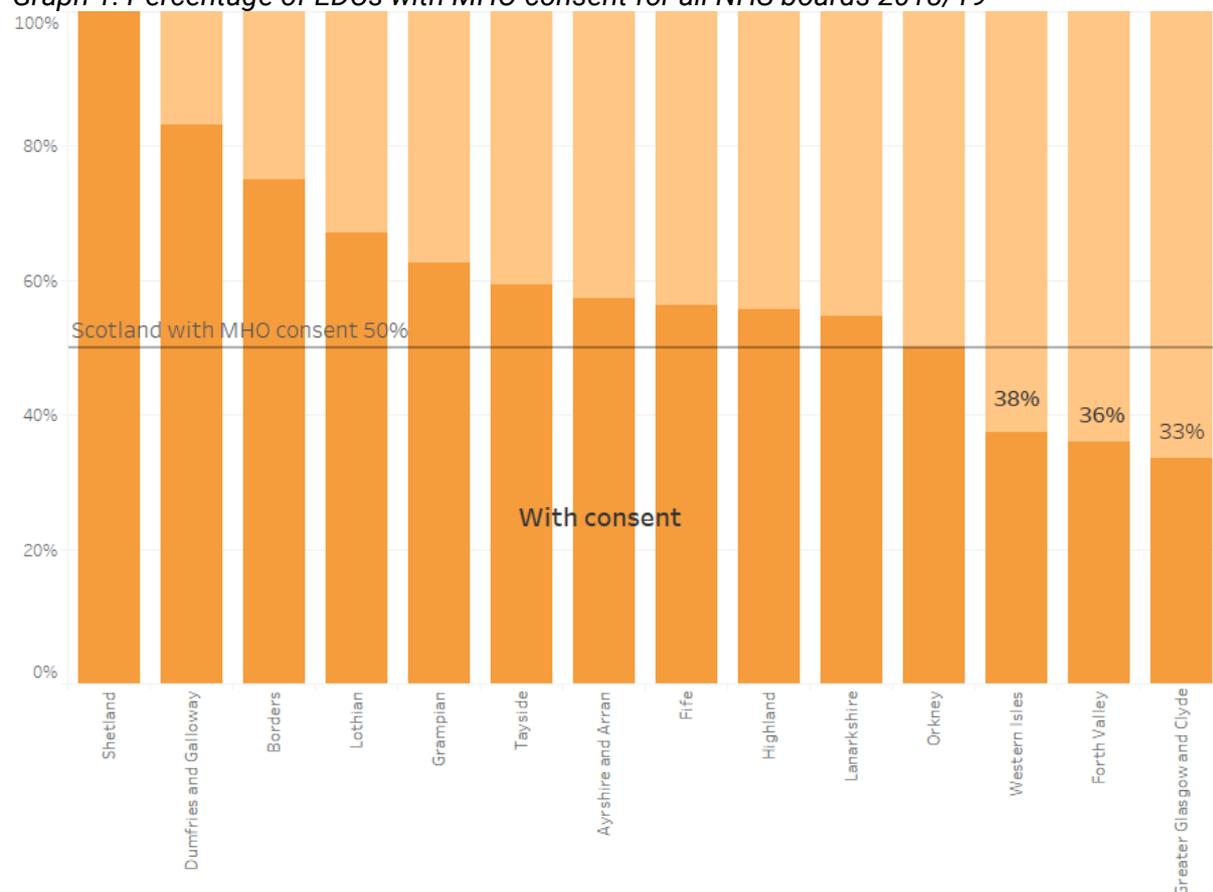
Figure 2. EDCs by health board 2018/19 (rate per 100,000 population with 95% confidence intervals) (Monitoring report)



60. However, the interpretation offered above about EDC rates and compulsion generally being an inverse marker of the quality of the therapeutic relationship might be interpreted in other ways.
61. For instance, it has been suggested that the different models of service provision (intensive home treatment teams/crisis teams) might be a factor that leads to different rates of detention (Palin 2019).
<https://onlinelibrary.wiley.com/doi/abs/10.1002/pnp.530>

62. Further the Commission monitoring report described the breakdown of these EDCs by gender and age and identified a marked rise in the detention rates of children and young people which warranted further exploration.
63. This mental health monitoring data set was presented to a group of CAMHS clinicians in January 2020 who suggested that the rise may indicate an actual growing awareness of protecting rights by ensuring that people are properly detained rather than relying on any considerations of parental consent (a particular issue for this group) that adds further complexity to this picture.
64. The Review could commission research to explore the relative effect of service models (as per paragraph 61), and wider socio-economic factors on detention rates to determine whether this is a significant factor not just for this group. (An analysis based on postcode of residence is possible- which might clarify the relationships between detention rates and deprivation indices.)
65. The Commission is currently exploring the diagnoses and reasons for detention for all young people detained under EDCs and STDCS, 2015-2019, to gain a better understanding on what might explain the increase in rates of detention for young people. This work will be available in the Autumn of 2020.
66. An important safeguard on the use of EDCs is the consent of an independent Mental Health Officer (MHO) (a social worker with particular training and experience in mental health).

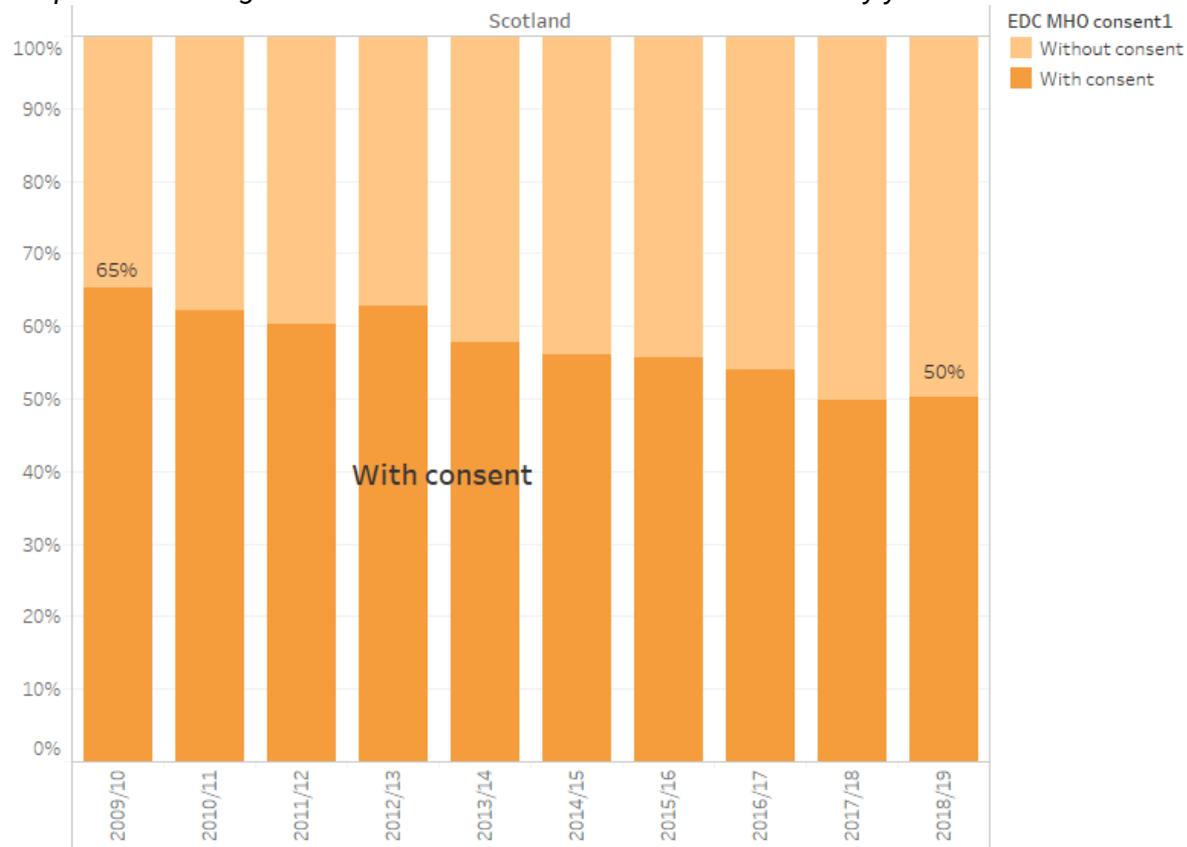
Graph 1: Percentage of EDCs with MHO consent for all NHS boards 2018/19



67. Over a ten year period the proportion of EDCs across Scotland with MHO consent has fallen despite calls from the Commission in its 2016 publication as part of its duty to

promote best practice around the Act. (Mental Welfare Commission for Scotland (June 2016) Emergency detention certificates without mental health officer consent.)
https://www.mwscot.org.uk/sites/default/files/2019-06/edc_report_2016.pdf

Graph 2: Percentage of EDCs across Scotland with MHO consent by year

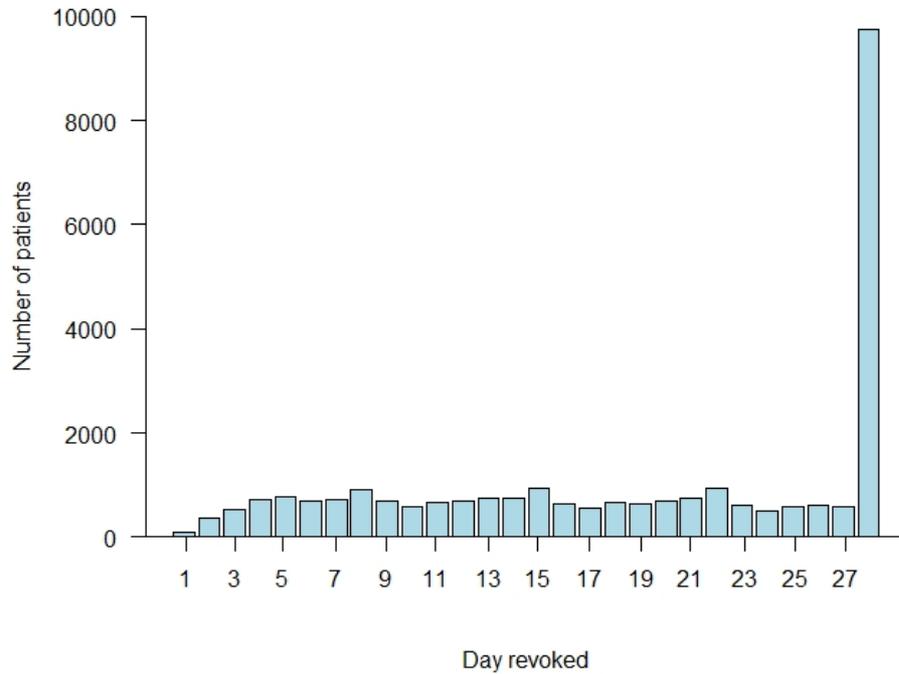


68. The data would suggest that this protection of an independent MHO under the Act consenting to the detention is not working as intended; that there may be specific groups more likely to be detained under an EDC; and that the arguments around higher rates of detention being a marker of poor therapeutic relationship may be mediated by many other factors such as service design, and considerations of risk. On risk, the Wessely review considered to what extent risk aversion may be a factor in rising rates of detention in England (p8).
<https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>
69. A further question that the data raises is whether the safeguard around MHO consent is not considered meaningful or properly understood (and whether there may be different safeguards that could be considered) or whether this reflects a workload that is not sustainable or given lower priority within rising demand.
70. The Commission is concerned about the rise in the number of EDCs and the lack of safeguard. Given that this was not the intended route into detention (see paragraph below) it warrants further consideration.

Short Term Detention Certificates

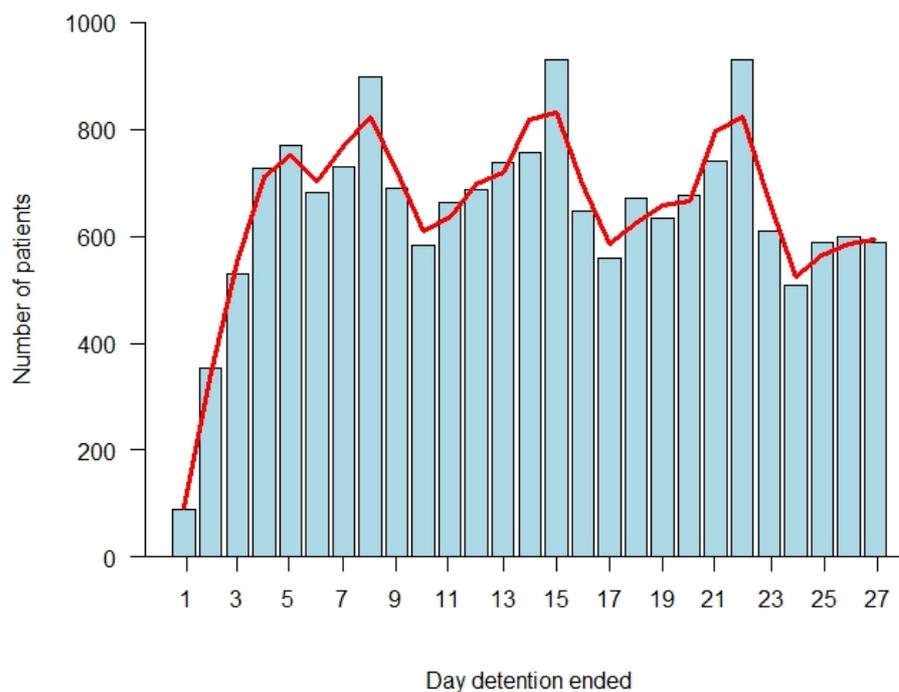
71. The preferred route to compulsory treatment is through short term detention orders. They should only take place if recommended by a psychiatrist and a mental health officer. These certificates can detain an individual in hospital for up to 28 days. Similar to EDC there has been a rise in the use of STDCs over the years (see figure 1. above).
72. The STDC duration is 28 days although there is a duty to keep the detention under constant review.
73. In the Wessely review an assertion is made that suggests that the use of the Act is reflexive: *'in other words it is influenced by the time frames under which people can be detained before a safeguard "kicks in". We think that the tendency for some RCs to discharge a patient shortly before a hearing is proof of this.* (p120)
74. There is a duty to keep the detention order under continuous review but there are competing demands on the time of an RMO and there are models of service delivery and workforce issues that can limit the opportunity to do this or dictate when this duty is discharged. It is therefore important to ensure that there are checks on the way that the powers are used and these are used for as short a time frame as is practicable. **(Proportionality)**
75. There does not appear to have been any discussion about the length of a STDC (28 days) at the time of the last review of legislation (Millan report) with most respondents suggesting that this time frame was about right. The duration of detentions authorised through the Act has remained the same for decades and does not appear to reflect the strides made in treatment and care for people with mental health difficulties in hospital and community settings.
76. The Commission has analysed the data we hold to explore when STDCs are most likely to be revoked or when the authority to detain expired. This work has not been published yet but as this is so important for the case around proportionality for the Review, we are providing some of the findings here. A full report will be available in Autumn 2020.

Graph 3: Number of patients who had short term detention orders ended on each day of detention from day 1 to day 28 (whose detentions did not progress to CTO) detained from 2005-06 to 2019-20 (n = 27317)



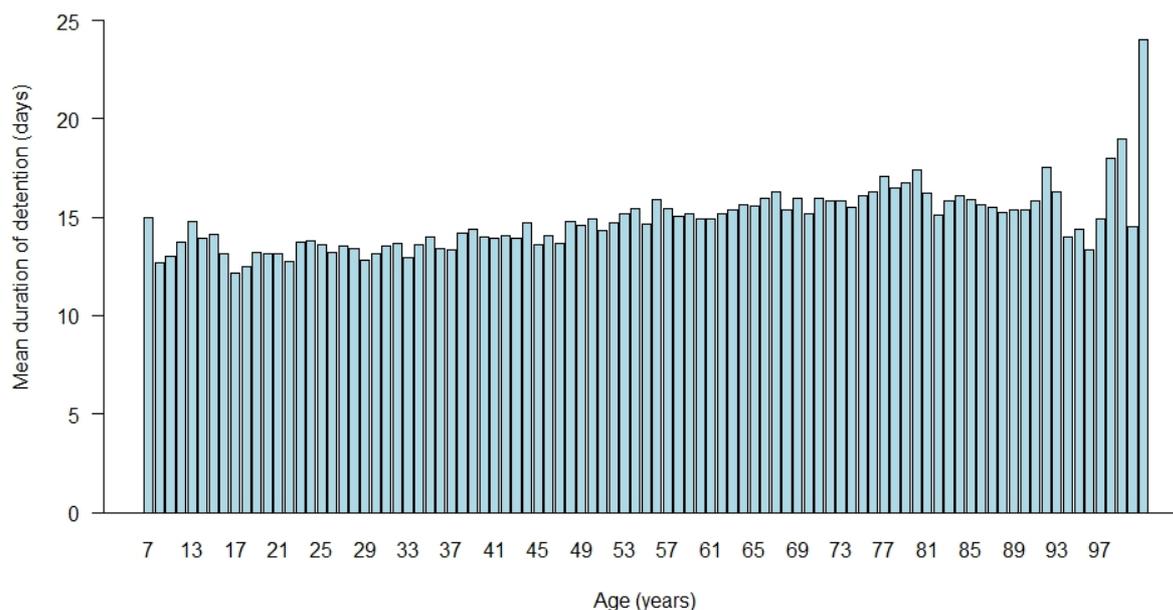
77. This graph illustrates that the vast majority of patients had their detentions revoked/ or the authority to detain expired on the 28th day. These are STDCs that do not progress to CTOs. On removing the 28th day revocations/expiry to detain from the data set, the following pattern emerges:

Graph 4: Number of patients whose detention ended before day 28 who had their detention ended on each day of detention from day 1 to day 27 including loess (locally estimated scatterplot smoothing) curve (n = 17577)



78. In the final graph in this section, we explore the mean duration of detention by age for those whose detention lasted less than 28 days.

Graph 5: Mean duration of detention (days) for patients of different ages whose detention ended before day 28 detained from 2005-06 to 2019-20 (n = 17577)



79. This suggests that for most people detention lasts, when it isn't stretched (reflexively) to the full 28 days, for shorter durations.

80. However, there is also a noticeable gradual increase in duration with increasing age. This might reflect the initial process involved in detaining some people for conditions such as dementia.

81. It is arguable whether the STDC fits the needs of people with dementia or whether for conditions like dementia, there is a gap in legislation. The Commission notes the recommendations of the review of AWI (2000) and specifically its recommendation around short term 'placement' orders.
<https://consult.gov.scot/health-and-social-care/adults-with-incapacity-reform/>

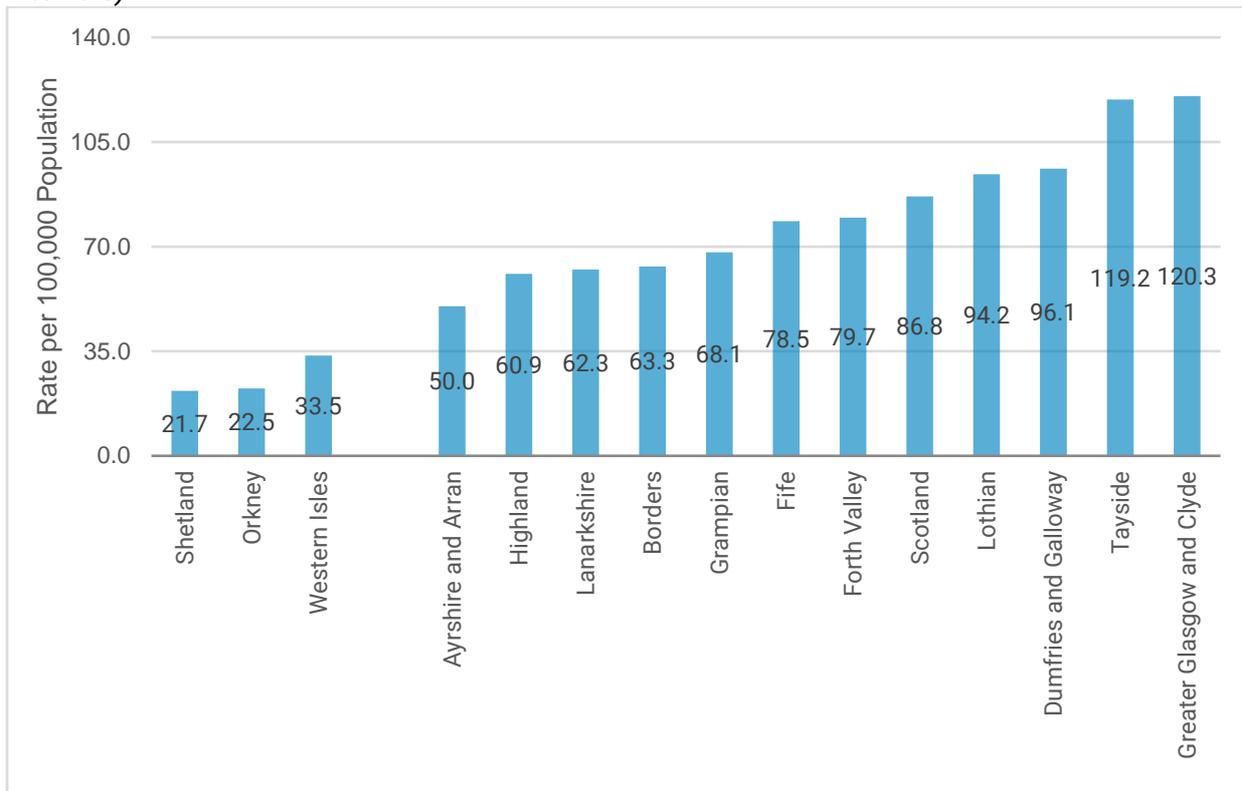
82. There are jurisdictions like New Zealand that have a shorter 'extension' of the equivalent emergency detentions and a shorter 'short term detention' so that the original detention is much shorter in duration and is then reviewed by MHO and RMO (equivalents) in order to extend this (although direct comparisons would be flawed)
<http://www.legislation.govt.nz/act/public/1992/0046/latest/DLM263018.html>

83. At the time of the introduction of the Act, it was considered world-leading, there are jurisdictions that have features that are more progressive that the review ought to consider (such as the example above from NZ; please see example in Advance Statements section from India). It is important to take a globalist approach when searching for evidence- actively seeking out people with lived experience, practitioners

and experts in Scotland who also have experience of other jurisdictions and seeking their perspectives on our laws.

84. The Commission is taking a 'globalist' approach in this response- however at the same time we are mindful that cross-jurisdictional comparisons miss the nuances of how the law is applied. An academic paper in the Lancet Psychiatry (Rains, 2019) commissioned for the Wessely review makes a cross-jurisdictional comparison of detention rates.
[https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(19\)30090-2/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30090-2/fulltext)
However, to take just one example: in comparison to England, whereas our stated preferred entry detention is a STDC, in England this distinction is not made- indeed the recent review concludes that use of assessment sections of a similar duration to a STDC (the section 2) should be used for 'assessment'. This makes comparisons on use difficult and lacks clinical meaning. Information gathering on cross-jurisdictional comparisons could take a more qualitative assessment of the lived experience of the Act and of its use by professionals to understand differences.
85. The duty to keep the detention under regular review is not realised as well as it could be and some colleagues who have had a look at this data suggest factors such as ward rounds might be a determining factor in the way in which the Act functions. It might be helpful for the review to consider whether functional splits or combined inpatient-community models of work, or practices that bridge community-inpatient divides have a discernible effect on the way that the law and its safeguards are applied.
86. There is further analysis on this data which illustrates differential effects on age groups, and the days of the week on which detentions are more likely to start and finish. This is not presented here but will be published in due course.
87. This detailed analysis demonstrates the information that might inform the review that is available through the Commission data-set. We would be happy to discuss further questions that might be helpful to the review team. The Commission is grateful for the expertise that it received from statistician Gail Robertson at University of Edinburgh for the statistical work in the data on durations of STDCs presented above.
88. Similar to EDCs there is substantial variation across Scotland with regards rates of STDCs by Health Board.

Graph 6: STDCs by health board 2018/19 (rate per 100,000 population with 95% confidence intervals)

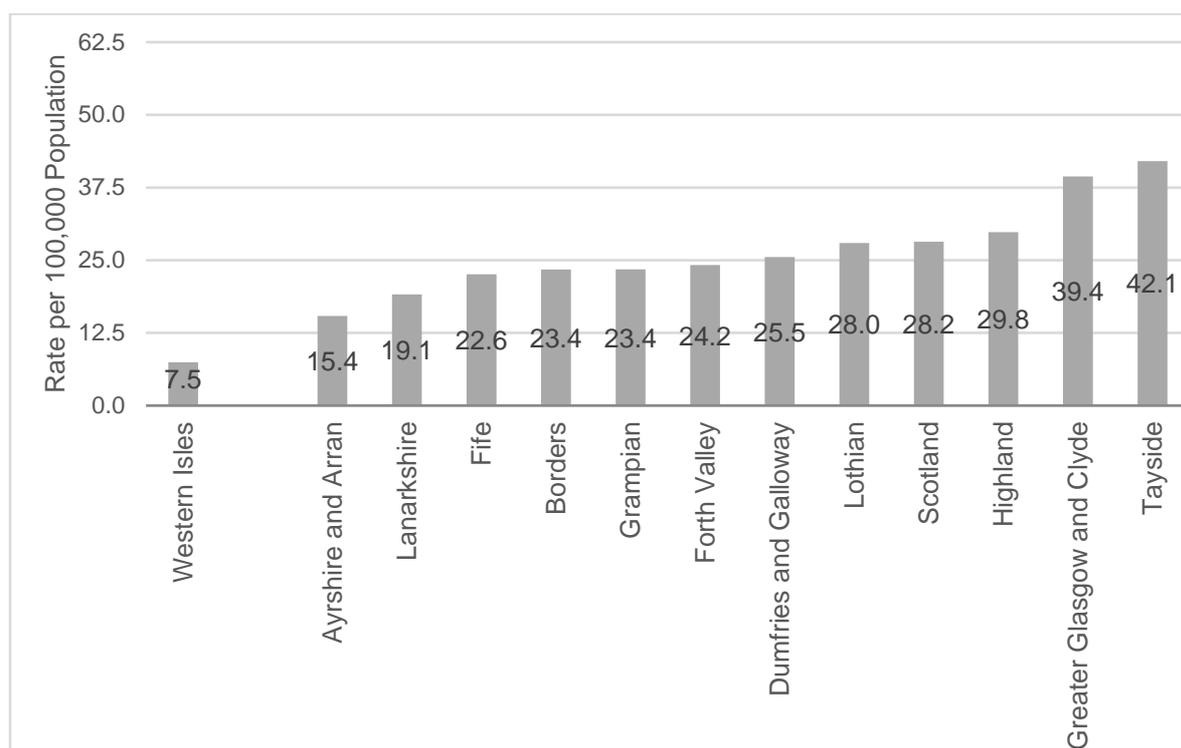


89. The Millan Committee on page 97 of its report noted that the lack of a breakdown of statistics for patients 'discharged to informal status' between those who remain in hospital on an informal basis and those who are discharged was a serious gap in statistics. The Commission does now collect this data. Looking at data for recent years, where the data is reported to us following a revocation (as opposed to a lapse in the detention for which this information is not recorded) about 50% of patients stay informally. Further detailed breakdown available on request.

Compulsory Treatment Orders

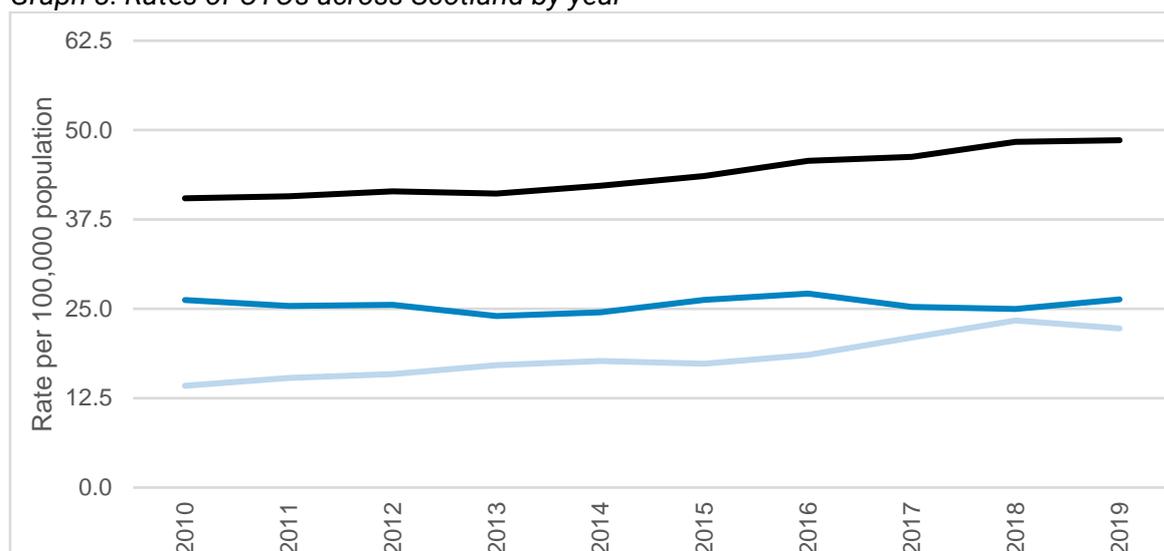
90. A mental health officer (MHO) can make an application for a CTO to the Mental Health Tribunal. The application must include two medical reports, an MHO report and a proposed care plan. The Tribunal decides whether a CTO is to be granted. The Tribunal is made up of three people - a lawyer, a psychiatrist, and another person with relevant skills and experience, e.g. a nurse, social worker, or someone with personal experience of serious mental illness. The CTO can last up to six months. It can be extended for a further six months and then for periods of 12 months at a time.
91. Similar to EDCs and STDCs, there is considerable variation in the rates of CTOs across Health Boards

Graph 7: CTOs by Health Board



92. The monitoring report 2018/19 provides the details on the rise in rates of compulsory treatment orders. We comment in this that there was no rise in the rates of hospital based Compulsory treatment orders and that the rise is attributable solely to the continuing rise in the number of people subject to and the rates of community based compulsory treatment (this is depicted in graph 8).

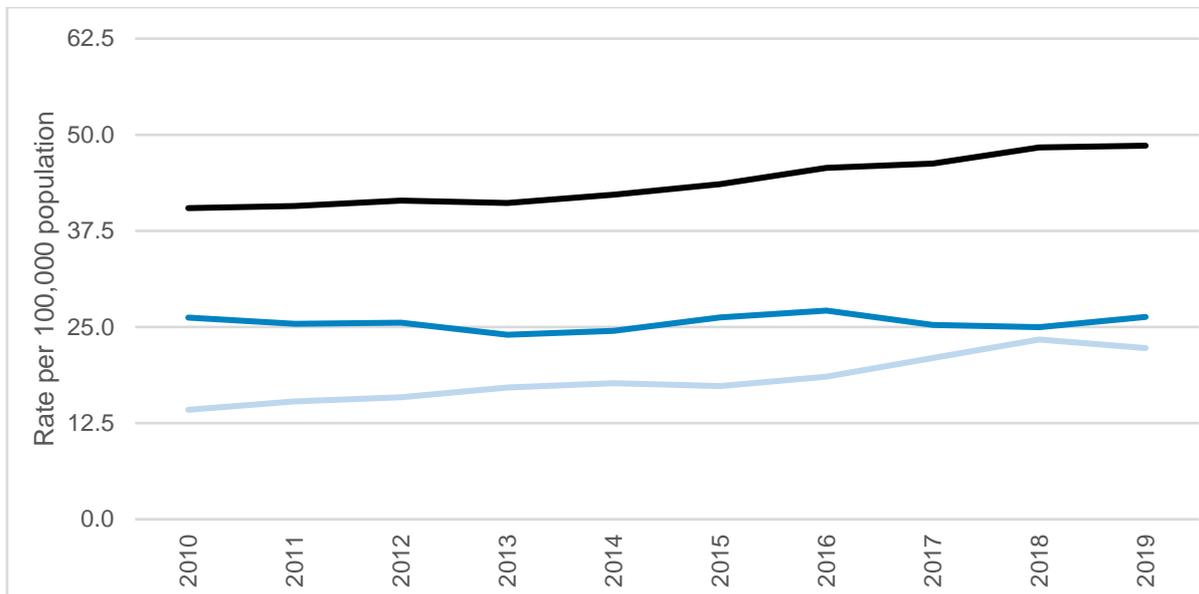
Graph 8: Rates of CTOs across Scotland by year



93. The health think tank, The Kings Fund published a report focusing on the early findings following the introduction of community based treatment orders in 2006. At this stage the Act and its powers were new. The estimate was that about 200 people would be subject to compulsory community powers. The Kings Fund report suggests that these

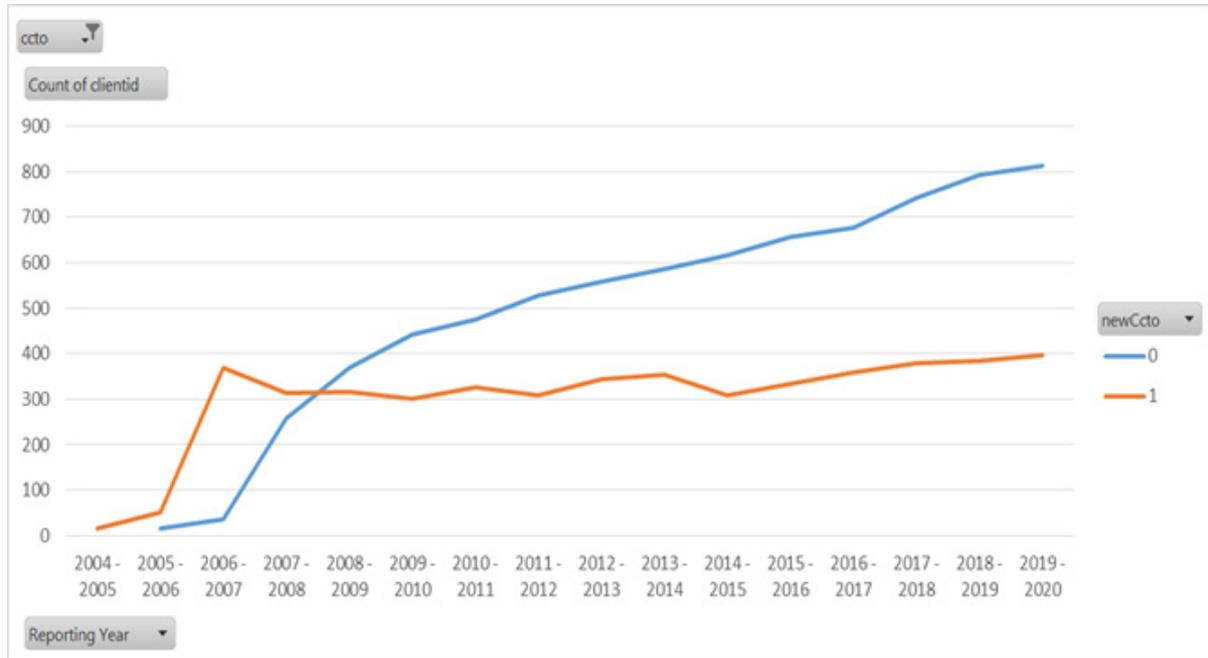
powers were welcomed.

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/community-based-compulsory-treatment-orders-scotland-early-evidence-simon-lawton-smith-kings-fund-20-november-2006_0.pdf



94. Take up of these community powers has been extensive. Over the ten year period the point prevalence of all (community and hospital) CTOs has increased by 20.1% from 40.5 (per 100,000) at January 2010 to 48.6 (per 100,000) at January 2019. This continues the upward trend. Most of the increase is due to the 56.4% rise in point prevalence of community based orders from 14.2 to 22.3 (per 100,000) while that of hospital based CTOs has been static at 26.2 to 26.3 (per 100,000). What is driving the increased rate of community based CTOs? And was this the intention of the Act to drive compulsion into the community. Across the world there has been considerable ethical debate about these sort of powers and yet there seems remarkably little debate currently about whether these powers should continue in their current form.
95. The OCTET study on English Community Treatment Orders found no evidence that these reduced admission rates (Burns 2013):
[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60107-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60107-5/fulltext)
Whereas a smaller study in Scotland suggested that bed-days might be reduced by use of the CCTOs (Taylor, 2016):
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4887728/>
96. The Wessely review called for a dramatic reduction in use (p28). It would be worth revisiting the research using Commission data to explore the impact of restrictions of liberty in community settings. The English review has suggested that Community Treatment Orders have an end date rather than to be repeatedly extended although the Responsible Clinician (RMO equivalent) would still be able to make a new application.
97. The data set presented below has not been reported in the monitoring report and has been developed to explore the questions around the use of Community based CTO to address the concern about rising numbers of detained patients in the community specifically to inform the Review.

98. The following graph shows the increase over time of the total number of cCTOs in the community in Blue, and new cCTOs initiated each year in orange, contributing to the overall rise in numbers of people subject to compulsion in the community. (Data collection was incomplete before 2006 so we advise to not consider the earlier years' data).



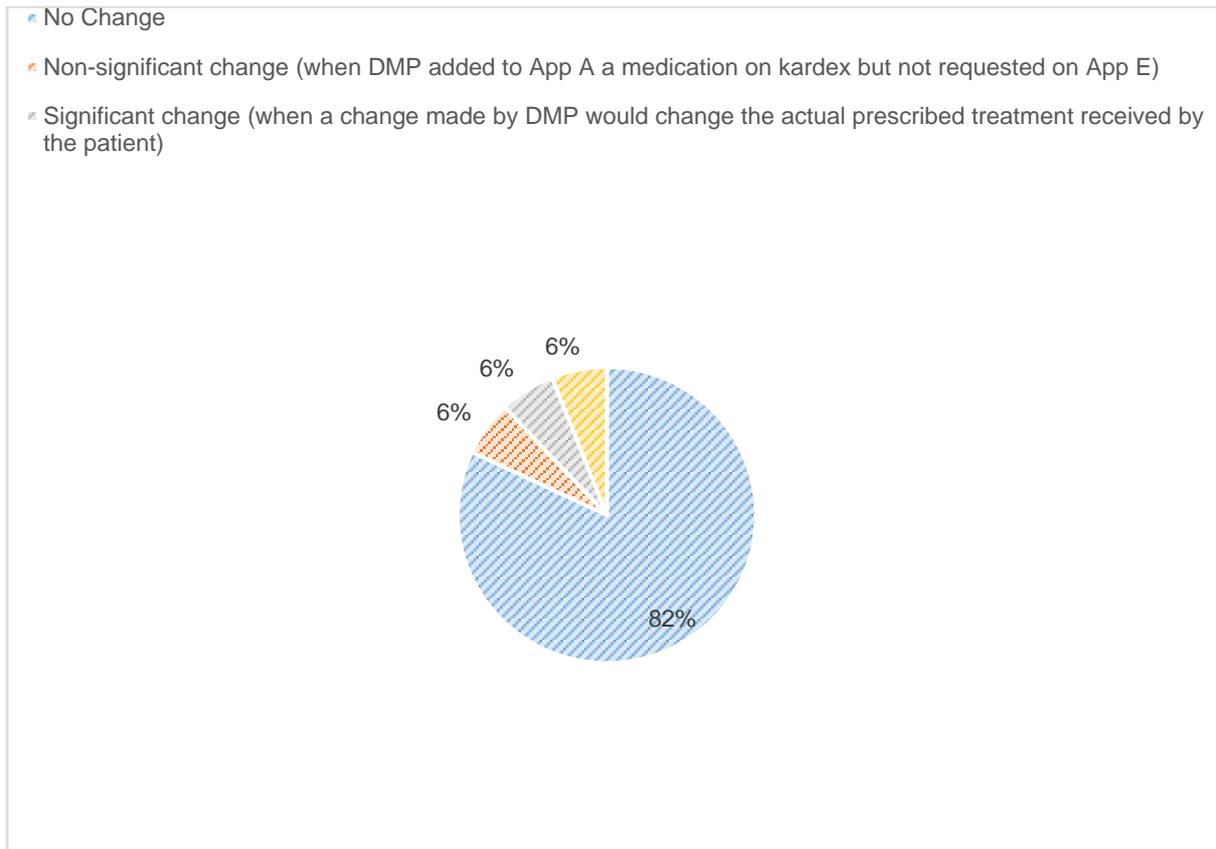
99. Millan Committee did not consider an 'end' point to the cCTO order nor is this fixed in the Act. The general duty that it must be kept under regular review applies. What this continual increase of people subject to restrictions in the community means for the operation of the Act could be profound with impacts on a range of human rights. There will need to be a mobilization of resource to support community based activity. The reciprocity principle will need to be considered within the community setting.
100. The Commission Themed Report on the care of people subject to cCTOs provides an account of Commission visits to almost 200 people who had been subject to a cCTO for more than two years. The findings suggest that people were receiving good care and many felt that the order was of benefit. The Commission did recommend that care plans should have a 'revocation strategy' that aims to help a person recover to the point where formal measures are not needed.
<https://www.mwcscot.org.uk/sites/default/files/2019-06/Lives%20Less%20Restricted%20CCTO%2010-11.pdf>
101. We also explored whether the Act was working in the way that the Millan Committee had considered, i.e., that it would be unlikely that a person would be considered suitable for a community treatment order without a previous period of hospitalisation. Our records report that 88 people were directly detained onto a cCTO (out of 1824 community CTOs). The median number of detentions prior to a cCTO was 2. This suggests that the Act is working as it was intended to for this purpose.
102. However, the data on rising rates of CTOs in the community suggest that the Commission recommendation about a revocation strategy might not be realised in practice and the Review might consider whether a CCTO should have an end point (with ability to apply for a new cCTO) and what might be a reasonable end point for a cCTO.

103. Although last year's monitoring report did not describe a breakdown of CTO by age and gender this is available. In 2018-19, 47% of people detained under a CTO were women. The average duration of a CTO is 501 days (based on data from previous four years). In the future, this information will be included in Monitoring Reports.

Designated Medical Practitioner Safeguard

104. Another safeguard to protect the rights of the patient under the Act is the Designated Medical Practitioner safeguard. The Commission appoints DMPs to authorise treatments for those who do not consent or cannot consent to certain treatments that are safeguarded. These include ECT, provision of nutrition through nasogastric feeding, Neurosurgery for mental disorder, TMS and medication beyond two months from when treatment started. The purpose of the DMP review is to check the legality of the treatment (i.e., is the person detained in accordance with the law) and for the DMP to determine whether the treatment plan that the RMO proposes for the patient is likely to alleviate or prevent deterioration in the patient's condition. The criteria for ECT determination are somewhat different. The numbers of DMP authorisations undertaken are reported in the Commission's Monitoring report mentioned above.
105. The Commission sought the views of DMPs who might want to inform/ contribute to this response through the Commission. An issue reported was whether the safeguard with regards neurosurgery was fit for purpose given that this surgery no longer occurs in Scotland (patients who are referred for this attend in London). It was unclear to the Commission whether any Scottish patients have received such treatments in recent years- it would appear not from the CQC data set where these numbers are reported.
106. The questions that arise with regards to whether the Act is working to protect rights are whether the safeguard works, whether the right treatments are safeguarded (these can be amended through secondary legislation), and whether the aim of the Act is realised.
107. The Commission undertook an audit of 100 recent DMP visits to explore to what extent DMPs appeared to be challenging or suggesting changes to an RMO treatment plan. This shows changes were reported to the Commission in 12% of the cases audited. The Commission is grateful to Dr Anna Fletcher, a then higher-trainee in psychiatry who undertook this work as part of her placement with the Commission. The Commission has recently been liaising with the CQC that runs a similar scheme and noted the CQC report that suggested 29% challenge rate in their equivalent scheme.

Pie chart 1. Changes to treatment plans reported to MWC by DMPs.



108. Although the audit would suggest a limited sense of any challenge, the discussion of this data at the Commission's annual DMP Seminar in November 2019 highlighted just how much 'behind the scenes' activity is taking place that means that by the time the DMP is writing the authorisation (T3) that records the agreed treatment plan, many issues have been discussed and amended.
109. There needs to be a review of how this safeguard works to ensure that information is correctly recorded and that the aim of the Act of the use of the DMP safeguard is realised and demonstrable. Options to consider include whether more treatments or different treatment should fall under the remit of the treatments that are scrutinized by DMPs. This might include considerations of seclusion beyond a certain time period as well as traditional treatments that have been subject to this review or whether the DMP might have regard for whether the treatment advocated by an RMO is proportionate, is the least restrictive alternative and whether duties around reciprocity might be safeguarded. This would need to be resourced.
110. In the Commission's view this is a vital safeguard that should be protected and may need to be enhanced (including considerations of appeal against a decision of a DMP) or provided earlier as the current system that allows medications and treatments to be administered (with some exceptions) without review even in the face of refusal for two months is probably incompatible with ECHR (*X v Finland*).
<https://mentalhealthandcapacitylaw.wordpress.com/2012/07/18/x-v-finland-are-we-in-trouble/>

The Mental Welfare Commission

(As a safeguard for the human rights of people with mental illness and associated condition and its various functions as defined by the Act.)

111. The 2003 Act lays out the powers, duties and functions of the Commission.
112. In practice, the Commission defines its purpose as to promote and protect human rights of people with a mental illness, learning disability, dementia and associated conditions.
113. For the Commission to be able to safeguard human rights effectively across mental health services, there is need to bring about a shift towards a human rights culture across services. To this end, the rights and duties of the treaties that apply to Scotland would need to be directly reflected in law. Rights would need to be interpreted in ways that fit with the Convention on the Rights of Persons with Disabilities, the European Convention on Human Rights and other treaties.
114. The Millan Committee heard extensive evidence on the Commission from a variety of stakeholders (the role of the Commission was one of the terms of reference set). The report suggests that stakeholders wanted the Commission to play a more 'interventionist' role across the mental health landscape and there are an extensive number of recommendations made about the powers that the Commission ought to have and the role it might play. Most of these recommendations (see chapter 23 of Millan) found expression in the current Act.
115. For obvious reasons, it is for others to assess whether the Commission has succeeded and how well in its duty to discharge the functions conferred on it through the Act. Measures of success that we suggest to consider how well the Commission has achieved against the expectations that the Act sets out, include the use of the phone/email system to address queries, the impact of the recommendations following investigations it has undertaken, the statistical monitoring of the Act, and of the visits the Commission undertakes, and the guidance and advice it produces.
116. During the Covid pandemic, the Commission guidance notes that were rapidly produced and frequently updated, have been widely shared on social media and quoted from by practitioners keen to sense check whether what they are doing is 'right' in the new-normal that the pandemic created. The Commission has been actively involved in discussions with other stakeholders across the sector to develop mechanisms to determine when and if emergency powers might be commenced. The support for the Commission to undertake the scrutiny function of how greater powers were/are used across the sector would appear to demonstrate the value placed on the Commission's independence from the professions and from Government.
117. Due to the pandemic the Commission has yet to explore our most recent stakeholder survey to consider the views and whether any relate to powers or functions discharged through the Act. This analysis and consideration of the resources that the Commission needs may be helpful for the Review to consider the role of the Commission.
118. The Commission has taken a lead role in instigating recent Judicial Reviews where there appeared to be a disregard to the use of the Act to safeguard the rights of people with impaired capacity who were moved from hospital to care homes without proper authority.
119. The Commission needs to be adequately resourced to be able to take forward cases that it considers require further legal challenge to services and practice.

120. It has made reference to the MHTS Tribunal where it has been concerned that a patient wanted to appeal and there was no legislative provision under which they could.
121. There are powers, however, that the Commission has not used under the current Act e.g., the power to revoke detentions. The Commission considers that it is more appropriate for it to refer cases of concern to the Tribunal so that there is a proper exploration of issues in a designated process
122. The 'Trust and Respect' report (Strang Review) into Tayside mental health services makes a recommendation (no. 12) that there ought to be a review of the powers of organisations such as HIS and the Commission for governance assurance across the sector.
<https://independentinquiry.org/final-report-of-the-independent-inquiry-into-mental-health-services-in-tayside/>
123. Part of the issue here may relate to people who sought input from mental health services not being offered the help that they were asking for. This is not unique to Tayside. There is no effective mechanism within the powers of the Commission under the Act to review decisions or to have a sense of whether the proportion of people who are not detained during a MHA assessment is greater in one area than another; and neither are we notified, nor would it be practical for the Commission to hold information of the numbers of assessments where someone is not detained.
124. The Review may reflect on the powers that the Commission has under the Act in the light of the Strang report and the Rome Review recommendations that include a strengthening of the Commission powers and functions. Recommendation 12 (mentioned above) should also be shaped by the recently constituted Quality and Safety Board that has not met after its initial meeting in February 2020, due to the Covid pandemic. Further discussion with other scrutiny bodies who may have overlapping interests has not yet happened and a planned the Commission staff 'Away Day' to discuss this issue and then discuss with the Board in March 2020 also had to be cancelled due to the pandemic.
125. The Commission already has duties and powers under sections seven and eight to bring matters to the attention of Scottish Ministers and others and also powers in relation to investigation at sections 11 and 12 and sections 13. Any consideration of further powers or roles that could compromise the independence of the Commission would require careful consideration by the Board and other key stakeholders. This would represent a significant move towards an enforcement and inspectorate role and a shift in the how the Commission carries out its functions primarily by way of influence, challenge, and the promotion of best practice.
126. The size of the organisation reflects its inability to undertake further scrutiny as a safeguard. In the past, Commission staff would review all Social Circumstances Reports. This is not possible now due to the volume of reports. The extent to which the lack of scrutiny may then impact on the non-delivery of the SCR target requires consideration. (Please see below for more on SCRs as a safeguard under the Act that is not being delivered consistently or at anywhere near the intended level).
127. The Commission has supported reviews on Excessive Security including considerations of making a reference to MHTS for a detained patient who was unable to raise this themselves.
128. The Commission undertakes investigations where it feels that the case and the findings that might emerge might lead to recommendations across Scotland. The Act provides the Commission discretion to consider what it might wish to investigate. We feel that this important discretionary power.

129. 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. In Appendix B we attach considerations from this important aspect of the Commission's work that are relevant to the Review.

Social Circumstances Report

130. An MHO is regarded as having expertise in analysing the interaction between the health and social circumstances of the person who has been detained, together with the knowledge of alternative care and support options which may be available in the community.
131. Having a wide sense of a person's circumstances is vital to be able to explore the range of options that might be available to them and to properly consider the social context that might have contributed to the detention/relevant event and is essential if mental health services are to be able to comply with their duties to fulfill people's social, economic and cultural rights. One of the duties required of an MHO is produce a Social Circumstances Report (SCR) under section 231 of the 2003 Act.
132. The Act introduced significant changes relating to the statutory provision of Social Circumstances Reports (SCRs). The Mental Welfare Commission welcomed these changes, which resulted in an increase of over 50% in the provision of SCR's compared to the number provided under the 1984 Act. However this safeguard has not been maintained
133. In our 2009 report we report our concerns about the lack of a strategic approach among most local authorities to assist Mental Health Officers (MHOs) in determining when an SCR should be provided. This led the Commission to prepare guidance on best practice with regards SCR's.
<https://www.scie-socialcareonline.org.uk/social-circumstances-reports-good-practice-guidance-on-the-preparation-of-social-circumstances-reports-for-mental-health-officers-and-managers/r/a11G000000182hQIAQ>
134. 2018/19 data shows only 37% of SCR's were completed. The Commission received 282 SCR's in 2018/19 and 270 'no purpose' letters- these often do not explain why there is no purpose and merely state this. There is a risk that with the integration agenda and a lack of awareness of the legislation some senior managers will de-prioritise the SCR work in favour of partnership auditable work. The Commission suspect some managers may not monitor their staff's compliance with SCR completion rates. The MHO Standards Doc is relevant especially Standard 7.
<https://www.gov.scot/publications/national-standards-mental-health-officer-services/>
135. Some MHOs might indicate they don't have time to prepare an SCR following a STDC because they are preparing the CTO application. The Commission is not sure that extending the timeframe from 21 to 28 days would improve the numbers of SCR's.
136. It is clear that the Act is not succeeding in its aim here and like the MHO consent point mentioned earlier, it is worthwhile considering whether this remains an effective safeguard. If it is considered useful than it ought to be afforded priority.

137. Independent MHOs are a vital safeguard under the Act and there is a concern that the integration agenda might dilute the independence of the MHO. In the Commission's Investigation into a delayed discharge – Ms ST one of the recommendations was:
- 5. To ensure that they have clear procedures in place in relation to Mental Health Officers (MHOs) which ensure that:
 - there is a system for MHO referrals which effectively prioritises people experiencing delayed discharge;
 - **MHOs' independent role is respected and supported;**
 - MHOs are always invited to Adults with Incapacity (AWI) case conferences and attend wherever possible;
 - disagreement with a care plan is not an indicator of the unsuitability of an applicant for guardianship; and
 - a negative MHO suitability report is always discussed with a manager.
- [https:// www.mwcscot.org.uk/news/investigation-delayed-discharge-ms-st](https://www.mwcscot.org.uk/news/investigation-delayed-discharge-ms-st)
138. The responses we have received to that recommendation have all emphatically reported that the independent role of the MHO is always observed in practice within their areas but we note that these responses have been provided by managers and might not fully reflect what happens in practice. The review may wish to gather evidence from frontline MHOs in this regard.
139. Millan Committee noted (p88) that MHOs are independent of health boards and are therefore able to take a genuinely independent view on the need for Compulsory measures. The Commission would like the review to consider how the MHO role can be supported moving forward, where it sits within the new integrated structures and how it can be supported to maintain the vital independent safeguarding role for which it was intended.

D. How well the Act maximises a person's ability to make their own decisions and give effect to them?

Advance Statements

140. Advance Statements were introduced in the 2003 Act as a mechanism to ensure service user and patient voice at a time when they might be unwell and unable to express their view. Professionals are under a duty to have regard for these statements.
141. A register of AS was established in Mental Health (Scotland) Act 2015 and held by the Commission- but this does not note content- just the existence of an AS. Baseline numbers of ASs are low. In 2018/19 – 271 returns (253 people).
142. Scottish Government has made AS a quality indicator benchmark which may lead to a greater uptake of these documents as Boards promote them. Important to ensure quality though. (P4 Number of people with advanced statements registered per year with the Mental Welfare Commission for Scotland- SG QI indicator- rationale for inclusion as a marker of person centered care is that this shows collaborative working.)
<https://www.gov.scot/publications/mental-health-quality-indicators-background-secondary-definitions/pages/10/>
143. Advance Choice Documents are emerging as a choice following the English Review. These will be statutory documents that will enable people to make choices and statement about their care and treatment. The recommendation is that these need to be piloted identify the level of detail that is needed to impact practice. Several papers published about barriers to implementing advance planning in England might be relevant to our jurisdiction too.
 - Barriers for patients (Morriss 2017)
<https://pubmed.ncbi.nlm.nih.gov/28644738/>;
 - Barriers for psychiatrists (Morriss 2017)
<https://pubmed.ncbi.nlm.nih.gov/29234508/>
144. These studies report concerns such as perceived low value by patients as they can be overridden and a lack of a sense of when they are best completed (psychiatrists).
145. The Commission's forthcoming Advance Statement Overrides SO paper (late Summer 2020) will cover aspects of what is overruled which might be helpful in Scotland's context to understand how these are currently functioning. At this stage, to provide an indicator on this important measure to the Review, we can report that for the 81 **patients for whom the Commission received notifications of treatment that was given that in conflict with an advance statement in 2018/19, almost half of these were wishes to not receive a depot medication. The full data will be published in due course.**
146. Despite the low level of interest, the AS under the Act was the first time that there was a legal duty to have regard for the wishes expressed when well and are seen as tool to empower patients, and improve care. India's new MH Act published in 2017 is an ambitious Act. It was motivated by a desire to increase concordance with UNCRPD and has what is regarded as a more powerful Advance statement about treatment that can only be overruled in an emergency or through referral to an independent Board (Owen et al 2019)

https://kclpure.kcl.ac.uk/portal/files/108537609/Advance_decision_making_in_mental_health.pdf

How this will be implemented and what the consequences may be will need to be assessed.

147. The distinction between a decision to refuse treatment and an expressed wish to receive something is an important one and has legal and ethical significance. Current advance statements do not reflect the distinction well.
148. The Covid pandemic has done much to spread awareness of Advance planning documents and it might be that across healthcare more could be done to create advance planning documents and that these are then given parity across mental and physical health with prescribed checks and balances with regards their use and procedures to override.
149. It is difficult to say whether this aspiration of the Act has been realised but on the basis of the data we hold the Commission does not think that Advance Statements have 'taken off' despite the work done by health boards and the Commission on this so far.

Advocacy availability

150. The 2003 Act established a right to advocacy for anyone with a mental disorder regardless of detention status. As well as a mechanism of empowerment and ensuring that the service user voice was heard in difficult circumstances, in practice this was considered another mechanism to safeguard against concerns regarding de facto detention.
151. In 2015 Act in response to concern that this right to advocacy was not being fully the Commission was given power to monitor and report on NHS and LA strategies to secure independent advocacy. Our sense of the position now based on work reported in March 2018 is that:
 - Individual advocacy is widely available
 - Some collective provision
 - Some gaps in non-instructed advocacy
 - Significant gaps in provision for children and young people- our monitoring report on young people admitted in adult setting particularly highlighted the lack of specialist advocacy for this group.
 - Most services prioritising referrals for people subject to MHA
 - Majority of budgets at a standstill over past two years
 - Lack of strategic outcomes & approach to promotion
 - Lack of attention to equalities

<https://www.mwcscot.org.uk/news/right-advocacy-review-advocacy-planning-across-scotland>

152. Advocacy including non-instructed advocacy should be available across Scotland and should be adequately resourced. Provisions in the MHA on advocacy are not adequate for CRPD compliance with Article 12.

153. There does appear to be a tension between Supported Decision Making (if someone is supported to make a decision) and a competent Advance statement that might conflict with the decision that a person had made with support.

E. How have things changed since the Act came into force in 2005?

154. We have commented above on the rising rates of detention in Scotland.
155. This has taken place at the same time as there has been a greater policy focus on mental health and considerable media interest, particularly on children and young people's mental health. There have been constraint issues.
156. There has also been the impact of the 2008 recession on public services.
157. The Scottish Government's ten year mental health strategy provides a sense of direction on priorities. The landscape in which the Act operates in terms of public bodies has changed.
158. There has been a focus on realistic medicine from the CMOs office that has placed an emphasis on patient participation and there has been a focus on human rights in SG.
 - <https://www.realisticmedicine.scot/>
 - <https://www.gov.scot/policies/human-rights/>These aspects of medicine and law have perhaps enabled a growing awareness within the health sector and wider society of the need for patient participation.
159. It is unclear at this stage whether and how the covid pandemic might impact on priorities and resources in the mental health sector.

F. Are there certain things that hinder the Act from working effectively? What would improve things?

160. The following is a non-exhaustive list of comments from Commission colleagues on aspects that could be improved based on issues that we are often contacted about.
161. 2015 revisions to Named Person and listed initiators require some work to make them work as mentioned in the carer perspective comments at the beginning of this report. There is also an issue in that people under the age of 16 cannot nominate a named person and this is done by a default mechanism which may or may not be the person that the young person would want to choose. The review might wish to consider whether the Act should promote the principle of participation for any competent person regardless of age although parental rights and UNCRC will need to be part of these considerations.
162. The current specified persons provisions (only) cover:
- posted mail
 - use of landline telephones
 - "Safety and security in hospitals" - measures and restrictions to manage a patient who (in the RMO's opinion) "has sought to acquire or is likely to seek to acquire, any item which is likely to be prejudicial to the health or safety of any person or to the security or good order of the hospital". (This can include, in some cases, testing for use of substances).

Usual, regular, access to and use of modern IT resources and communication methods has developed exponentially since the regulations were written (such as mobile phones, internet access, e-mails, use of social media). Restrictions for all such equipment and communications defaults to the safety and security in hospitals provisions.

There is need to develop legislation specifically cover restrictions to access and use of such equipment and communications by detained patients where this is necessary, with documentation of reasons for specific restrictions, and appropriate rights to review of those. This also needs to cover staff review of IT activity if indicated (i.e. searching internet histories, checking e-mail content, etc).

The current requirements under regulations to notify the Commission on each occasion that an item is withheld from the recipient or from the post from a person subject to these measures can be problematic for services.

163. Cross border transfers are complicated and cumbersome and require update/simplification.
- In some cases they can appear to work against the person as if a person is made informal and wants to leave, technically the RMO still requires SG approval despite not having a power to enforce this; nor would it be ethically acceptable. This might be a role undertaken within two weeks by an independent doctor such as a DMP.
 - The Commission takes the view that it should be possible to revoke the STDC of a person detained in Scotland who has absconded from another jurisdiction under cross border absconding provisions but this view is not shared.
 - The requirements of the cross border transfer regulations for detained patients appear unrealistic where they say that the Scottish Ministers require to have regard for arrangements which will secure corresponding measures for the

patient where they are to go. It may not be possible to obtain a guarantee that the patient will be detained in the country they are going to - that will be often be determined by those who assess them after they arrive.

- The review might also wish to consider whether it would be possible to work with other near-jurisdictions in a four nations approach to harmonise the mechanisms around cross border transfers with our immediate neighbours.

164. There are concerns about the treatment of people who require depot medication and are detained in the community for whom our guidance is that the depot should not be forced in the community and if the person refuses this then consideration ought to be given to recall for a short period to hospital.

There were concerns expressed to us that this approach was not always helpful for some patient with learning disabilities and psychosis who was subject to a CCTO and required depot medication that during periods of agitation they might refuse. Is there a way that a mechanism to administer treatment, with force, could be done in the community on a regular basis? We did not and do not think so, but we accept that it is possible to consider an alternative frame of reference where the difficulty and agitation caused by a trip to hospital is to be balanced against the risks of treatment against someone's will in the community. The Review may wish to consider this issue.

G. Are there groups of people whose particular needs are not well served by the current legislation? What would improve things?

Learning disability

165. There has been concern about whether people with learning disability and others with a stable cognitive impairment should be subject to the same Act that governs treatment of mental disorder. The Commission's response to the third stage of the review that looked into the place of LD and Autism in the Act is here:
<https://www.mwcscot.org.uk/sites/default/files/2019-11/Response%20to%20LD%20and%20autism%20in%20MHA%20consultation.pdf>.
The Commission has not formally responded to the final report from the Rome Review.
166. We were supportive of the idea of human rights assessments to determine the need for treatment and detention.

Offender mental health

167. The Commission response to the Barron review (independent review of forensic services) is here:
https://www.mwcscot.org.uk/sites/default/files/2020-02/FinalResponse_theCommission_ForensicReview-CallForEvidence.pdf
168. In addition the wider service points mentioned within this, on the specific issue with regards legislation for this group that might be of benefit.
- Consider legislation to allow patients on compulsory measures in the community to continue to be given compulsory medication should they be in prison. A DMP safeguard could apply although there would need to careful consideration of other safeguards to ensure that the e.g., giving of depot medication (potentially with force) in a prison health centre is done with an appropriately trained health team safely. Further safeguards could be put in place for that to be authorised.
 - The Commission is aware of the frustration of some patients in this group and their families regarding the length of time they are in hospital which they then compare with prisoners with a similar offence. The relationships between tariffs of sentence and CPSA orders could be considered to facilitate transfer between settings dependent on need. It would also allow patients who require ongoing treatment to be able to move from CPSA to civil legislative authority for treatment, and no longer be subject to "criminal" legislation, with reduced potential for experiencing any stigma related to that.
 - The Forensic disposals are considered complicated. Many mental health professionals lack familiarity and confidence in this area of work. Training and support, for this area, particularly ought to be vital to the implementation of any new Act.
169. The excessive security appeal system set up by the Act and extended by the 2015 Act has been well regarded but the lack of forensic estate at the medium and low secure level is hampering progress on this.
170. We mention in our response to Barron review that other patients now being disadvantaged e.g. people in IPCUs who need to be in secure care due to a lack of low secure provision.

171. We are also concerned about the level of resource available to community based forensic patients and the implications that this has to the continuation of compulsion in the community in order to ensure that patients continue to receive services.

Children and young people

172. As stated above (paragraph 38) in under the principle of Child Welfare - we do not believe that the duty under section 23 to provide 'sufficient' resource to meet the needs of children is met. As mentioned earlier (paragraph 161) there is also an issue in that people under the age of 16 cannot nominate a named person and this is done by a default mechanism which may or may not be the person that the young person would want to choose. The Commission has been contacted about this before.

A particular difficulty for this group is the number of different options that are available for authorisation of treatment for the under 16s that derive from different legal frame works (Age of Legal Capacity Act 1991, Mental Health (Scotland) (Care and Treatment) Act 2003, the Children (Scotland) Act 1995 & Children's Hearing (Scotland) Act 2011). This can create confusion, for young people and for the people who care for and matter to them and for clinicians working with them.

The Act offers more safeguards than when authority is provided by individuals who hold parental rights and responsibilities through the Children (Scotland) Act 1995. The Commission advises using the 2003 Act where any young person who lacks capacity is being treated against their will for mental disorder, is objecting to and resisting treatment or is undergoing treatment that significantly restricts their freedom and/or interferes with bodily integrity such as restraint or artificial nutrition; at the same time being mindful of parental rights and the role of parental guidance under UNCRC Article 5. The Review might wish to explore this complexity.

Finally for this group, certain treatments of informal patients under the age of 16 are subject to additional checks under s244 of the Act. The Commission has recommended that Artificial nutrition should be added to these treatments.

Perinatal

173. We do not believe that the duty under Section 24 for health boards to make provision for women to be admitted with their baby (where this is in the interests of both mother and baby), is currently being met. Our 2016 themed visit report into perinatal mental health recommended "Health boards should ensure that, in accordance with Section 24 of the 2003 Act, provision is available for women who want to be admitted to hospital with their babies."

(https://www.mwscot.org.uk/sites/default/files/2019-06/perinatal_report_final.pdf)

Two health boards still do not have a service level agreement with an MBU, which can mean their patients are not prioritised for admission. This problem was highlighted again in the Perinatal Mental Health Network's report (March 2019) which recommended: "All NHS boards should have equity of access to a regional MBU for those women who require inpatient care. The Scottish Government should ensure that MBU beds are provided as a national resource and decisions on admission made exclusively on clinical need".

(<https://www.pmhn.scot.nhs.uk/wp-content/uploads/2019/03/PMHN-Needs-Assessment-Report.pdf>)

Personality Disorder

174. In 2018, we published our report “Living with Borderline Personality Disorder”. (https://www.mwcscot.org.uk/sites/default/files/2019-06/nov2018bpd_report_final.pdf)
This report identified deficits in provision of services for people with Borderline Personality Disorder (BPD), the stigma and often negative associations with the condition.
The key priorities identified as the most important areas in the lives of people with a diagnosis were:
- Stigma and discrimination
 - The assessment and diagnosis of BPD
 - Access to treatment and support
 - Support after therapy and treatment finishes
 - Access to help in crisis and out of hours
175. The report looked at the use of the MHA for people with a diagnosis of BPD. Figures from 2016/17 show that mental illness accounted for the vast majority of people detained under the Mental Health Act; 89% of new short term detention treatment certificates were for mental illness. Mental illness with personality disorder accounted for a further 5% of these detentions. Two percent of these detentions related to a diagnosis of personality disorder (PD) only. The rates of people with PD alone detained under this type of order have changed little over the past 10 years. However, the proportion of patients discharged from psychiatric hospitals in Scotland with personality disorder recorded as a diagnosis has increased year-on-year since 2002-03, rising from 5.36% to 11.33% by 2016-17.
176. This suggests that fewer people with personality disorder are likely to be subject to detention. This needs to be interpreted with people with lived experience and those who work with them,
177. The interaction of under-diagnosis, stigma and discrimination and the contentious nature of the diagnosis and the nature of the condition can lead to polarised views on the value of admission for this group amongst professionals with effects on the use of the Act, in both directions- in terms of restrictiveness, or the Act not being used to protect the safety of the individual.
178. A particular aspect of this debate that warrants consideration is the definition of conditions that fall under the remit of the Act. This differs from jurisdiction to jurisdiction. If in a cross jurisdictional comparison, it would appear that the naming of personality disorder, explicitly, within the definition of conditions that are within the scope of the Act, appears to be helping with access to treatment and support this would strengthen the continued case for inclusion. This debate about whether personality disorder should be included is not new. The Millan Committee discussed this and in paragraph 91 of the report talks about how Psychiatric diagnoses can change- and to deny a group of people the protections of an Act may be unhelpful. This view continues to have resonance today.
179. Our report highlighted that this group reported access to treatment and support as a key priority and understanding whether the Act is helping with this or not would be helpful for the review to explore.

People with suspected mental disorder who are in a public place

180. Under Section 297 if the police are alerted to an individual in a public place who they believe may have a mental disorder and be in need of immediate care and treatment, they can take that person to a 'Place of Safety' for up to 24 hours. This is in order for them to be assessed and any necessary arrangements made for their care and treatment. All NHS Health Boards have designated places of safety, usually at an emergency department or mental health facility. Police stations may only be used as a place of safety in exceptional circumstances.

Our monitoring of the use of 'Place of Safety' legislation continues to highlight regional variations in the use of these measures. Much progress has been made in ensuring that the use of s297 by police is proportionate, and aligns with local and national initiatives to effectively respond to individuals who present in mental health crisis. A balance is needed between keeping people in mental health crisis out of the criminal justice system and maintaining appropriate safeguards. Most recently, use of s297 fell (1025 instances in 2018/19 compared with 1178 instances in 2017/18). We recommend that consideration is given to ensuring that s297 powers continue to be available as a 'safety net' where they offer benefit to individuals, as our healthcare delivery systems evolve, such as with the advent of 'Distress Brief Interventions', and the expansion of mental health diversion options within NHS 24.

H. The Act has a set of legal tests to justify making someone subject to compulsion. Would you suggest any changes to these?

181. Yes. We use the the five legal tests (in bold in sections below) for STDC detention (section 44(4) (below) to substantiate views and points for the review to consider:
182. **The patient has a mental disorder:** please see considerations in section on interplay between AWI (2000) and MH C&T(2003) below where we discuss the role of a 'diagnostic test' in consideration of arguments about fused legislation, that the review has set out as a consideration in terms of reference. (Diagnosis Test)
183. **Because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired; (SIDMA).** The Commission monitors the use of the Act and has noted difficulties in how SIDMA is recorded. The Commission has produced guidance on recording SIDMA in the context of eating disorders but the considerations in this document maybe useful in considering whether this construct ought to continue to be part of the tests around compulsion. <https://www.mwscot.org.uk/sites/default/files/2019-06/sidma.pdf>
184. One of the papers cited in this Commission report was work undertaken on a sample of 100 forms where SIDMA had been recorded. five broad themes were noted for reasons why SIDMA was present – Lack of Insight, cognitive impairment, presence of psychosis, severe depressive symptoms, and learning disability. More than half of the forms were related to 'lack of insight' with a conclusion that SIDMA was not well recorded and a recommendation for better recording of the reasons as to why someone had SIDMA. <https://www.cambridge.org/core/journals/the-psychiatrist/article/understanding-significant-impaired-decisionmaking-ability-with-regard-to-treatment-for-mental-disorder-an-empirical-analysis/E59ECCFCCD423CBC504AAF5AD3F1B5FC>
185. In a random sample of 10 detention forms assessed in July 2019 at the Commission not a single one of the 10 linked the mental disorder or symptoms of the mental disorder to the inability to make decisions about treatment. Some reiterated that SIDMA is present. Others provide a list of diagnoses and then say there is SIDMA. Some just say lack of insight. This work was done to assess whether it would be possible to do a larger scale project to determine how SIDMA is recorded and the Commission would be happy to discuss this with the Review.
186. On the other hand, SIDMA can be seen as a helpful way to bring capacity-like considerations into considerations of detention. Its place or whether it should be replaced with capacity and the debate around its inclusion at the time of the Millan Committee, ought to be reconsidered in the light of the evidence and feedback along with training considerations.
187. **It is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient;** (please see concern mentioned above in relation to X v Finland- treatment should not automatically flow from detention, in paragraph in treatment safeguards above)
188. **If the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person;** (Risk). Please note comment above that the culture around risk is important to note. Professionals to not operate in a vacuum- societal interpretation of risk and the contract mental health services are perceived to hold with society will determine

practice. Risk, like capacity, is also a construct that carries with it a subjective component.

189. The granting of a short-term detention certificate is necessary.

190. Rather than why detention is necessary a framing of questions on a human rights basis might be more helpful- see the Independent report into learning disability and autism in the Act's final report

191. Still evaluated primarily by doctor/doctors- the assessment might be strengthened by elevating the principle of regard for carer into a mandatory duty to consult prior to undertaking the assessment and this could be opened up more to demonstrate early involvement of the people significant to the individual liable to detention- polyphonic voices at the initial compulsion phase. This is in keeping with ideas that originate from the Open Dialogue model that has some support. However a system that worked in Western Lapland might not be suitable for Scotland (<http://open-dialogue.net/>). Risk was given a lower weight in the assessment process in the experience of one Commission colleague who attended Open Dialogue training (some years ago). Nevertheless there are ideas in this model that might have relevance for us and could be given expression through the Act.

I. The Act requires a local authority to provide services for people with a mental disorder who are not in hospital, 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.

192. Initially in response to these sections of the Act LA's started to develop services that would influence some change in areas such as training and employment, especially with regards section 25. The publication of With Inclusion in Mind also added to this. The effect of these provisions contributed to the commissioning of new residential and community services.
193. However, this was not sustained and there seemed to be a lack of ongoing creative thought on how these services could develop and change with mental health social policy. For example not everyone wants to live in core and cluster supported accommodation and different models could have been opened up.
194. SDS could have changed that but again with finite resources, there have been difficulties in this for people with mental illness as care packages for learning disability having to be reviewed and resourced. We provide an example of where SDS works well below.
195. There are difficulties for the individual in qualifying for any support that might be seen to derive from these provisions. The 1968 Social Work (Scotland) Act recognised the central role of the local authority in determining where there is a need for the provision of community care services and how such need should be met. The legislation, as amended in 1990, describes assessment as a two-stage process: first the assessment of needs and then, having regard to the results of that assessment, the local authority shall decide whether the needs of that person call for the provision of services (12A of the Social Work (Scotland) Act 1968).
196. The use of eligibility criteria applies to this second stage of the assessment process; they are used by councils to determine whether a person assessed as needing social care requires a service to be put in place in order to meet those needs. National eligibility criteria for social care were agreed by the Scottish Government and COSLA in 2009 and while originally developed for older people as part of the response to Lord Sutherland's report on free personal and nursing care, the criteria were explicitly designed to apply consistently across all adult care groups
197. It is recognized that the use of eligibility criteria as a means of managing demand for social care is imperfect and unless properly deployed can result in resources being narrowly focused on individuals with acute needs or on specific client groups. There is also evidence that inappropriate application of eligibility criteria can hinder the person-centred and outcome- focused assessment and support planning. Each local authority will have their own clear locally agreed eligibility criteria that should be referred to by managers and practitioners as part of the assessment process but in the main the criteria uses a risk based model as detailed below:
- **Critical Risk:** Indicates that there are major risks to an individual's independent living or health and well-being and likely to call for the immediate or imminent provision of social care services.

- Substantial Risk: Indicates that there are significant risks to an individual's independence or health and wellbeing and likely to call for the immediate or imminent provision of social care services.
 - Moderate Risk: Indicates that there are some risks to an individual's independence or health and wellbeing. These may call for the provision of some social care services managed and prioritised on an on-going basis or they may simply be manageable over the foreseeable future without service provision, with appropriate arrangements for review.
 - Low Risk: Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.
198. For adults who have a mental disorder, there is a likelihood that unless they fall into the top two categories then they would be unlikely to meet the criteria for the allocation of a budget or access to services. The principle of reciprocity is perhaps not given its full expression (as the Millan Committee intended).
199. Within local authorities there is a view that needs which fall into the sort of needs described in the two lower categories can be met by access to more generic community development type services – local self-help groups, activity groups etc. This assumption is flawed in two ways:
- It presumes the existence of suitable groups in the community; and
 - It relies on the adult making contact and self-motivating to initiate involvement in these activities which depending on the stage of Recovery that a person is at may not be possible.
200. There remains a view that HSCP's are obliged to meet basic needs, not personal outcomes and since adults with mental disorder can often perform basic personal care needs, they will often fall outwith the qualifying criteria of being at substantial or critical risk. Further work is required to ensure the intention of Sections 25 & 26 are compatible with eligibility criteria and acknowledge the preventative potential of timely and targeted intervention.
201. How these sections are interpreted in the new structures of HSCPs and IJBs requires consideration. Since the Act was written the structures have changed markedly. Some local authorities do not have a direct provision of housing or accommodation e.g. Glasgow City.
202. There should be some consideration of how these sections or similar sections are monitored. It can appear that any number of services commissioned by a local authority can be considered as meeting the needs of the people with a mental disorder without actually being tailored to meet the needs of a vulnerable group of society. The role of the third sector in delivering services and support needs further development.

203. Example (good example of things working) below:

Andy is a 35 year old man who has a history of severe depression and addiction issues. After a lengthy inpatient stay, he was deemed fit for discharge back to the community.

He was independent in self-care but was anxious that without some meaningful activity, he would resort to seeking out acquaintances who were drug users and the same pattern would repeat.

He was not deemed to meet the eligibility criteria for access to services but as a SDS test was offered a budget of a one off payment of £500. With this he purchased a set of golf clubs and paid an annual subscription for a municipal golf course.

He was supported by a befriender initially to go to the golf course, gradually building up relationships and confidence. By the end of the year he was playing golf most days, volunteering with the greenkeeper, is mentally and physically as well as he has been for many years.

Personal outcomes for Andy were met and the savings to health and social care services were illustrated as the cost of a day in hospital = a year of health and well-being in the community.

J. 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?

204. Yes. Mental health law reform could further influence these practices appropriately in several ways. Human rights law effectively requires us to reform mental health law into law that has the purpose of promoting and protecting all human rights relevant to mental health and reducing the social injustice that follows from a disability. This can be better understood by considering theories of justice, particularly the Capability Approach that aims to increase the real capabilities of people as a way of reducing social injustice. The Nobel prize winning economist, Amartya Sen (*The Idea of Justice*, 2009, Allen Lane) comments:
- ‘The relevance of disability in the understanding of deprivation in the world is often underestimated, and this can be one of the most important arguments for paying attention to the capability perspective. People with physical or mental disability are not only among the deprived human beings in the world, they are also, frequently enough, the most neglected.’ (p258)
205. The review offers the opportunity to improve the real condition of this marginalised group of people with severe mental illness and disabilities. Mental health law could give authority to Tribunals to make decisions that proportionately promote and protect the human rights of all persons across all relevant domains. The law can set up a clear set of rights and duties to promote independent living and avoid unnecessary hospital use. Several other examples of how domestic legislation might incorporate international treaties are mentioned in work by Stavert (2018).
<https://www.tandfonline.com/doi/abs/10.1080/13642987.2017.1390307>
206. Housing, education, employment are all bound by their own legislation and practice standards and it might be seen as difficult to see how mental health law could further influence these practices other than calling on these agencies to further apply rights based practice to existing legislation. An example of this is within Housing, where the law is clear about how a tenancy is allocated, agreed and surrendered. This is applied in mainstream housing allocation policy but is less apparent where the tenant lacks capacity and tenancies are signed for without a proxy decision maker in place – e.g a social worker signing on behalf of the adult with no legal authority. The onus should be on the Housing provider to ensure the adults rights are upheld using existing legislation rather than mental health law requiring to “police” this.
207. There is also a tension that this legislation is designed to meet the needs of the people with mental illness and the professionals working with them and extending rights to this group in a manner that protects this group through legislation may set up perverse incentives that might lead to greater compulsion that practitioners might argue that they are doing for the benefit of the individual-these are universal rights that should be available to all.
208. The Act might work to promote these rights through a revised set of principles that underpin the approach – reciprocity- e.g., might be the mechanism for an appeal to the provision of support for someone detained for a period of time.
209. A comparison with the way in which s117 works in the Mental Health Act in England would be worthwhile. It has more enforceability than these sections (25-27) but there has been a perception that it makes clinicians consider section three detentions (longer detentions) in order to secure s117 aftercare.

210. Duties incumbent on local authorities under the Act include:
- S25 – Care and support to minimise effect of illness/impairment and lead life which is ‘as normal as possible’
 - S26 - Services which are designed to promote the well-being and social development, including social, cultural and recreational activities, training, assistance in obtaining employment
 - S27 – Assistance with travel
211. Our attempts to establish what LAs were doing did not find any clear evidence that these duties were being taken more seriously than the general Social Work duty and increasingly focused on people at highest risk – not on either supporting people in preventive way, or on relatively low level interventions that might ensure people could maintain decent living standards.
212. The Commission themed visit (mentioned above) to people on cCTOs – who were being supported and treated in community showed that many were not flourishing, even though were still subject to the Act. The report was based on interviews with about 25% of patients subject to CCTOs for more than two years. We recommended that Local authorities should identify how they can more effectively discharge their duty under s26 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to support people on community-based CTOs to secure and sustain employment, and work with the Scottish Government to consider new opportunities to improve support for this group.
https://www.mwcscot.org.uk/sites/default/files/2019-06/ccto_visit_report.pdf
213. Since the Act was written the world has changed markedly. Some local authorities do not have a direct provision of housing or accommodation e.g. Glasgow City. The provision of services is therefore not direct. When we looked at S25 & 26 we found that SWD did not control how they delivered these. Many councils would say it was delivered on a corporate council basis, from arm’s length, commissioned, third and voluntary sector, etc. Day service placements are now so rationed that it cannot be delivered entirely through local authorities.

K. 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?

214. We are now 20 years since the AWI Act came into existence, and we still are able to identify corporate bodies who override basic human rights. Case examples of the unlawful moving of elderly people with dementia to specified care homes (please see section below), even when they are expressing resistance to the move. Sadly, the Commission is also aware of long term LD patients moving out of hospital after 10 years and services allow them to put an "X" as their signature, rather than seek applications for guardianship.
215. Even when the Commission points out the non-compliance, corporate bodies have to be forced to end the unlawful practices which may again demonstrate the need for more 'sharp' powers for the Commission to be able to resort to along with established role in influence and projecting 'soft power'. Currently the Commission can raise the issues with relevant authorities, and with Scottish Ministers under its powers under Section 7.
216. The issue here is not with the law, but the lack of sanctions that follow when practice deviates from the established codes of practice, and the lack of resources and workforce.
217. There are some positive examples of practice changes happening currently e.g. nursing observation practice to look at an interventions and therapeutic approaches rather than strict observation, but it needs to be wider.
218. The rights and dignity of people with mental health when compromised need to be clear and understood so that changes in practice can occur. Our 'Rights in Mind' work and document (<https://www.mwscot.org.uk/law-and-rights/rights-mind>) is often available on wards and in teams but rights, restrictions, and discrimination can often be misinterpreted by some and our role in defining when the line is crossed and what is good practice continues to be relevant. Finally, on this question - this question cannot be the preserve of mental health law. There are other pieces of legislation in place such as disability discrimination, human rights, and equality acts that add to the work on rights, and as we mentioned in the previous question, this is a universal paradigm.
219. Scottish Government has promoted a human rights based approach to public sector work but it isn't clear that the approach has been understood or reached all groups. There is a lack of clarity of what this means and if a new Act does seek to take a more Human Rights based approach, there will be a need for substantial training on what this actually means and how to implement this both on specific tests that might need to change and the underlying ethos. Work on creating the conditions for incorporation of international treaties on Human Rights into a Scottish context has been undertaken by Edinburgh University with partners.
<https://www.law.ed.ac.uk/research/research-projects/incorporating-human-rights-in-scotland>
220. The recommendations from the Rome Review under section 7.5 (Dignity, accessibility, equality and non-discrimination could also be considered for all people with a mental disorder).
<https://www.irmha.scot/>

L. 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 (ASP). Based on your experience, are there any difficulties with the way the three pieces of legislation work separately or the way they work together? What improvements might be made to overcome those difficulties?

221. The three Acts have evolved on the basis of plugging gaps in earlier legislation and refined definitions of vulnerable and at risk. Each Act meets distinct care groups and provision but where no one Act meets the needs of all adults with mental disorder for support and protection, it can be difficult for practitioners to decide how best to proceed. Even more difficult to explain to the subject of the actions as well as their carers/families.
222. Additionally there are still gaps – s47 of the 1948 National Assistance Act was repealed when the ASP legislation came into force in 2008– this offered some protection (albeit with minimal legal rights for those “in need of care and attention...living in unsanitary conditions...unable to devote to themselves...not receiving from other persons, proper care and attention”. In other words a capable adult, affected by mental disorder(thereby ruling out AWI), not needing treatment in hospital nor meeting grounds for removal under MHA (i.e., not likely to suffer significant harm) and who may not meet the criteria for the 2007 Act.
223. Evidence from practice suggests a high proportion of adults considered under ASP have a mental disorder – mental illness, learning disability, dementia, ARBD or are engaging in harmful activities e.g., self-harm, including suicidal ideation, addiction and outcomes for these referrals rely on AWI, MHA or community care services rather than use of ASP. ASP serves to provide the gateway for initial enquiry/ investigation.
224. ASP is predicated on obtaining the consent of the adult (unless evidence of undue pressure) however, some adults with mental disorder lack capacity to consent. ASP code of practice was amended to allow such cases to be taken to the Sheriff but the ASP Act has no compulsory powers to require the adult to accede to the protective powers. This appears to be a difficulty in the application of the ASP – protecting adults who lack capacity, who are incapable of giving consent and/or refuse to comply with a direction under the ASP Act. In this instance the AWIA would seem to be the more appropriate framework but there are no emergency provisions within this legislation, nor powers to ban “harmers” from ‘the adult’s’ home.
225. Similarly other groups may not be well protected under the ASP Act – e.g. adults with mental illness with a lack of insight into their circumstances as a consequence of their illness and who may as a result be open to harm. They may not see the need for support or protection under the ASP Act and would not necessarily comply with any powers. The MHA would appear to be the most appropriate legislation in this instance but this Act has neither banning provision nor substantive powers to protect welfare, finances and property.
226. These are some examples of where the interplay between the Acts do not always offer the solution required to safeguard a vulnerable adult. Consideration of consolidated legislation may offer the full gamut of options for care, treatment and protection for individuals whose circumstances at times fall between provisions.
227. Practice equally has evolved with practitioners becoming more skilled in navigating between Acts to effect the best outcome for the adult but a more unified approach

could streamline these processes and ensure a more coordinated response to individual circumstances. The current system can lead to problems in practice e.g a lack of clarity over who should do what formally and why and how this should be done. While MHO's receive detailed training in the three Acts it is difficult for practitioners who have not received this training to navigate across them to achieve the best outcome for the vulnerable adult. Council Officers in the main operate within the ASP Act and although they will be trained in these processes, they may lack knowledge of the provisions available within the other two acts.

228. Where ASP has been successful is in the development by all agencies of MDT procedures, and a developed framework and process for inquiries, investigations and conferences. This has meant that cases that may not have been dealt with in the past now are being looked at .It has also introduced the concept of harm and protection for adults.
229. Although ASP was developed to focus on those adults who have or can exercise their capacity on certain decisions, it has covered those with incapacity for such decisions too. This cross over can almost be viewed in two ways , one in that it does tie in with AWI , but also that it can become confusing for professionals and individuals alike.
230. There are other provisions which could also benefit from a more coordinated approach in legislation e.g., duties to investigate (section 33 MHA, Section 10 AWIA, Section four ASP) all with different purposes and processes; removal orders (Section 297 MHA, Sections 14-18 ASP) and the associated warrants for each- this can be a confusing and complex landscape to navigate to ensure the best outcome for the individual.
231. Similarly there are often difficulties with the interplay between the AWI and MHA Acts. Questions to the Commission's phone advisory line often illustrate the dilemmas that arise as to whether the proper authority to care and treat someone who lacks capacity ought to proceed on the basis of the MHA or the AWI. For historical reasons the thinking and practice around these legislative frameworks have developed in parallel.
232. It is time to ensure that they are brought together, to at least complement each other. The recent Covid pandemic has highlighted the need for these two pieces of legislation to be brought together, not just in law but also in thinking across government departments to reflect the heavy interplay these Acts have in practice. This decision as to which legal framework to adopt has significant impacts on the safeguards that are available to an individual who lacks capacity e.g., a depot medication may be given under AWI on a section 47 to a non-consenting and non-objecting person in a care home however in a hospital setting under MHA there may be safeguards available to review this treatment through the designated medical practitioner system.
233. These distinctions about which frameworks to apply have practical import. The Commission was recently involved in a legal case about whether people who were resident in a care home, where it appeared that there had been restrictions on their liberty, had been appropriately placed there when no authority had been sought under AWI (2000) mechanisms or MH (C&T) or under 13ZA provisions of Social Work Scotland Act 1968. This case is being addressed by the public bodies involved in the care of the residents and the Commission is working to ensure progress.
234. The provisions of section 291 (application to Tribunal in relation to unlawful detention) has been cited (Scottish Law Commission- section 3.61 as a mechanism to prevent a 'Bournewood' type scenario in Scotland however, the legal case referred to above appears to demonstrate that the existing s 291 (that applies to hospitals) is perhaps inadequate and may need to be extended in terms of scope.

http://www.scotlawcom.gov.uk/files/6414/1215/2710/Report_on_Adults_with_Incapacity_-_SLC_240.pdf)

235. The English review (December 2018) also acknowledged these tensions (see introductory section of the Wessely report, p 27) between similar legislation and sought to address these by suggesting that the test for which framework and laws to use might rest on whether the person 'objects' or not- so that an objecting adult is treated under a MHA and a non-objecting adult is treated under MCA. The impact of the 'Cheshire West' case (2014) in the UK Supreme Court cannot be under-estimated and the need for a legal process to regulate and provide remedy to persons deprived of liberty (as defined by the so called 'Acid test') in which the lack of capacity to make a decision is the basis of the deprivation, is clear.
236. With SIDMA, as a sort of a proxy for capacity (although some may reject this assertion) designed for the MHA in Scotland, our starting position is different as we incorporate a test of capacity (albeit a bespoke one with a longitudinal aspect captured within it) already so there would appear to be a greater potential to 'fuse' legislations that govern the care & treatment of people who object or cannot consent due to impaired decision making.
237. Some commentators (George Sczmukler's work) believe that this would be a more CRPD compatible approach to legislative reform (it could remove the need for a diagnostic test as a criterion for detention decision making <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4024199/>) however this ought to be balanced against the practical considerations that a diagnostic test has been seen as potentially protective by some service users (see Wessely review), and although NI is often cited as a jurisdiction that has embraced a capacity basis for detention, they have retained diagnosis as a consideration as the legislation does require the professional using it to determine what the cause of the impaired capacity is.
238. The English review considered the case for Fusion and decided against it citing several 'tests' for a 'fused' legislation that they did not feel were met.
239. Our starting position is different. NI legislation has been enacted. We already have an approximate measure of capacity within our tests for compulsion. The review may wish to consider how Scotland might fare against the 'Wessely' tests for fusion and hear about early experience in NI.

M. Is there anything else that you wish to tell the review?

240. In this section it is helpful to recall the genesis of the acts and laws for mental health. Specifically what is the purpose of the Act in the first place? Should the Act regulate coercive powers and have safeguards against the abuse of powers or should it be seek to promote alternatives to coercion, to achieve social justice for groups that have been subject to marginalization and to create a new framework for decision making empowering those who are marginalized based on respect for their rights, will and preference?
241. This is essentially a question about how Scotland moves towards compliance with the full range of human rights treaties that our Government has committed us to.
242. The fundamental legal and political questions are settled: Scottish Government intends and is required to bring about full compliance with the ECHR, whose meaning has evolved since 2003, and with UN treaties. From this perspective, the purpose of the Act must be to promote and protect all human rights that relate to mental health. UN Special Rapporteur for Health says we need to:
- Mainstream alternatives to coercion in policy with a view to legal reform;
 - Develop a well-stocked basket of non-coercive alternatives in practice;
 - Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders.
243. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health 2017 [A/HRC/35/21] <https://reliefweb.int/report/world/report-special-rapporteur-right-everyone-enjoyment-highest-attainable-standard-0>
244. So much has already been achieved. But there is always improvements that can be made. The CRPD puts an emphasis on determining will and preference to support decision making. Supported decision making is the next iteration of the process of ensuring the patient voice is heard to actually supporting participation and moving away from a substituted judgement situation, in the context of their rights. Essentially ensuring a consideration of rights, will and preference would form the basis of any supported decision making work.
245. Commission work that sought to understand 'will and preference' from the perspective of 86 service users illustrated how difficult it is to capture this. And questions were raised as to whether it is even possible. The voice of people with lived experience of the Act would suggest that there are times when judgement might need be substituted and this is a group or groups of service users and patients saying to the Commission, clearly, that in their view, the CRPD committee got this wrong.
246. Another observation from this group which is relevant to the review is that Language matters, terms matter- sectioning has connotations that those who have not been sectioned or those who hear the term at a particular moment might experience differently.
247. Detention in itself can be a traumatic experience. Can legislation ever be Trauma informed and what would that mean? There has been a focus on Adverse Childhood Experiences and Trauma informed care recently. How might these inform the development of the Act? The lived experience of those who have been detained might provide some pointers to reform.

248. The Alternative review of the Mental Health Act in England led by service users makes for compelling reading and issues that professionals might not have considered are highlighted in this report. <https://www.nsun.org.uk/news/an-alternative-review-of-the-mental-health-act>. Strikingly they report that 78% of the service users consulted for this report said that never or rarely were treated with dignity and respect when detained under the Act.
249. Can we reach a point where being detained is not considered stigmatising but is actually perceived as a point when society demonstrated its care rather than it being seen primarily as a moment when someone was treated against their will? These are not simple issues of semantics but speak fundamentally to the nature of the act of detaining someone.
250. There is a minority who feel that it ought never to be necessary to detain someone but most people would agree that this is sometimes needed and we should move away from the idea that being in hospital is a bad thing. Much good work is done by many good people in hospitals; and in community teams.
251. Services need to be adequately resourced both materially and to make an allowance for time; time to reach shared decisions and time to allow people to reach decisions when they can with support.
252. The law may never be a perfect law but we should aim that the law enables professionals to treat, and for patients and services users to receive, treatment and care or services, with dignity and respect.

Appendices

Appendix A:

Death in Detention project – information for the Review

This document can be found [here](#).

Appendix B:

Will and preference and the Mental Health Act -

The views of 86 people with lived experience of mental illness or as carers of people with a mental illness

This document can be found [here](#).



Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778

Freephone: 0800 389 6809
enquiries@mwscot.org.uk
www.mwscot.org.uk

Mental Welfare Commission 2020