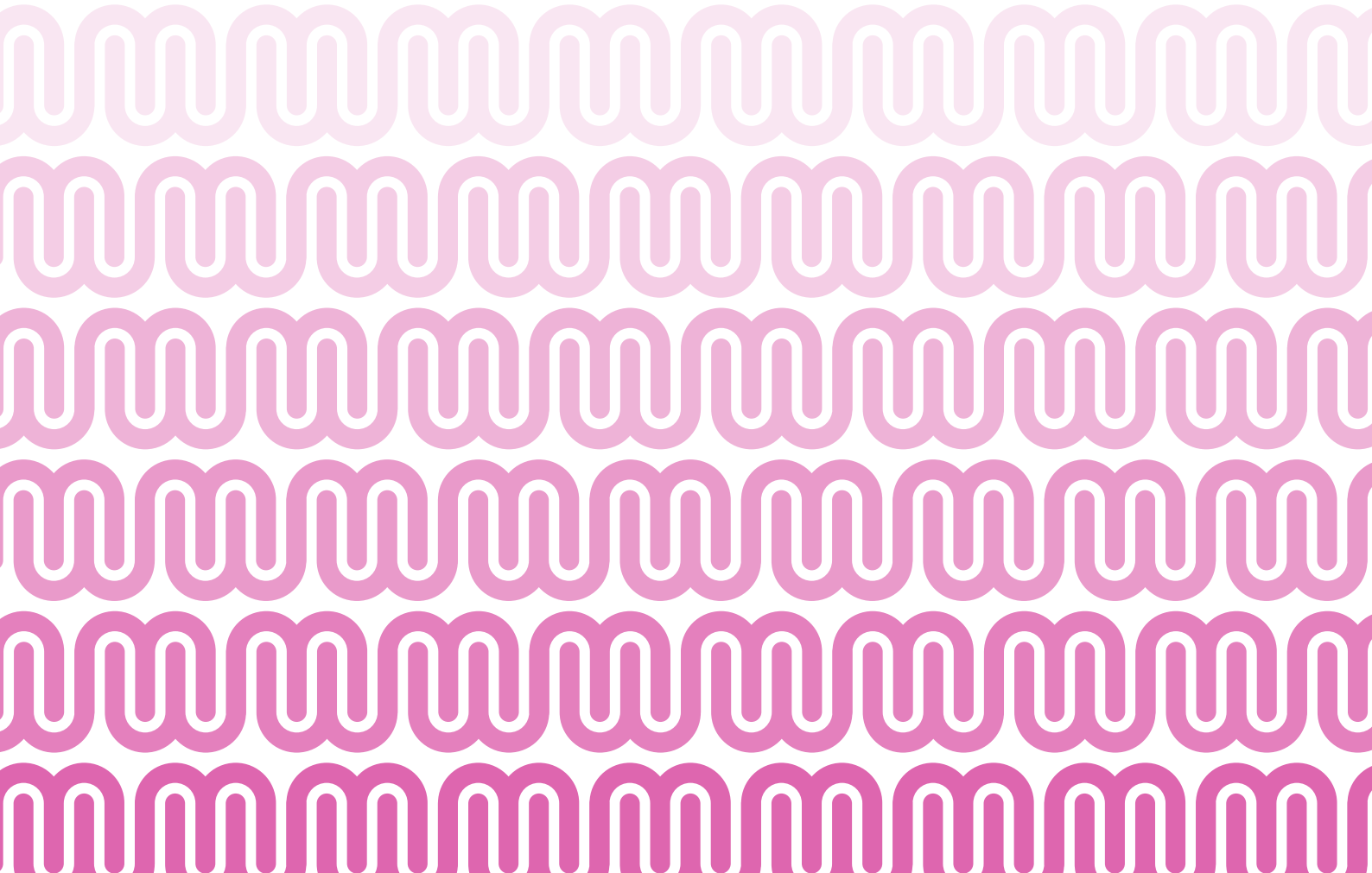
mental welfare commission for scotland

Decisions about technology

Good practice guide

May 2025



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

1. Introduction

We first published guidance on the use of technology in 2007, *Safe to wander*. Since then, we have seen an increase in the awareness, availability, and affordability of new technologies.

With the evolution of the use of technologies, the Mental Welfare Commission for Scotland subsequently published our *Decisions about technology* good practice guidance in 2015, which generally covered the use of telecare in the context of supporting people affected by dementia, although relevant to a wide range of people affected by mental ill health and incapacity. The guidance was updated in 2020 with minor changes and updated links.

However, with significant advances in technology and the increasing number of enquires the Commission receives around the use of technology from staff, families and carers when supporting a person with a mental illness, learning disability, dementia, autism or other related conditions, a full review of *Decisions about technology* was undertaken with the result of this revised good practice guide offering a wider consideration of the use of technology. As part of the guidance review, we have incorporated our *Hidden surveillance* advice note into this revised *Decisions about technology* guidance.

This updated guide sets out the principles and guidance to be considered by individuals, families, carers and professionals when considering the use of technology for people with mental ill health, dementia, learning disability, autism and related conditions.

2. About this guidance

This guidance is for families, carers and professionals considering the use of technology to support people to maximise their independence when they may no longer be in a position to do so themselves, for reasons of mental ill health and/or incapacity.

The Commission has an active role in ensuring that people have access to treatment, care and support that is most appropriate to their individual needs and their human rights. People with mental illness, dementia, learning disability, autism and related conditions may be vulnerable because they are less able, at times, to safeguard their own interests. They can have lawful restrictions placed on them in order to receive the care, treatment and support they require.

As the use of technology evolves, the principles of this guidance may prove helpful for people across a range of settings, including admission to hospital, living in registered care settings/residential care homes or living in their own homes.

The Commission is not expert in the range and suitability of various technologies and as such, this guidance does not aim to set out practical approaches on how to introduce and include specific technologies as part of a support package. Links to various sources of information about this are provided at the end of this document.

Additionally, this guidance does not constitute legal advice. The Commission's interest and expertise is in ensuring that people whose decision making may be impaired, or where the person may not have the capacity to consent to the use of technology, has the opportunity to benefit from it whilst having their human rights respected.

3. Digital health and assistive technologies – what's available?

Throughout this guidance we use terms such as digital health care and assistive technology. These are broad terms which encompass a range of digital and mechanical technologies used to support individuals to remain safe. These technologies can be used in care settings, such as hospitals, supported accommodation and care homes, as well as an individual's own home.

Below are some examples of digital health care and assistive technology. This is not an exhaustive list as technology is developing at a rapid pace.

3.1. Mobile phones

Mobile phones, with the ability to access a range of applications (apps), are widely in use. 93% of UK households had a mobile phone in 2021/2022 (www.statista.com). Their use provides significant benefits to individuals, including the ability to stay in touch with others and being able to quickly access information in relation to their health and wellbeing.

Mobile phones can help individuals to undertake a range of tasks as well as providing prompts, reminders and the ability to summon help. Many mobile phones can use voice activation capability, for example making a call by saying someone's name. Similarly, a phone can be set up to speak to an individual, for example reading a message or an e-mail out loud to them. Through mobile phone accessibility features, mobile phone apps can be set up to enable others to monitor an individual's mobile phone usage, providing an alert if it has been inactive for a period of time. Apps also provide individuals the opportunity to access a range of self-help tools and therapies, such as mindfulness and relaxation and even digital safety plans.

3.2. Remote monitoring

Remote monitoring can be carried out by a range of different devices:

- Mobile phone apps as discussed above.
- Wearable devices such as community alarms pendants, fall alarms and seizure alerts which are used to alert and summon assistance either actively or passively.

- Another wearable device is a wrist band that emits a warning signal if the person wearing it goes beyond a predetermined boundary e.g. WanderGuard
- Smart monitoring home systems can be used to monitor movement or sound.
- Global positioning systems (GPS) can be placed inside mobile phones, shoe insoles, watches, or key fobs to give details of the wearer's exact location to another mobile/tablet or to a call centre.
- Video/audio calling devices. These devices work with screens or speakers. Callers can 'drop in' remotely and see/speak to an individual.

Case example - Mrs. J: Drop in technologies (registered care settings)

Mrs. J is an 80-year-old woman with a diagnosis of dementia. She currently resides in a care home and her daughter has a welfare power of attorney (PoA). The PoA was triggered when Mrs. J was assessed as lacking capacity to make decisions regarding her welfare. Mrs. J's daughter can't visit her mum very often as she lives abroad. She has therefore provided her mother with a tablet and installed Alexa 'drop in'. This means that her daughter can 'drop in', appear on a fuzzy screen and ask mum's permission for a chat over the screen. What needs to be considered in Mrs. J's case?

- What is Mrs. J's views regarding the 'drop in'? Does she have the ability to refuse her daughter 'dropping in'?
- Is she able to communicate a view? If not, what support has been put in place to help her express her views, for example independent advocacy.
- Is the use of such technology following the principles of the Adults with Incapacity Act, 2000 (AWI Act)? For example, is it of benefit to Mrs. J?
- Have care home staff monitored Mrs. J's reaction when her daughter 'drops in'? Is it positive? How is she when the 'visit' is over?
- How is the privacy of others maintained when Mrs. J's daughter 'drops in'? For example, care home staff and other residents.

Is there a support plan that explores all of the above? Is it regularly reviewed and updated?

3.3. Infra-red technology

Infra-red technology is now available and allows monitoring of certain vital signs such as pulse. However, these technologies also have capabilities to monitor movement in the room and can provide short bursts of video of the person in the room and can be monitored by others.

3.4. Closed-circuit Television (CCTV)

CCTV can be found in some hospitals, care homes and private homes both in communal areas and sometimes in private spaces. The Commission defines a private space as a bedroom and a bathroom. CCTV can be used to manage security in relation to access to buildings. At times, CCTV can be used to support those who are displaying high levels of stress and distress by remote monitoring and intervening in the safest way.

3.5. Near Me

Near Me is a video conference service which allows an individual to remotely attend a health appointment. A mobile phone, tablet such as an iPad, galaxy or google tablet, and laptop can be used for Near Me. All require an internet connection for a video conference to take place.

4. Assess and plan

The use of digital health and assistive technology is sometimes considered when an individual presents in a way that may suggest risk to the individual and/or a cause for concern to others; for example, showing increased levels of stress and distress or getting lost when leaving home. It may be that the use of digital health and assistive technology will provide a good solution, however several factors should be considered first.

If an individual is presenting in a way that is causing concern to others, an outcome-focused assessment should be completed, especially if there is the potential for any digital health and assistive technology to place restrictions on the personal freedom, movement, privacy, and/or dignity of the individual ensuring that the individual is fully involved and their relatives/carers are involved, if possible.

An outcome-focused assessment should identify the needs of the individual, what can be put in place to meet those needs and what outcomes the individual hopes to achieve. If an individual is presenting in a way that is a cause of concern to others, consideration should be given to other factors that may be contributing to this presentation prior to introducing digital health care and assistive technology. This includes, but is not limited to, the following:

- A physical health assessment which includes a medication review and ensuring that the individual is not in pain or experiencing side effects from drugs and unable to communicate this.
- Environmental factors. Does the environment that the individual is living in fully meet their needs? Is the individual able to participate in meaningful and person-centred activities? Does the person have the opportunity to socially interact with others?
- Psychological factors. Has the individual had a recent mental health assessment? Have they experienced a distressing life event or trauma or a relationship breakdown? If they are showing signs of distress, are they able to communicate those feelings to others?
- Stress and distress secondary to psychiatric illness can be difficult to assess. Positive Behavioural Support (PBS) and psychological input should be considered.

Any assessment with individuals **must** include an analysis of potential risk. This must focus on the risk to the individual, not the organisation or care facility.

Positive risk-taking should be explored so that individuals are not overly restricted in an attempt to keep them safe.

A support plan should follow on from an outcome-focused assessment. It should include what supports and inputs need to be put in place and by whom, in order to meet the outcomes of the individual. If digital health care and assistive technology is identified as an option to meet the individual's outcomes, then the risks and benefits of such technology must be identified. All assessments and support plans should be monitored and regularly reviewed.

5. Legal context

Individuals with mental illness, learning disabilities, dementia and related conditions may, but do not always, lack the capacity to consent to the use of digital health and assistive technology. In law, there is a presumption in favour of capacity. Anyone who has the capacity to consent should be allowed to decide whether or not to use digital health and assistive technology.

Disagreeing with a suggested approach to care or treatment does not mean that a person lacks capacity. It is important to assess capacity in relation to the decision the person is facing, in other words capacity is decision specific. Assessing if someone has the capacity to make specific decisions can be complex. The following should be considered to determine whether an individual is able to make an informed decision regarding being supported by digital health and assistive technology:

- Is the individual able to understand information regarding the use of technology and retain it long enough to make a decision? Are they able to express their decision?
- Does the individual feel coerced into agreeing to the proposed device to make life easier for others?
- Does the individual understand what the device does? For example, are they aware that a tracking device has been placed in their mobile phone and that their movements can be monitored?

Efforts must always be made to support someone to make a decision whenever this is possible. This may include taking extra time to explain what is being proposed, involving advocacy, and using communication aids to help promote discussion and understanding.

For further information, see the Commission's good practice guide on supported decision making, *Supported decision making good practice guide 2024*[1].

If a decision is made that digital health care and assistive technology is required to support an individual and that individual does not give, or is unable to give, their consent for its use, then there must be the appropriate legal authority in place. Consideration should be given to the following legislation:

[1] Supported decision making good practice guide: https://www.mwcscot.org.uk/node/503

5.1. Adults with Incapacity (Scotland) Act (2000) (AWI Act)

Incapacity legislation in Scotland makes several provisions for the delegation of decision making for people lacking capacity. A person, while capable, may grant a welfare power of attorney (PoA) to make decisions on their behalf once capacity is lost. If an individual is deemed to have lost capacity and has not already granted a PoA, a welfare guardian can be appointed by the court to make decisions on that individual's behalf. The views of welfare attorneys and welfare guardians must always be considered when making a welfare decision.

If there is no attorney or guardian with the authority to make welfare decisions, anyone faced with a decision about the use of digital health care and assistive technology will need to consider whether to seek a guardianship order under part 6 of the AWI Act.

If there is a valid PoA or welfare guardianship order in place, legal advice should be sought as to whether this authorises the use of digital health care and assistive technology. A specific power may be required.

The principles of the AWI Act can guide the process of deciding on the use of digital health care and assistive technology. The principles are:

1. The intervention must provide a benefit that cannot otherwise be achieved.
2. The intervention must be the least restrictive in relation to the person's freedom in order to achieve the desired benefit.
3. The past and present wishes of the person must be taken into account.
4. The views of relevant others should be taken into account.
5. The intervention should encourage the person to use existing skills and develop new ones.

If a PoA or welfare guardianship order is in place, all those supporting the individual must be aware of the extent of the powers contained within the order. Having a copy of the order on file is good practice.

We are sometimes asked if an AWI Act section 47 certificate of incapacity should include restraint or interventions that would constitute restraint. We do not think that the section 47 certificate should include the use of digital health care and assistive technology as described above. The assessment and rationale for using digital health care and assistive technology should, though, be clearly recorded in any support plan and regularly reviewed.

Any primary or secondary health care setting or care home that use such digital health care and assistive technology should have a specific policy on its use for patients or residents who lack capacity to consent to its use, to ensure that patients and residents are treated with dignity and their rights are respected.

Further guidance on the use of the AWI Act can be found at:

- Commission's website
  www.mwcscot.org.uk
- Scottish Government
  https://www.gov.scot/policies/social-care/adults-with-incapacity
- Office of the Public Guardian (OPG)
  www.publicguardian-scotland.gov.uk
- NHS Scotland, NHS Education for Scotland
  Adults With Incapacity (AWI) | Turas | Learn (nhs.scot)

5.2. Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act)

The Mental Health Act applies to people who have a mental illness (including dementia), personality disorder, learning disability or related condition. The Mental Health Act describes these conditions as mental disorders. The Mental Health Act authorises detention in hospital and can also authorise compulsory measures to ensure treatment outside hospital.

When a person with a mental disorder is being prevented from leaving hospital, then consideration must be given to whether detention under the Mental Health Act is necessary. For example, if devices such as a WanderGuard are being used to restrict an individual's free movement, assessment under the Mental Health Act should be considered. Detention affords the adult safeguards such as a right of appeal to the Mental Health Tribunal for Scotland.

It is however unlikely that the use of compulsory measures under this legislation would be appropriate to authorise the use of technology alone unless this resulted in preventing someone from leaving hospital.

The principles of the Mental Health Act should be taken into account for professionals who are carrying out a function under this piece of legislation. These principles include:

1. Participation – individuals should be fully involved, as far as they are able to be, in all aspects of their care and treatment. This includes decisions regarding the use of digital health care and assistive technology.
2. Least restrictive option – care and treatment should be provided in the least invasive and restrictive manner. Alternatives to digital health care and assistive technology should be considered if they provide a less restrictive solution.
3. Benefit – any intervention under the Mental Health Act should be of benefit to the individual. The benefit could not be achieved other than by an intervention under the Mental Health Act. The use of digital health and assistive technology must be of benefit to the individual and not of benefit to others.

For individuals detained in hospital under the Mental Health Act, certain restrictions in relation to the use of telephones (including mobile phones) can be put in place. For this to happen, the individual must be first be designated as a 'specified person'. Once this happens, the individual can be restricted or prevented from using a telephone. Items, including mobile phones, can be restricted or access to them limited, under specified persons regulations. Specified persons regulations only apply to those detained in hospital and **do not apply** to those who are in hospital on a voluntary basis or to those who are subject to compulsory treatment measures in the community.

The Commission's good practice guide on specified persons[2] and easyread version[3] are available for more information.

Further guidance on the use of the Mental Health Act can be found on our website[4] and the Scottish Government website[5].

[2] Specified persons good practice guide: https://www.mwcscot.org.uk/node/512
[3] Easyread: specified persons: https://www.mwcscot.org.uk/node/418
[4] Mental Welfare Commission website: https://www.mwcscot.org.uk
[5] Scottish Government mental health legislation: https://www.gov.scot/policies/mental-health/legislation-and-guidance/

5.3. Human Rights Act 1998 (HRA)

In Scotland, civil and political rights of individuals are protected by the HRA. The legal rights of the individual have become increasingly established with the incorporation of the European Convention on Human Rights (ECHR) into UK law.

The HRA is founded on the articles of the European Convention on Human Rights. Under the Scotland Act 1999 all Scottish legislation including the AWI Act, the Adult Support and Protection (Scotland) Act 2007 and the Mental Health Act must be interpreted in a way which is compatible with convention rights of relevance. Key articles to consider in relation to the use of digital health and assistive technology, are:

Article 2: The right to life.

Article 3: The right to be free from torture and inhuman or degrading treatment.

Article 6: The right to a fair hearing.

Article 5: The right to liberty and security.

Article 8: The right to privacy and respect for family life

Any decision to use digital health care and assistive technology must be consistent with the above provisions.

Deprivations of liberty may occur where there are restrictions placed on someone's life if digital health and assistive technology is preventing someone from leaving their home or the place where they are being cared for. If it has been established or appears likely that the use of digital health care and assistive technology would amount to a deprivation of liberty, then that deprivation of liberty must have a legal basis and be in accordance with a procedure prescribed by law.

Consideration can be given for an individual to document their wishes about digital health care and assistive technology in an advance statement. An advance statement is a written statement, written when a person is well, which sets out how the person wishes to be treated or not to be treated, if they were to become unwell in the future. This relates only to treatment for those with mental disorder under the Mental Health Act. However, where technology forms part of the person's care and treatment, the inclusion in an advance statement may be appropriate.

The Commission encourages individuals to complete or be supported to complete their advance statement, where they are happy to do so. Further guidance on advance statements can be found on our website[6].

5.4. The UN Convention on the Rights of Persons with Disabilities (UNCRPD)[7]

The UNCRPD is also relevant in deciding whether actions comply with human rights principles. It is not currently directly enforceable in the same manner as the ECHR, but a court may look at it to decide how to interpret domestic law or the ECHR. It contains many similar provisions to the ECHR but emphasises even more strongly the prohibition against discrimination. Important UNCRPD provisions include:

> **Article 5** – Disabled persons are entitled to the equal protection and benefit of the law without discrimination.
>
> **Article 12** – All measures affecting the exercise by a person of their legal capacity should have effective safeguards to prevent abuse, and should respect the rights, will and preferences of the person.
>
> **Article 14** – The state must ensure that persons with disabilities enjoy rights to liberty and security of person on an equal basis with others. The existence of a disability shall in no case justify a deprivation of liberty.
>
> **Article 16** – The state must take measures to protect persons with disabilities from all forms of exploitation, violence and abuse.
>
> **Article 17** – Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

[6] Advance statements guidance: https://www.mwcscot.org.uk/law-and-rights/advance-statements
[7] Ibid fn 1

5.5. Case law: Cheshire West

This judgement of the Supreme Court in 2014 has wide implications for people who may lack capacity to make decisions. Briefly, it states that adults who lack capacity and are under "continuous supervision and control" and "are not free to leave" are deprived of their liberty. This will be in breach of Article 5(1) of the ECHR if done without lawful authority.

The Cheshire West decision poses challenges to the operation of incapacity law in Scotland as it currently stands. The UK Supreme Court's view on the definition of deprivation of liberty considerably broadens existing interpretations in Scotland which have been held, for the most part, by health and social services.

The ruling states that deprivation of liberty is a matter of fact and does not depend on the purpose of the intervention or the nature of the person's individual circumstances.

This is a substantial development from previous decisions of domestic courts and the European Court of Human Rights such as the HL or Bournewood case. The implications for Scottish legislation have been considered by the Scottish Law Commission, which reported[8] on proposed legislative changes in 2014. More recently in September 2022, the Scottish Mental Health Law Review[9] (SMHLR) clearly calls for change in relation to the law as it applies to deprivation of liberty, which at the time of writing is being considered by the Scottish Government as set out in its response to the SMHLR.[10] It is the Scottish Government's intention to prioritise adults with incapacity legal reform, which is indicated to include options to address deprivation of liberty for individuals who may not have the capacity to make decisions for themselves.[11]

In the meantime, services need to operate within the existing statutory frameworks and be informed by the developing case law. If services believe that a person who cannot consent will be deprived of their liberty, it is necessary to consider what lawful authority justifies that detention. At the same time, unless and until Parliament or the courts determine otherwise, current legislation remains in full effect.

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[8] Report on Adults with Incapacity - SLC 204 (scotlawcom.gov.uk)
[9] [ARCHIVED CONTENT] (nrscotland.gov.uk)
[10] Scottish Mental Health Law Review - Our Response (www.gov.scot)
[11] Of note is the decision in *Aberdeenshire Council v SF (No2)* [2024] EWCOP 10 and implications around but not limited to, Article ECHR 5(4) in relation to a person's right to be heard re deprivation of liberty, guardianship and requisite safeguards.

In short, the Commission believes that what was good practice before the Cheshire West case will, in large part, remain good practice now, but that this decision makes it even more necessary that there is a proper and auditable process for taking decisions on care arrangements for people who lack capacity, and that this process fully reflects the principles of the AWI Act.

Where it is determined, in accordance with those principles, that an application for welfare guardianship should be made, it is important to identify any particular measures which may constitute or contribute to a deprivation of liberty, ensuring that the measures are necessary and justified, and seeking specific authority in the order. Such measures may include restraint or any use of physical force, preventing a person from leaving or requiring them to return to their place of residence, or intrusive surveillance, whether personal or through technology.

6. Concerns & benefits of using digital health care and assistive technology

Undoubtedly, digital health and assistive technologies provide significant benefits and opportunities. Fundamentally, they can support an individual to remain living independently. We know, for example, that some individuals who have the opportunity to walk freely receive positive health benefits from this activity. Assistive technology can play a part in promoting individual health and well-being, rather than confining a person to a limited area. In care settings, assistive technologies may provide assistance without unduly restricting the individual, which can happen with face-to-face support. Consideration must always be given to: good design of the living environment, stimulation, meaningful activity, appropriately staffed settings, and trained caregivers.

Despite the benefits, digital health and assistive technology can present ethical and practical challenges. Some technologies have the potential for abuse if not used in a proper legal framework and with reference to good practice guidance. Where such technology is used, great care must be taken to ensure that the person concerned has their rights protected. Assistive technology must never stigmatise, and it should never fully replace direct contact with caregivers. The use of assistive technology can be seen as empowering and supportive or intrusive and demeaning. This is why we believe a rights-based approach to decision making is required.

6.1. Restraint

Those considering the use of digital health and assistive technologies should be aware of the potential for their actions to constitute restraint and to take this into account in their decision making. This includes those who are not employed to do so, but who support someone living in their own private home. In our guidance, *Rights, risks and limits to freedom*[12], we provide a definition of restraint.

> *'Restraint is taking place when the planned or unplanned, conscious or unconscious actions of care staff prevent a resident or patient from doing what he or she wishes to do and as a result are placing limits on his or her freedom.'*

The Commission increasingly receives calls to our advice line from individuals concerned about assistive technology being used in a way that may compromise

[12] Rights, risks and limits to freedom good practice: https://www.mwcscot.org.uk/node/508

an individual's dignity and privacy. If devices are being used to monitor another individual's activities, or to limit an individual's freedom, and the individual does not give their consent (or is unable to give consent), then there must be an appropriate legal authority in place authorising the use of assistive technology. This may be a specific power under a welfare guardianship order (AWI Act).

Case example - Ms. S: Video monitoring (own home)

Ms. S is a 35-year-old woman with a diagnosis of learning disability. She moved from hospital into her own accommodation and was provided with support from a care agency on a 24/7 basis. During the night, staff were awake in another room. It has been suggested by the social worker that staff are no longer required during the night. Ms. S's parents would like the support to remain or have a monitor placed in her bedroom so that someone can visually check if Ms. S is okay. What should be considered in Ms. S's case?

- Has the social worker completed an outcome focused assessment and support plan? Has a risk assessment been completed? If so, what needs does Ms. S have during the night? What are the associated risks?
- What is the reason for the change in support provision at night? It may be a positive one in that Ms. S is able to live more independently.
- What are Ms. S's views regarding ending support during the night?
- Whilst Ms. S's parents' views should certainly be taken into account, if they are not her proxy decision maker (PoA or welfare guardian) they have no legal rights to be consulted.
- Installing a video monitor in Ms. S's bedroom is intrusive and raises issues of dignity and privacy. It may require a specific power under the AWI and as such legal advice should be sought.

6.2. CCTV surveillance

The Commission is often asked about the use of CCTV in care homes and hospital settings. There may be limited situations where this form of surveillance can be helpful in communal areas of care facilities. This must be justified by, for example, the protection or safety of individuals, and be proportionate, the minimum necessary intrusion into the privacy of individuals.

It should be noted that disproportionate use of CCTV may be an intrusion into an individual's privacy and dignity which is protected by article 8 of the European Convention on Human Rights. The presence of a camera, whether it is activated or not, may be deemed a threat to individual privacy. Any such interference must be proportionate, for a legitimate aim and be lawful. It must only be undertaken where there is the proper legal authorisation in place, e.g., via a welfare guardianship order with the specific power for a specific purpose to use CCTV in respect of the individual's welfare.

CCTV surveillance must not be used as a 'blanket' measure to observe individuals. It should never be used to compensate for a lack of available staff. The support of individuals is best carried out by way of human interaction. In some exceptional situations, however, it may be the least intrusive way of keeping a person safe. Where this is the case, it should be discussed by the multidisciplinary team, with families and carers and accompanied by a specific support plan outlining why the use of CCTV is necessary, how long it will be in place and be subject to regular review. The support plan should include an exit pathway out of the use of CCTV. The Commission would not expect individuals to be supported long-term using CCTV. If CCTV is used longer term, then the Commission would recommend a review is carried out by an independent reviewer.

When CCTV is used to support an individual, any information gathered should only be viewed by the minimum number of people necessary and should be safely stored only for as long as is necessary. It should not be unnecessarily disclosed. Those operating CCTV should be properly trained to understand the implications of these principles. This information should be recorded in an individual's support plan.

We strongly suggest that any care service provider obtains the advice of the Care Inspectorate before pursuing the use of CCTV. The Care Inspectorate has written guidance for care providers in relation to the use of CCTV in their services.[13] In addition, the use of CCTV is regulated by the Information Commissioner's Office under the Data Protection Act 1998.[14]

[13] CCTV guidance v2.pdf
[14] Please see Homepage | Scottish Information Commissioner for further information.

6.3. Hidden surveillance

Hidden surveillance is the use of hidden cameras or audio equipment to monitor the actions of staff or others in their interactions with someone under their care.

We are increasingly aware that small discreet video recording devices are being used to monitor the actions of care staff in care homes, hospitals or when adults are receiving care at home from a registered care service. These are often put in place by relatives or concerned others when there is a suspicion that the adult is not receiving proper care. Covert recording has also been used by journalists to uncover cases of serious abuse.

We would always hope that anyone who had any concerns about the care, treatment or support of a vulnerable person would raise these with the staff involved in the first instance or their manager. Alternatively support and advice could be sought from an advocacy worker, ward staff, the individual's social worker, the Care Inspectorate, or by making a formal complaint. If it was felt that the adult was at risk of harm then the local authority should be contacted and a referral made under adult support and protection legislation. The Commission's view is that there would need to be clear and evidenced reasons why hidden surveillance was thought to be necessary instead of using these procedures, particularly if the person being cared for cannot give consent.

There are a number of general considerations to be taken into account when considering using hidden surveillance. These include:

- **Capacity** – those who have capacity to consent to being filmed have the right to refuse. An individual should not be placed under surveillance without their agreement.
- **Legal and human rights issues** – the use of hidden surveillance is undoubtedly an intrusion into an individual's privacy, which will generally require legal justification. However, it is important to remember that using surveillance may also affect the legal and human rights of all those being filmed.
- **Practical considerations** - where the camera is positioned, who is viewing the images and who the images will be shared with, will the recordings be visual only or record sound also, will they be date/time stamped, how are the images stored and for how long?

We believe that the use of covert surveillance of staff raises complex legal, ethical and human rights concerns. The Commission would therefore recommend that if hidden surveillance is being considered then legal advice is sought locally, advice is sought from a professional body and reference made to professional codes of practice. If hidden surveillance is being used in a registered care setting, then advice should be sought from the Care Inspectorate.

6.4. Infra-red technology

The Commission has been asked about the use of infra-red technology, given that it has the capability to monitor and video an individual. This technology raises questions of privacy and dignity and we would therefore advise that its use should be proportionate to, and subject to, careful monitoring of its use.

Case example - Mr S: CCTV

Mr S is a 25-year-old with a diagnosis of Autistic Spectrum Disorder. He is subject to detention under the Mental Health Act and has been in hospital for the last two years. When stressed and distressed, Mr S can present as physically aggressive towards staff and his environment. As such, he has been placed in a part of the ward where no other patients can access. Nursing staff monitor Mr S by the use of CCTV on a 24/7 basis. What needs to be considered in Mr S's case?

- Is Mr S aware that he is being monitored by CCTV? If so, does he consent to this? If a guardianship order is in place, has the guardian, family and/or carer been consulted?
- If Mr S lacks capacity to understand that he is being monitored by CCTV, what efforts have been made to support him with this? For example, speech and language input, talking mats, supported decision making.
- What legal safeguards are in place authorising the use of CCTV? What are the organisational policies and governance arrangements in place for the use of CCTV?
- Is there a detailed assessment, support plan including a risk assessment and management plan in place? Do these plans outline the costs and benefits to Mr S of the use of CCTV surveillance? What alternatives have been considered and tried? What plans are in place for Mr S to begin interacting with others again? What are the timescales for this? How often are the CCTV arrangements being reviewed and by whom?

- What is causing Mr S's stress and distress? Can he communicate this? If not, what support has been given? Have physical/emotional/environmental factors been explored?
- Is there a care team working with Mr S who are appropriately trained and staffed? Have staff increased their time with Mr S to ensure that there is not an over reliance on the use of CCTV?

6.5. Social media

For many, social media is an important way to get information and stay in touch with others. However, posts made on social media may compromise an individual's privacy, safety and dignity and cause embarrassment and regret at a later date. There is risk of a breach of a person's right to privacy under article 8 ECHR where the person has not consented to participate on social media, or where there is no legal authority in place when the person may lack the capacity to consent.

Individuals should be supported, wherever possible, to make an informed choice in relation to participation on social media. This should include supported decision-making activities[15] around explaining the implications of private information being made public. Additionally, any involvement with social media should take account of the principles of the AWI Act including what benefit there is to the adult in relation to being on social media and the views of others with an interest in the adult.

Therefore, where it is deemed that an individual has lost capacity to make decisions about their involvement in social media, consideration should be given to making an application for a welfare guardianship order or an intervention order under the AWI Act.

Where involvement in social media generates an income, consideration may need to be given to financial guardianship to protect the adult's finances and to ensure they are not subjected to financial harm/subject to adult support and protection requirements. Any application under the AWI Act would be subject to scrutiny by the Sheriff to ensure the adult's rights are upheld.

The Commission is aware that mobile phones can be used to record others without the permission of those being recorded. These recordings, which can be

[15] For further information, please refer to the Mental Welfare Commission's good practice guidance Supported decision making good practice guide 2024

either visual or audio, may then be placed on social media platforms, again without the consent of the person being recorded. These recordings can take place in a variety of settings, for example a hospital, care home, or an individual's own home. It is beyond the scope of this guidance to outline how these situations should be managed. However, it is clear that these recordings raise important legal and ethical questions, and we would advise that reference is made, for example and not limited to, local policies (admission policies to care homes and hospitals), legal safeguards (specified persons Mental Health Act), guidance from professional bodies (e.g. British Medical Association) and the seeking of legal advice.

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