

Health and Social Care Alliance Scotland (the ALLIANCE)

Response: Scottish Mental Health Law Review –
phase 1 consultation
27 May 2020



Introduction

The Health and Social Care Alliance Scotland (the ALLIANCE) welcomes the opportunity to respond to the phase 1 consultation of the Scottish Mental Health Law Review (the Review). Our response is informed by engagement and consultation with members and partners on taking an equalities and human rights based approach to Scottish mental health law, policy and practice¹.

As co-convenors of the Health and Social Care Action Group of Scotland’s National Action Plan for Human Rights (SNAP)², the ALLIANCE co-authored a paper on human rights and mental health³. More recently, we supported public involvement in the Independent Inquiry into Mental Health Services in Tayside⁴, and the development of Scotland’s Suicide Prevention Action Plan in partnership with the Scottish Government, Samaritans Scotland and Public Health Scotland⁵. Members of the ALLIANCE team previously introduced the Charter of Rights for People with Dementia and their Carers in Scotland⁶ and led the development of Rights for Life, a declaration of rights for mental health in Scotland. The ALLIANCE is also represented on the Review’s Communications and Engagement Advisory Group.

The main aim of the Review, as set out in the Terms of Reference, is: “to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a

¹ Including a partnership event with See Me in September 2019, at which John Scott QC was a keynote speaker <https://www.alliance-scotland.org.uk/blog/resources/event-report-the-alliance-and-see-me-review-of-mental-health-law/>

² <https://www.healthandsocialcare-snap.com/>

³ <https://www.healthandsocialcare-snap.com/resources/consultation-response-mental-health-in-scotland-a-10-year-vision/>

⁴ <https://www.alliance-scotland.org.uk/wp-content/uploads/2018/12/Tayside-Report-03.12.18-v2.pdf>

⁵ <https://www.alliance-scotland.org.uk/blog/resources/suicide-prevention-strategy-report/>

⁶ https://www.alzscot.org/sites/default/files/images/0000/2678/Charter_of_Rights.pdf

consequence of having a mental disorder, and remove barriers to those caring for their health and welfare.”⁷

It is widely recognised that people with lived experience of mental health problems in Scotland do not enjoy their human rights as fully as they could, and that barriers exist for unpaid carers, for example due to concerns about patient confidentiality. The Scottish Government has previously made commitments to take a human rights based approach to mental health care and support⁸. The ALLIANCE therefore welcomes the Review’s ambition, given how central legislation is to ensuring a human rights based approach. We also value the human rights based approach taken by the Review, and the efforts made to engage people with lived experience of mental health problems.

How well does the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) help people to get the right care, treatment and support?

The Act is not intended for everyone with lived experience of mental health problems but for those with a ‘mental disorder’ whose ability to make decisions about medical treatment is considered to be significantly impaired as a result, and there would be a significant risk to the person or others if detention or treatment was not provided. Under the Act, people can receive compulsory or voluntary care, treatment and support either in hospital or in the community, and it can take many forms, including nursing, medication, psychiatric and/or psychological therapy, detention, artificial feeding, restraint, and electroconvulsive therapy (ECT).

Evidence is mixed as to whether people subject to compulsory treatment and/or detention can achieve recovery and good clinical and personal outcomes, when assessed across a range of measures like reduced hospital admissions and length of stay, improved medication adherence, and better quality of life⁹.

People who have been subject to the Act in Scotland also report mixed experiences¹⁰. One 2013 qualitative study found that there was an over-emphasis on drug treatment in compulsion as opposed to other forms of therapy, despite

⁷ <https://cms.mentalhealthlawreview.scot/wp-content/uploads/2020/01/Terms-of-Reference-1.pdf>

⁸ https://www.parliament.scot/S5_PublicPetitionsCommittee/Submissions%202017/PE1667G_Minister_for_Mental_Health.pdf

⁹ <https://www.bipsolutions.com/docstore/pdf/16188.pdf>;
<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004408.pub5/full>;
[https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(13\)60107-5.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(13)60107-5.pdf);
<https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2524.2009.00847.x>;
<https://www.tandfonline.com/doi/abs/10.1080/09638230802053326>;
<https://journals.sagepub.com/doi/10.3109/10398562.2011.603330>;
<https://academic.oup.com/schizophreniabulletin/article/40/6/1347/1855219>.

¹⁰ <https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12041>

participants reporting extremely debilitating and negative side-effects. Although some benefits and changes in medication due to negative side-effects were reported, “[n]on-medical aspects received far less attention despite the recovery thrust of the legislation and national service developments.”

Around half of participants felt that compulsion had been the right thing to do at the time, though these feelings were mixed – it was seen as ‘a necessary evil’ that could help keep people out of trouble and stabilise. A substantial minority believed compulsion to have been wholly unnecessary. For them, detention in particular was traumatic and severely hindered, rather than helped, recovery. Overall, participants’ experiences of detention were mixed:

- There were few opportunities to engage in meaningful activities, partly as a result of staff shortages.
- High levels of boredom due to the lack of occupation.
- Some appreciation of the benefits of a regime, although this could also be inflexible and depersonalising.
- Some appreciation of the experiences of camaraderie from fellow in-patients.
- Some felt hospital was the safest place to be.
- Generally poor conditions, including cramped and mixed wards.

This study found that participants’ experiences of care were linked to staff attitudes and behaviour. The experience was good when professionals “took the time to listen and be of benefit to patients, had a ‘good understanding of people’; and were enthusiastic and responded flexibly to individual circumstances.”

In terms of community-based compulsory treatment orders (CTOs), participants reported that this mostly took the form of medication compliance and monitoring – they were disappointed that more holistic care packages weren’t available. If they were, participants felt that community-based orders would be preferable to involuntary hospitalisation, although the best option would be to be free of compulsion completely.

Another study carried out in 2013 found that: “people who took part in this study from around Scotland consistently voiced dissatisfaction with the process of being compulsorily treated / detained – although not the principle of compulsory treatment / detention, which most believed was necessary in situations where people had become very unwell and could no longer care for themselves. The process of being detained was frequently described as inhuman and degrading.”¹¹

¹¹ https://www.mwscot.org.uk/sites/default/files/2019-06/rightsinmentalhealth-report-final_apr_2013.pdf

Section 25 of the Act (which is also explored in more detail below), sets out duties for local authorities to provide care and support for people with lived experience of mental health problems that are designed to “minimise the effect of the mental disorder” and “give such persons the opportunity to lead lives which are as normal as possible”. However, the independent inquiry into mental health services in Tayside, in particular the consultation with over 200 people with lived experience led by the ALLIANCE¹², identified a range of issues related to mental health care, treatment and support. This included overly long assessment and treatment waiting times, lack of investment in prevention and early intervention, an overly complex and disjointed landscape of services, and a lack of therapeutic, empathetic and recovery focused environments and practice.

Some of these findings echo reports by the Mental Welfare Commission for Scotland in its consultations with people who have been subject to the Act^{13 14}. The Mental Welfare Commission also regularly makes recommendations in its visit reports for improvement in relation to care, treatment and support, for example that restrictions should be applied in the least restrictive way¹⁵.

See Me’s response to the Review’s consultation highlights that some people with lived experience have resorted to trying to use the Act because they cannot access care, treatment and support, while others may try to conceal their ill-health for fear of becoming subject to compulsory measures.

Recommendation – Evidence suggests that experiences are very mixed, but there are clear reports from people with lived experience about what works and what does not. People with mental health problems are ‘experts by experience’, and their views are as critical to the Review as ‘experts by training’ from the health, care and legal sectors. People with lived experience should therefore continue to lead changes to the law and how it is implemented, to ensure they get the right care, treatment and support.

How well does the Act protect people’s human rights?

The Review’s call for evidence cites a substantial list of human rights that are most applicable to mental health law.

¹² <https://www.alliance-scotland.org.uk/people-and-networks/wp-content/uploads/2018/12/Tayside-Report-03.12.18-v2.pdf>

¹³ https://www.mwcscot.org.uk/sites/default/files/2019-09/20190725_PurposeOfHospital.pdf

¹⁴ https://www.mwcscot.org.uk/sites/default/files/2019-07/20181203_HowMuchWeWantToKeepOurAutonomyWhenBeingCaredFor_0.pdf

¹⁵ https://www.mwcscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf

The ALLIANCE suggests that other rights applicable to mental health law include:

- Freedom of information
- The right to participate in decisions that affect your rights
- The right to work and employment
- The right to education
- Freedom of movement

Rights are found in a wealth of international human rights treaties that Scotland (as part of the UK) is bound by, including the UN Convention on the Rights of Persons with Disabilities (UNCRPD). However, many of these rights are not explicitly referred to as *rights* within the Act, and few are incorporated into domestic law. The Act is also based on 10 Principles that anyone taking any action under it must take into account. Although these are not legally binding, some reflect human rights principles: non-discrimination; equality; respect for diversity; reciprocity; informal care; participation; respect for carers; least restrictive alternative; benefit; and child welfare.

The ALLIANCE suggests that other human rights principles applicable to mental health law include:

- The duties to respect, protect and fulfil human rights¹⁶
- Progressive realisation and non-regression¹⁷
- Maximum available resources¹⁸
- Minimum core¹⁹
- Legality²⁰
- Empowerment²¹

A comprehensive list of the rights included within the Act is set out in the Mental Welfare Commission's 'Rights in Mind' booklet²². Evidence of how well international human rights and the rights and Principles within the Act are protected is found in a number of different places, including reports by people with lived experience, third sector research, and the Mental Welfare Commission. The Scottish Human Rights Commission 'Getting it Right?' report also contains a substantial section on human

¹⁶ <https://www.ohchr.org/en/professionalinterest/pages/internationallaw.aspx>

¹⁷ <https://www.escr-net.org/resources/progressive-realisation-and-non-regression>

¹⁸ <https://www.escr-net.org/resources/maximum-available-resources>

¹⁹ <https://www.escr-net.org/resources/minimum-core-obligations>

²⁰ <https://www.scottishhumanrights.com/rights-in-practice/human-rights-based-approach/>

²¹ <https://www.scottishhumanrights.com/rights-in-practice/human-rights-based-approach/>

²² https://www.mwscot.org.uk/sites/default/files/2019-07/rights_in_mind_1.pdf.

rights and mental health²³. Exploring all the rights applicable to mental health law in detail is beyond the scope of this response. However, a systematic analysis of how well the Act currently protects people's human rights would provide valuable data for the Review.

In terms of the right to life, as indicated in the previous section some people have reported that detention and compulsory treatment stopped them from harming themselves, albeit as a 'necessary evil'. HUG Action for Mental Health has noted that, without the use of these measures, the right to life and other rights will be breached²⁴. They advise that compulsory treatment is sometimes needed "in critical situations where all other sources of support have been exhausted".

As an absolute right, there is a duty to protect people from the risk of harming themselves, whether they are compulsorily detained or otherwise. What is less clear is whether measures taken in the care, treatment and support of people subject to the Act protect the right to life in the longer term, for example is there enough known about how many people subject to compulsory measures subsequently go on to complete suicide at a later date, or whose lives are negatively impacted by the reported debilitating side-effects of medication and ECT? It is also unclear whether compulsory measures are systematically only used in cases where there is serious risk – particularly if the person disagrees with decisions made on their behalf by clinicians, Mental Health Officers and the Mental Health Tribunal – and whether all other alternative forms of potential support have been fully explored and exhausted²⁵.

Compulsory treatment and detention impacts on the enjoyment of other rights within the UNCRPD, including the right to respect for physical and mental integrity (Article 17), right to liberty and security (Article 14), and rights to private and family life (Articles 22 and 23). The UN Special Rapporteur on the rights of persons with disabilities has made several recommendations on how reforming mental health laws and practice can remove the need for compulsory treatment and detention and better protect these rights²⁶.

There is also a strong connection with realising the right to health, a key test of which is whether the following aspects are met²⁷:

²³ <http://www.snaprights.info/wp-content/uploads/2016/01/Getting-it-Right-An-Overview-of-Human-Rights-in-Scotland.pdf>

²⁴ <http://vox.mtcserver3.com/wp-content/uploads/2015/01/Compulsory-Treatment-Report.pdf>

²⁵ <http://www.snaprights.info/wp-content/uploads/2016/01/Getting-it-Right-An-Overview-of-Human-Rights-in-Scotland.pdf>

²⁶ <https://undocs.org/en/A/HRC/40/54>

²⁷ <https://www.ohchr.org/EN/Issues/ESCR/Pages/Health.aspx>

- Are health facilities, goods, services and programmes all fully accessible, available, acceptable and of a good quality ('AAAQ')?
- Do rights holders participate in decision-making?
- Are duty bearers accountable?

If these key tests were applied to people's experiences of care, treatment and support under mental health law, the results would be mixed. For example, as indicated in the previous section, some people view hospital as the safest place to be, albeit they also report an over-emphasis on drugs compared to other forms of therapy, including in community based treatment. Others have reported feeling unsafe and distressed in hospitals. The Scottish Human Rights Commission has noted the gaps between human rights, the law and practice in Scotland, including reports of people being kept in hospitals for too long, inappropriate blanket policies and practice, over-prescribing, seclusion, restraint and poor environments²⁸. SAMH has recommended that more work could be done to explore how the 10 Principles, particularly reciprocity, can be met to ensure that people receive person centred care²⁹.

It is generally recognised that people with lived experience of mental health problems still do not fully enjoy good access to the right support at the right time. National policy and practice work is underway to address this with activity like the Suicide Prevention Action Plan³⁰, Distress Brief Intervention (DBI)³¹, 'street triage'³², and improving Early Intervention in Psychosis³³. Continuing to develop and invest greater resources into work like this and other programmes that support self management³⁴, early intervention and prevention – like Open Dialogue³⁵ – can help people from reaching a crisis, thus potentially reducing the need for compulsory measures.

Despite it being illegal to discriminate directly or indirectly against people with mental health problems in public services³⁶, See Me's response to the Review consultation highlights that people face stigma and discrimination within mental health facilities while detained under the Act. It is unclear to what extent people enjoy their right to

²⁸ <http://www.snaprights.info/wp-content/uploads/2016/01/Getting-it-Right-An-Overview-of-Human-Rights-in-Scotland.pdf>

²⁹ https://www.samh.org.uk/documents/SAMH_view_compulsory_treatment.pdf

³⁰ <https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/>

³¹ <https://www.dbi.scot/>

³² http://scottishjusticematters.com/wp-content/uploads/Pages-from-SJM_5-2_PolicingAndCommunityMentalHealthTriage.pdf

³³ <https://ihub.scot/improvement-programmes/mental-health-portfolio/early-intervention-in-psychosis/>

³⁴ <https://www.alliance-scotland.org.uk/self-management-and-co-production-hub/what-is-self-management/>

³⁵ https://www.alliance-scotland.org.uk/wp-content/uploads/2018/02/Open_Dialogue_Report_Final_WEB-compressed.pdf

³⁶ <https://www.gov.uk/guidance/equality-act-2010-guidance>

an effective remedy in situations like this, when their rights are infringed. A report by SAMH contains worrying examples of people being disbelieved and discredited when trying to raise concerns about their treatment³⁷.

Recommendation – Mental health engages a wide array of human rights, which are indivisible, interdependent and interrelated, however the Act does not protect these rights as well as it could. The ALLIANCE believes equalities and human rights should be incorporated into mental health law and mainstreamed within practice. This includes robust oversight to ensure effective safeguards against arbitrary decisions and strong accountability mechanisms to provide redress for people if things go wrong.

How well does the Act maximise a person’s ability to make their own decisions and give effect to them?

The right to actively participate in meaningful decision-making is a fundamental right in itself and is also necessary for the enjoyment of a wide range of other rights. General Comment No.1 on Article 12 of the UNCRPD has clarified that “mental capacity should not be used as justification for denying people the right to make decisions about their care and treatment”³⁸. Supported decision-making based on a person’s ‘will and preference’ should be used rather than substitute decision-making, whereby decisions are made by another party on someone’s behalf for their ‘benefit’. However, the Act currently provides for substitute decision-making and there are few measures to ensure a person’s views take precedence, particularly if there is disagreement from professionals.

The Act and 10 Principles contain provisions to facilitate participation in decision-making, including advance statements and independent advocacy. However, it is widely recognised that neither of these work as well as they should, thereby compromising people’s opportunities to have a meaningful say in their own care, treatment and support under the Act.

There is an ongoing lack of awareness and understanding about advance statements, amongst both professionals and people with lived experience, and there are concerns about the number that are overturned³⁹. Work by third sector organisations like the Mental Health Network Greater Glasgow (MHNGG)⁴⁰ has been

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https://www.samh.org.uk/documents/SAMH_response_to_call_for_evidence_on_clinical_governance_2017.pdf

³⁸ https://www.samh.org.uk/documents/SAMH_view_compulsory_treatment.pdf

³⁹ https://www.samh.org.uk/documents/SAMH_view_compulsory_treatment.pdf

⁴⁰ <https://www.mhngg.org.uk/>

invaluable in identifying misunderstandings and obstacles, and developing wider use and application of good quality advance statements.

Independent advocacy services, which provide a vital form of supported decision-making under the Act, are chronically underfunded; demand has increased by 11.5% while statutory funding has decreased by 4%⁴¹. The Mental Welfare Commission reports that only five NHS Boards have strategic advocacy plans⁴².

Recommendation – The ALLIANCE believes that mental health law would better maximise participation in decision-making if it complied with the UNCRPD, with greater regard given to a person’s ‘will and preference’ rather than substitute decision-making. In the meantime, further work is needed to boost the number of good quality advance statements and ensure compliance with them. Increased funding for, and access to, independent advocacy – and investment in other forms of supported decision-making⁴³ – would also help protect people’s right to active participation in decisions that affect them.

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

Mental health arguably has a much higher profile in Scotland than it did in 2005. This is also reflected in a growing policy focus. For example, within the last few years the Scottish Government has produced a 10-year mental health strategy, expanded its team into a new Mental Health Directorate, started large-scale reform of mental health services for children and young people, and launched several reviews into different aspects of mental health legislation⁴⁴. Nevertheless, there are still calls for greater parity of esteem between mental and physical health services, and reports that mental health services still lag behind in terms of funding and prioritisation.

The Act is founded on human rights principles, however there have been substantial changes since it was passed. The UNCRPD and growing body of work by the UN Committee on the Rights of Persons with Disabilities has shifted the focus towards a social and human rights model of disability. People with lived experience of mental health problems are being viewed less as passive recipients of charity and ‘patients’, and increasingly as rights holders and change agents.

⁴¹ https://www.siaa.org.uk/wp-content/uploads/2017/09/SIAA_Advocacy_Map_2015-16-1.pdf

⁴² <https://www.mwcscot.org.uk/news/right-advocacy-review-advocacy-planning-across-scotland>

⁴³ For example, Sweden’s Personal Ombudsmen system - <https://zeroproject.org/policy/sweden-2/>

⁴⁴ <https://www.gov.scot/policies/mental-health/>

Viewing mental health law through a human rights lens aligns with a wider emphasis on rights in Scotland⁴⁵, including work to incorporate international human rights law into Scots law⁴⁶ and launch the second National Action Plan for Human Rights⁴⁷.

The shift towards human rights is also complemented by an increased focus on recovery⁴⁸, ACEs (Adverse Childhood Experiences)⁴⁹, and trauma-informed approaches⁵⁰, both nationally and internationally.

Are there certain things that hinder the Act from working effectively?

The Mental Welfare Commission has reported that in the last 10 years there has been a 41% increase in the number of CTOs and a 40% increase in the number of short-term detention orders⁵¹. There is also a hugely variable rate in the number of emergency detention certificates issued in different parts of the country. While the reasons for this are still unknown, explanations could be that, across Scotland, detention and compulsory treatment are increasingly used because of insufficient regard being given to people's views, or because there are not enough alternative forms of community-based prevention and early intervention to support people in distress and pre-crisis. As previously indicated, valuable evidence on this was gathered during the independent inquiry into mental health services in Tayside⁵², including the substantial consultation led by the ALLIANCE with over 200 people with lived experience⁵³.

Another limitation of the Act is its use of deficits based and medical model language, for example, words like 'disorder'. The ALLIANCE agrees with the See Me response to the Review's consultation that future legislation needs to move away from stigmatising and discriminatory terminology.

A further barrier that has been reported is the difficulty in recruiting and retaining Mental Health Officers (MHOs). A report by the Scottish Recovery Network indicates that people with lived experience value MHOs if they demonstrate skills, expertise

⁴⁵ <https://www.gov.scot/policies/human-rights/>

⁴⁶ <https://www.gov.scot/groups/national-taskforce-for-human-rights-leadership/>

⁴⁷ <http://www.snaprights.info/snap-2>

⁴⁸ <https://www.scottishrecovery.net/what-is-recovery/>

⁴⁹ <https://www.gov.scot/publications/adverse-childhood-experiences/>; <https://www.alliance-scotland.org.uk/wp-content/uploads/2018/11/ACEs-Paper-2018.pdf>

⁵⁰ <https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx>

⁵¹ <https://www.mwscot.org.uk/sites/default/files/2019-11/MHA-MonitoringReport2019.pdf>

⁵² <https://www.alliance-scotland.org.uk/wp-content/uploads/2020/02/Final-Report-of-the-Independent-Inquiry-into-Mental-Health-Services-in-Tayside.pdf>

⁵³ <https://www.alliance-scotland.org.uk/people-and-networks/wp-content/uploads/2018/12/Tayside-Report-03.12.18-v2.pdf>

and legal knowledge to help challenge stigma and discrimination and protect people's rights, and if they have a commitment to support informed risk taking and people's autonomy⁵⁴.

In order to effectively uphold their rights, people need to know what they are and be able to claim them effectively. However, people in Scotland generally have low levels of awareness of their rights⁵⁵, and this is also true for people with lived experience of mental health problems and their rights under the Act. Research in 2013 found that, unless they were already actively involved in national mental health policy making or they occupied a service provider role, even people who had been subject to CTOs were unaware of their rights⁵⁶.

As indicated elsewhere in this response, other factors that hinder the Act from working effectively include under resourcing of independent advocacy, lack of investment in other forms of supported decision-making, and the low uptake of advance statements.

What would improve things?

The ALLIANCE would add the following recommendations to those made elsewhere in this response:

- Invest more resources in community-based prevention, early intervention, and self management so that people get the right help at the right time before reaching states of distress and crisis that trigger the Act.
- Implement the recommendations by the independent inquiry into mental health services in Tayside, including those from people with lived experience, and explore how learning from this inquiry can be applied to other parts of Scotland where similar issues exist.
- Increase investment in tools and programmes that raises both rights holders' and duty bearers' awareness and understanding of rights, like the Mental Welfare Commission's 'Rights in Mind'⁵⁷ and See Me - Scotland's Programme to tackle mental health stigma and discrimination⁵⁸.

⁵⁴ https://www.scottishrecovery.net/wp-content/uploads/2020/05/Using_Lived_Experience_to_Inform_MHO_Service.pdf

⁵⁵ <http://www.scottishhumanrights.com/actionplan/downloadfullreport>;
<http://www.scottishhumanrights.com/actionplan/readfullreport>

⁵⁶ http://www.mwcscot.org.uk/media/129344/rightsinmentalhealth-report-final_apr_2013.pdf

⁵⁷ <https://www.mwcscot.org.uk/law-and-rights/rights-mind>

⁵⁸ <https://www.seemescotland.org/>

- Ensure people with lived experience are actively involved in meaningful decision-making across all aspects of mental health, including policy/law, budgeting, service design and delivery, monitoring and oversight.
- The Review should fully explore the independent accountability mechanisms available within the law for people to claim their rights and seek redress if things have gone wrong.
- Implement the recommendations made in the Scottish Recovery Network report 'Using lived experience to inform the development of the Mental Health Officer service', for example better involvement of people in the creation of their Social Circumstance Reports⁵⁹.
- Undertake a thorough Equality and Human Rights Impact Assessment⁶⁰ of future mental health legislation, regulations and guidance.

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

Available data suggests the following groups may not be well served by the law and its implementation:

- People with lived experience of homelessness⁶¹
- Women⁶²
- People from the BAME community⁶³
- Young men⁶⁴
- Young women⁶⁵
- People with learning/intellectual disability⁶⁶
- People with autism⁶⁷
- People with a diagnosis of Borderline Personality Disorder⁶⁸
- People with dementia⁶⁹

⁵⁹ https://www.scottishrecovery.net/wp-content/uploads/2020/05/Using_Lived_Experience_to_Inform_MHO_Service.pdf

⁶⁰ <http://eqhria.scottishhumanrights.com/>

⁶¹ https://www.mwcscot.org.uk/sites/default/files/2019-06/themed_visit_to_homeless_people_with_mental_ill_health.pdf

⁶² https://www.mwcscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf

⁶³ <https://www.mwcscot.org.uk/sites/default/files/2019-11/MHA-MonitoringReport2019.pdf>

⁶⁴ https://www.mwcscot.org.uk/sites/default/files/2020-05/YoungPeopleMonitoringReport_2018-19.pdf

⁶⁵ <https://www.mwcscot.org.uk/sites/default/files/2019-11/MHA-MonitoringReport2019.pdf>

⁶⁶ <https://www.irmha.scot/wp-content/uploads/2020/01/IRMHA-Final-report-18-12-19-2.pdf>

⁶⁷ <https://www.irmha.scot/wp-content/uploads/2020/01/IRMHA-Final-report-18-12-19-2.pdf>

⁶⁸ https://www.mwcscot.org.uk/sites/default/files/2019-06/nov2018bpd_report_final.pdf

⁶⁹ https://www.mwcscot.org.uk/sites/default/files/2019-06/dementia_in_community_may2018.pdf

- Older people⁷⁰
- People on longer term community-based CTOs⁷¹

Article 31 of the UNCRPD requires the state to “collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention”⁷². Unfortunately there is a lack of systematic equalities and intersectional research and analysis in relation to the Act.

Recommendation – In order to identify which groups are not well served by the current (and future) legislation, the ALLIANCE recommends an ongoing programme of longitudinal research to capture qualitative and quantitative data, framed within an equalities, human rights and intersectional lens. Appropriate action should be taken to address the issues that are already known for some groups. For example, problems experienced by people with learning/intellectual disability and autism could be addressed by implementing the recommendations of the Independent Review of Learning Disability and Autism in the Mental Health Act (IRMHA)⁷³.

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

Recommendation – The ALLIANCE recommends that any changes made to legislation, including legal tests, comply with UNCRPD and guidance on legal and mental capacity from the Committee on the Rights of Persons with Disabilities and the UN Special Rapporteur on the rights of persons with disabilities.

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?**

Sections 25-26 place duties on local authorities to provide care and support services to people with lived experience and promote their wellbeing and social development. Services to promote wellbeing and social development include social, cultural and recreational activities and training and employment assistance for people over school

⁷⁰ https://www.mwscot.org.uk/sites/default/files/2020-05/OlderPeoplesFunctionalMentalHealthWardsInHospitals_ThemedVisitReport_April2020.pdf

⁷¹ https://www.mwscot.org.uk/sites/default/files/2019-06/ccto_visit_report.pdf

⁷² <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-31-statistics-and-data-collection.html>

⁷³ <https://www.irmha.scot/wp-content/uploads/2020/01/IRMHA-Final-report-18-12-19-2.pdf>

age. The ALLIANCE also believes that section 27, which places a duty on local authorities to provide assistance with travel, should not be overlooked.

Although they are not expressed as such, the duties set out in sections 25-27 engage a wide range of human rights within the UNCRPD⁷⁴. This includes:

- The right to work and employment (Article 27)
- The right to education (Article 24)
- Adequate standard of living and social protection (Article 28)
- Personal mobility (Article 20)
- Independent living and inclusion in the community (Article 19)
- Access to information (Article 21)
- Participation in political and public life (Article 29)
- Participation in cultural life, recreation, leisure and sport (Article 30)

As previously indicated, both rights holders and duty bearers have a general lack of awareness about international human rights, the rights within the Act and 10 Principles. This may be even greater in relation to the rights found within sections 25-27, given that focus is usually placed on other provisions.

The ALLIANCE is not aware of any systematic research, monitoring or oversight of sections 25-27. It is beyond the scope of this response to go into detail, however there is widespread evidence that people with lived experience of mental health problems do not fully enjoy these rights⁷⁵. For example, people with lived experience face problems when released from compulsory orders⁷⁶, accessing employment⁷⁷, stigma and discrimination in the workplace⁷⁸, and barriers to fully engaging in civil and public life⁷⁹.

Recommendation – The provisions in sections 25-27 of the Act give rise to a wide range of human rights. The ALLIANCE recommends further research on what people and local authorities understand about these duties and what is being done to implement them. We also recommend greater scrutiny and oversight of these duties in future.

⁷⁴ <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>

⁷⁵ <https://www.healthandsocialcare-snap.com/resources/consultation-response-mental-health-in-scotland-a-10-year-vision/>

⁷⁶ <http://www.snaprights.info/wp-content/uploads/2016/01/Getting-it-Right-An-Overview-of-Human-Rights-in-Scotland.pdf>

⁷⁷ https://www.samh.org.uk/documents/SAMHs_Views_Employment.pdf

⁷⁸ <https://www.seemescotland.org/workplace/>

⁷⁹ <http://voxsotland.org.uk/wp-content/uploads/2018/06/14183-Mental-Health-DRLL-Report-A4-Rev7.pdf>

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?

Yes.

The ALLIANCE welcomed indications from John Scott QC that ensuring the legislation reflects economic, social and cultural rights is a crucial underpinning of the review⁸⁰. This is closely aligned to work being undertaken by the National Human Rights Task Force to incorporate international human rights into Scots law⁸¹.

Work by Professor Bernadette McSherry at the University of Melbourne demonstrates how mental health law could incorporate economic, social and cultural rights, and mainstream human rights principles, to ensure that people’s rights are respected, protected and fulfilled⁸². She notes that “obligations on States to provide supports and services for persons with disabilities under the CRPD might provide a more nuanced approach to mental health care and treatment than focusing on substituted decision-making regimes.” Professor McSherry suggests that placing more emphasis on the duty of the state to fulfil human rights, and take pro-active steps to provide rights based, recovery focused mental health and community-based services and support, would increase voluntary access.

The World Health Organisation’s QualityRights Tool Kit⁸³ provides training and practical tools to help countries review and improve services with direct reference to the UNCRPD. This could be used to ensure rights based law results in rights based practice.

Recommendation – The ALLIANCE recommends incorporating economic, social and cultural rights into mental health law, and using the WHO QualityRights Tool Kit to carry out training and country-wide and facility based assessments, in order to improve access to quality, rights based mental health services.

Do you think the law could do more to raise awareness of and encourage respect for the rights and dignity of people with mental health needs?

Yes.

⁸⁰ <https://www.alliance-scotland.org.uk/blog/resources/event-report-the-alliance-and-see-me-review-of-mental-health-law/>

⁸¹ <https://www.gov.scot/groups/national-taskforce-for-human-rights-leadership/>

⁸² <https://www.mdpi.com/2075-471X/4/2/125>

⁸³ https://www.who.int/mental_health/policy/quality_rights/en/

Mental health law could include provisions specifically aimed at increasing awareness of rights and ensuring they are respected, protected and fulfilled. Article 8 of the UNCRPD⁸⁴ places a duty on the state to:

- Raise awareness and foster respect for the rights and dignity of disabled people.
- Combat stereotypes, prejudices and harmful practices relating to disabled people.
- Promote awareness of the capabilities and contributions of disabled people.

SAMH research from 2017 found that that 40% of 319 people surveyed who use NHS services felt they had been treated disrespectfully⁸⁵. However, as reported by the independent inquiry into mental health services in Tayside, trusting and respectful relationships are essential for the delivery of good mental health services⁸⁶. People's experiences of care are linked to staff attitudes and behaviour. They report good experiences when professionals take the time to listen, have a good understanding, and respond enthusiastically, flexibly and in a person centred way⁸⁷.

Recommendation – The ALLIANCE recommends adopting the measures suggested by the UNCRPD to increase awareness of the rights and dignity of people with lived experience, including publicity campaigns, education and training programmes.

Is there anything else you wish to tell the Review?

The UN Special Rapporteur on the rights of persons with disabilities has noted that the UNCRPD, and in particular the development of the right to equal recognition before the law, is a paradigm shift for people with lived experience of mental health problems⁸⁸.

Changes to the law could support a cultural shift and address the imbalance of power between the state and people with lived experience of mental health problems. However, legislative reform in Scotland requires human rights competence and a cultural shift towards the social and human rights model of disability. This will

⁸⁴ <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-8-awareness-raising.html>

⁸⁵

https://www.samh.org.uk/documents/SAMH_response_to_call_for_evidence_on_clinical_governance_2017.pdf

⁸⁶ <https://www.alliance-scotland.org.uk/wp-content/uploads/2020/02/Final-Report-of-the-Independent-Inquiry-into-Mental-Health-Services-in-Tayside.pdf>

⁸⁷ <https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12041>

⁸⁸ <https://undocs.org/en/A/HRC/37/56>

necessitate training, support and ongoing CPD for the many different people that currently work within the various structures and mechanisms associated with mental health law and its application, including lawyers, social workers, the Mental Health Tribunal, independent advocates, police, mental health professionals, and so on.

Recommendation – The ALLIANCE recommends consideration is given to seeking further advice and expertise from national and international experts in academia, the UN and WHO in developing recovery focused, human rights based mental health law and practice.

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About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. We have a growing membership of over 2,900 national and local third sector organisations, associates in the statutory and private sectors and individuals. Many NHS Boards, Health and Social Care Partnerships and Medical Practices are associate members.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.

- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.
- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.