

SMHLR Consultation Response – May 2022

Forensic Mental Health Services Managed Care Network

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The Forensic Mental Health Services Managed Care Network (“Forensic Network”) welcomes the opportunity to provide a response to the Scottish Mental Health Law Review Consultation document.

The Forensic Network was established by invitation of Scottish Ministers in 2003 following a review and consultation on the governance and accountability of the State Hospitals Board for Scotland (“The Right Place, the Right Time”, Scottish Executive, 2001). The aim of establishing the Forensic Network was to bring a pan-Scotland approach to the strategic planning of forensic mental health services, address fragmentation and inconsistency across the estate, streamline patient pathways, and determine the most effective care for Mentally Disordered Offenders (MDOs). Forensic Mental Health Services are those which assess, treat and care for MDOs, or others who require secure care, due to risk of harm to the public. The new National Secure Adolescent Inpatient Service (Foxgrove), opening later this year, will provide secure care for young people up to the age of 18; therefore, whilst we have focused primarily on the proposals as they relate to adults in forensic mental health settings, we have also provided specific comment on the potential impact for children and young people within Chapter 9.

Whilst the focus of the Forensic Network is largely on the care and well-being of mentally disordered offenders (and those requiring similar services), the principles and proposals for changes to civil mental health legislation are highly relevant to our patients, their carers and our staff. We look forward to commenting on the proposals for legislation directly pertinent to forensic mental health.

Chapter 2: What is the purpose of the law?

1. What are your views on our purpose and principles?

The Forensic Network supports the aspiration of promoting the positive fulfilment of rights of individuals receiving mental health care services. The scope of the proposals appears very broad, including health, economic, social and cultural rights that are applicable to the general population. Ensuring that the proposals are developed in sufficient detail to enable implementation in practice will be key to achieving positive outcomes for people with defined mental health conditions.

The Forensic Network continues to be of the view that reciprocity is an important principle for individuals receiving compulsory care, including those in forensic mental health settings. It is our view that the strengthening of this principle would make a real difference to those whose care comes under the remit of any new legislation.

2. What do you think about the approach that we are proposing for Scottish Government to meet core minimum obligations for economic, social and cultural rights in this area?

Service standards, including for forensic mental health settings, have been developed by a range of organisations. For example, the Forensic Network and the Royal College of Psychiatrists have quality assurance processes that can help services develop action plans to improve standards. In a resource limited environment, the risk of core minimum obligations is that only the core minimum obligations will be met. They will necessarily be broad and may not reflect the particular needs of specialist areas or reflect developments in clinical practice. Rather than legislation being the vehicle for service improvement, the Forensic Network supports continuous quality improvement approaches that are more dynamic. Other measures in the proposals may be more effective in ensuring organisations and government departments

meet their human rights obligations for those in receipt of mental health services.

3. What are your views on our suggestions for reforming sections 25 to 27 of the Mental Health Act?

The Forensic Network supports efforts to achieve a right to health, including both physical and mental health. Broader social, economic and housing rights may be better located in legislation applicable to the population as a whole, rather than within mental health legislation; this may appear discriminatory.

4. Do you have suggestions on how law could be reformed to address stigma, and issues towards mental disability?

Stigma towards those with mental health conditions is wide spread, and extends to professionals and services for people with these conditions. This can be reflected in the disparity of resource allocation between acute physical health care settings and mental health care settings. Ensuring people with complex and severe mental health conditions have access to high quality evidence based care and treatment will improve both their health as well as reducing the impact these conditions can have on wider society in the absence of services. Public health approaches to de-mystify mental health conditions and to promote inclusion will further help to reduce stigma. Legislation can provide for remedies when people experience discrimination, but is unlikely to be able to address the underlying societal attitudes that underpin stigma.

5. Do you have suggestions on how the law could lead to prevention, and how the law could address the social determinants of mental health?

The social determinants of both physical and mental health have a robust evidence base, giving a basis for public health, social and economic policy approaches that can improve physical and mental health at a population level. Developing mechanisms whereby legal challenge can be brought if inadequate housing or lack of services, for example, is contributing to poor health outcomes in a particular area may assist in improving disparities. Proposals for collective advocacy as outlined may be a helpful approach.

6. What are your views on our proposals on adequate income, housing and independent living, inclusion in society and accessible information?

These factors as outlined are all relevant for improving mental health outcomes. These aspirations require significant resources (financial, infrastructure and staffing resources), which may limit the ability of legislation to effect the changes envisaged.

7. What are your views on the system-wide changes which we think are needed?

We would note that in order for true change to be achieved, this would require change at various levels within society and it is perhaps ambitious to expect legislative changes to be effective in achieving the change required. The scope of what is proposed may result in unintended consequences if the practical implementation is overly bureaucratic, complex or time-consuming. Recognition of the wide range of clinical situations for which the proposals need to work in practice is needed, with consideration of case studies to 'stress test' the proposals once these are developed in greater detail. Ensuring that those most in need receive high quality services should be a key aspiration.

Chapter 3: Supported Decision Making

1. What are your thoughts on our proposals for a wide ranging supported decision-making scheme? What do you consider would be the barriers to this? How do you think the Supported Decision Making scheme should be taken forward?

The Forensic Network agrees that there needs to be a collective understanding of what Supported Decision Making (SDM) means and guidance on this would be beneficial. Ensuring SDM can be delivered in a range of clinical situations, including urgent and 'high stakes' situations will be key to ensuring it is embedded in practice.

The Forensic Network recognises that this is a difficult area of practice and works best where there is time for relationships to be built and a patient's mental health to improve, and advocacy services are well developed. It is of note that the highest uptake of the advance statement is within forensic services. This is more difficult in acute adult general psychiatry settings.

2. How do we mitigate against undue influence or pressure in Supported Decision Making generally?

Situations where undue influence or pressure are identified can be extremely challenging. Guidance for professionals would be welcome in this area, as well as robust appeals processes available to any interested party when faced with such a situation.

3. Should there be legal duties on public bodies to secure Supported Decision Making for people who need it? (Agree – If so, given that advocacy is a form of SDM, what should be the relationship between that and the existing duties in respect of advocacy?)

The Forensic Network agrees that there should be a legal duty on public bodies to secure SDM for those who need it. Greater clarity on where responsibility and accountability lies for ensuring these duties are met would be welcome. Ensuring high quality advocacy is consistently available would be helpful.

The Forensic Network notes the proposal for a SDM Centre of Excellence. We are not convinced that this is the best approach to achieve the stated aim. We are unclear why this particular aspect of the proposals is thought to require that there be a legislative requirement for such a Centre, rather than for example a proposal for a Centre of Excellence on strategies to reduce restrictive practices. Several organisations, such as the Mental Welfare Commission, already undertake research and provide guidance on good practice in this area. We would propose that these existing efforts are supported, and if necessary expanded.

Chapter 4: The Role and Rights of Carers

1. What are your views on our proposals for mandatory Carer Awareness training for all mental health staff?

The Forensic Network is supportive of the proposals for mandatory Carer Awareness Training for all mental health staff, particularly in relation to awareness raising of the Carers (Scotland) Act 2016 and the rights within this. We would highlight that, in our view, training should be tailored to specific environments in order to be meaningful. For example, the 'Equal Partners in Care' module is helpful but too generic for forensic mental health inpatient settings. Training should take the form of an online learning module, as well as a half-day workshop in which carers can participate in the facilitation of discussions based on their lived experience. We would also advocate a tiered approach to training, with Consultants and Keyworkers within inpatient settings being required to engage in more detailed learning/training in this area.

2. What are your views on information sharing with unpaid carers of all ages?

Information sharing in both directions is usually extremely helpful and in the interest of the patient. However, where a patient refuses to allow health staff to disclose confidential information then it is not possible to do so unless the patient has made an advance statement setting out that this may occur. This in our experience is the fundamental difficulty for carers and health professionals in information sharing. The MHO has duties under mental health legislation to gather information from carers and can be an information conduit where permission from the patient is absent. This aspect should be examined by the Review and strengthened if possible.

3. What is needed to ensure mental health services identify and engage with young carers?

Any information sharing with young carers would need to be age appropriate and consider levels of maturity; particularly in relation to forensic mental health settings where offence details may form part of the necessary paperwork. Depending on the age of the carer, it may not be in the best interests of the carer or patient in terms of sharing of specific information; it is unclear who would make the decision on this and

whether that is appropriate. There should be a proactive approach to determining who a young carer is, why they are fulfilling the role of carer and their preferences in terms of modes of communication and best time to contact them (around school/college commitments etc.). It is also important to ensure that the person liaising with the young carer has a clear understanding of how to engage effectively with them (e.g. a more mature member of staff who is unfamiliar with the use of social media platforms may find it more difficult to engage a young carer who primarily uses this form of communication).

4. What are your views on including unpaid carers in discharge planning and processes, as stated in Carers (Scotland) Act 2016?

The Forensic Network believe that unpaid carers are fundamental in successful discharge planning. We note that carers are often excluded from this process at the request of patients and this can make their involvement in the process difficult and potentially less successful. Understanding the role carers undertake in terms of supporting this transition should not be underestimated. Engaging at the outset of the planning journey and not as an afterthought is important to ensure that discharge is planned around the needs of both the patient and carer, and not discharging services.

5. What needs to happen to ensure unpaid carers of all ages are respected and valued?

- Assessment to understand the needs of carers of all ages
- Ongoing support from skilled people
- Respect for lived experience as another form of 'expertise' (which often differs from professionals who are assumed to be the experts)
- Tangible evidence of translation of carer feedback to practice – legislation informed by lived experience rather than theory.
- Respite opportunities for carers providing other support where appropriate.
- Carer's forums as an integral part of service improvement delivery plans

6. Please tell us anything else you think may be relevant to the role of unpaid carers when supporting someone experiencing mental disorder and working with services.

We feel it is important to recognise that the definition of a 'carer' may be different for carers of those in an inpatient mental health setting, than the one described in the Carers (Scotland) Act 2016. For example, within The State Hospital, a high secure forensic mental health setting, the following definition is used to identify carers: *"the word carer is used to describe those who have regular contact with the patient and Clinical Team, who may attend CPA/Tribunal meetings and, with the patient's consent, may have access to relevant information relating to care and treatment. This descriptor therefore includes, Named Person, nearest relative, and any other person the patient identifies as a 'carer'"*

7. Please use the space provided below for any other comments you would like to make relevant to this chapter.

The majority of legal care and treatment review planning documentation remains 'doing to', rather than 'doing with' in terms of language, process and feeling truly collaborative. We would also highlight our view that many of these issues are already covered within the Carer Scotland Act and we are not convinced that further legislation is required in order to effect real, positive change in this area.

Chapter 5: Human Rights Enablement

1. What are your thoughts on the proposed Human Rights Enablement (HRE) framework?

The consultation document outlines the proposed Human Rights Enablement (HRE) framework in some detail; whilst the principles guiding the proposed framework appear appropriate, overall it would benefit from further elaboration and detail as to how the framework would work in practice.

There is concern that expectations would be raised within the development of a HRE document that would not be met, and therefore pressures would come to bear on individual professionals or public bodies to uphold rights where these are out of reach for most. Where then is the compromise here? What might be considered as good enough upholding or balancing of rights with what is available and who would be accountable for rights, will or preferences not being met?

There is a suggestion that the HRE could be completed by a number of professionals, in dialogue with any number of other individuals who are relevant/significant to the person (family, carer, independent advocacy etc.), and that some level of HRE could be completed for **any** type of intervention, be this complex or simple. This could result in a wide-ranging number and versions of HREs and amended HREs unless there is some central co-ordination of this. If an initial HRE has not been completed and a simple intervention is required, would the professional/individual involved in providing the simple intervention be expected to complete the 'comprehensive evaluation' and, if so, would they have the confidence and competence to do so? If not, would they require to refer for this to be completed before their simple intervention was undertaken? This seems impractical, time consuming and resource intensive.

There is also the suggestion that a person could decline an HRE, but that if the person is deemed not to have the ability to make an autonomous decision in this regard it should be completed anyway. This does not sound equitable if others do have a right to decline. It is similarly unclear on what basis a decision making representative could decline or agree on a person's behalf and what the process for this might be. There would be a need for new collaborative working arrangements to be put in place to facilitate the completion of these records to assist with consistency and governance, which also provide that crisis interventions can be undertaken without disadvantageous delays.

2. How do you see the framework as proposed working in practice? What barriers do you see to its operation in practice?

Overall, it is our view that this framework will be challenging to implement and may face a number of barriers initially as it may be that new systems and processes will be required to support the process.

The consultation document is not clear on who would complete the HRE record. There is potential for many supplementary versions to exist simultaneously in different files and it is not clear how this would work in practice. In addition, there seems to be a suggestion that for every new intervention a further updated record would need to be included. This would be problematic on a day-to-day basis; if records cannot be carried out for every new intervention at the time of the intervention taking place (thinking of care home and hospital settings); with potential disagreements between professionals regarding who would complete the record or on what basis the record would be completed. How would this be monitored in any workplace or clinical setting? How could this be achieved in any meaningful way? Ultimately, many records may not be completed at all. The principle of reciprocity would be fundamental here. It is worth noting that electronic systems across agencies, and sometimes within organisations, do not easily communicate with each other or allow for a single document to be shared across platforms. There are significant challenges with resolving this, and this practical challenge may impede achievement of the process for HRE as outlined.

Similarly, the workforce is already stretched and many practitioners work within a context of eligibility criteria and limited resource; this may make easy targets for legal challenges. Whilst organisations are ultimately responsible for this, the stress on individuals will be significant. Clear and robust training around Human Rights and the Law for all practitioners will be required for this to work well in practice. It may be preferable to embed the HRE within existing systems, such as the Care Programme Approach or Assessments of Needs.

3. What are your thoughts on who should initiate an HRE?

If the legal test for capacity remains as it is now, then the autonomous decision making (ADM) test would identify the areas where a person has or lacks capacity. The key issue then becomes who is involved with

the ADM and how this is undertaken, rather than leaving the HRE to a number of different professionals, where differences in perspective and views are likely to arise.

Additionally, although the consultation document suggests that the HRE is not another assessment, it is difficult to perceive how any initial or baseline HRE could be anything but an assessment for the person completing it. If it is the case that the totality of a person's rights requires to be considered (so including social, cultural and economic rights). The nature of these rights could not be understood unless the full circumstances/context of the person's life and needs are known. This work is undertaken already as a matter of course in a range of different assessment and formulation approaches by social workers, mental health officers and other NHS staff, depending on professional remit and background, for example, psychology.

4. What are your views on the triggers for an HRE? Is there anything not included which should form a trigger?

The list of triggers/relevant events covers various scenarios but could never cover all eventualities where an update or review of any HRE might be required; we would suggest that it needs to be simpler and more practical. The question again here would be who would have the responsibility to identify this change and record it. This is not dissimilar to care, support or treatment reviews or life changing circumstances for those individuals who do not require any ADM because they have capacity and may choose to record their views in a different document (ACP/Living Will etc.).

5. What are your views on the right to request a review and the right of remedy and appeal as proposed?

There would need to be a definition of who would constitute an 'interested party'. More fundamentally, how can the person themselves ask for an ad-hoc review if they have been assessed as lacking capacity. Would this fall to a decision making representative and how would this decision be made? On this basis, it would seem more appropriate for there to be a process of regular review with timeframes for the number of reviews/appeals being undertaken say, over a 12-month period.

6. Would the body for remedy and appeal differ if the request for a review was in respect of a group of persons rather than an individual?

The MWC or MH Tribunal may be more appropriate public bodies for reviews for a group of persons rather than an individual. There may be a potential for a greater number of individual reviews. The MWC currently carry out reviews and checks, for example, of the care and circumstances of those adults where welfare guardians are in place. The MWC could become an 'interested party' to undertake a review when requested to do so but independent panels could also be created between the new National Care Service/NHS to undertake this function. There may be merit in a group of persons wishing to challenge a specific aspect of service provision to have the option of doing so to the Court for a ruling in terms of whether or not human rights have been breached (and what the remedy should be).

Chapter 6: Autonomous decision making test

Capacity and SIDMA (Significantly impaired decision making)

Option 1: are you in favour of the current capacity and SIDMA tests remaining unchanged?

(Agree/Disagree)

The strength of the current capacity test is that it is well established and well understood by clinicians, with extensive case law relating to this area of practice. The benefit of the SIDMA test is that it considers a holistic care and treatment plan for mental disorders, rather than individual measures separately. There may be benefit in greater alignment between the tests (i.e. capacity more clearly relevant for a care and treatment plan where appropriate, rather than a specific intervention). It is acknowledged that SIDMA is at

times poorly understood and poorly described within current practice, and aligning more closely with the current capacity test may help to address these concerns.

Option 2: are you in favour of the current tests remaining, distinctly – but with one, or both, reframed, if possible to address the current problems articulated above? (Agree/Disagree)

Reframed as a single test would be preferable, allowing for comprehensive treatment plans to be the focus of the assessment and not just a single decision. Having the same safeguards following a capacity test is required to ensure equitable treatment, even if different legislation applies (either mental health or incapacity legislation).

Option 3: are you in favour of the current tests remaining but reframed as a single test? (Agree/Disagree)

Reworking to conjoin them would be preferable. See above.

Option 4: do you see little value in the current tests, preferring to see one, or both of them replaced?

Both have value and are important components when considering whether a legal framework is required to authorise treatment. To remove the current tests would cause a high degree of concern across a range of settings. Any alternative would need to address the factors considered in capacity testing and needs to be practicable across a range of situations (both urgent and non-urgent). We recognise from the MWC's work that SIDMA is not well applied in practice and that this needs to be addressed. However, there is the risk that would also apply to a new concept such as ADM.

1. We seek your views on the concept of the test of autonomous decision-making, distinct from a capacity or SIDMA test.

The focus seems disproportionately focused on non-urgent situations, where there is time and resources for extensive consultation and assessments. In clinical practice this would be the minority of cases. A clear, practical framework for use in urgent, time-sensitive situations would better meet the needs of individuals who are most vulnerable and in greatest need of safeguarding. The presumption seems to be that people have clear, settled views that are stable over time. In practice, people often change their minds or, due to the nature of their illness/impairment, are unable to provide a settled will. It would be helpful to distinguish between acute causes impacting on decision making (e.g. a manic episode in someone with bipolar illness, or delirium due to an infection) – where someone could regain decision making within a relatively short period of time, long term impairments of cognition (such as severe learning disability or severe acquired brain injury), and long-term deteriorating conditions such as dementia. Requiring yearly review in long standing or deteriorating conditions would not be a good use of limited specialist resources. Lengthier review periods would be more appropriate, particularly if there is a mechanism to appeal against assessments of autonomous decision making ability. The term crisis varies greatly in its definition and the use of term urgent would be more useful.

2. What are your views on the skills and experience required for someone to competently undertake a test of a person's ability to make an autonomous decision?

This will depend on the complexity and seriousness of the decision being taken. For simple procedures, such as podiatry interventions or having a blood test, a clinician undertaking the procedure should seek reassurance that the person understands they can refuse, and that the person has sufficient understanding of the reason for the intervention. However, for complex interventions with the potential to impact on life expectancy or significantly affect quality of life, greater expertise is required in assessing and supporting individuals being asked to make decisions on these matters. For example, the decision to proceed or not with dialysis in someone with a chronic delusional disorder will require multidisciplinary assessment and consideration. For less urgent situations, supported decision making approaches can be helpful and can guide clinicians in their assessment. However, for urgent situations, a clear legal framework that enables

intervention whilst it can still have an impact on the outcome is required, even if there is insufficient time to fully explore supported decision making and lengthy assessments by a range of professionals.

3. **What are your views on the ADM appeal process? What qualities should the appeal have?**

Appeals should be considered in a timely fashion, whilst allowing for urgent interventions to proceed if delay will result in death or irreversible harm.

Who can trigger an appeal? It would be appropriate for any interested party to be able to trigger an appeal. This should include the person, close relatives, professionals involved in their care, advocacy, solicitor/curator ad litem and the MWC.

Should it have escalation – for example, commence with an internal review before secondary or external review? This seems excessively cumbersome and would lead to delays. If there is to be an appeal process, this should mirror appeals against compulsory treatment (e.g. trigger a Tribunal).

Who should conduct an external review? This will depend on the complexity of the issue. Any external review should be done by someone with the necessary expertise and experience to consider the relevant issues.

Should there be easy access to an independent second opinion? Independent review would be necessary if an appeal process is to be meaningful. How this will be resourced and/or funded would be a key consideration for a workable system.

Should there be any limit on the frequency with which one can dispute an ADM outcome? One independent review of a specific clinical situation should make a final determination, in our view. Further review may be appropriate if circumstances materially change.

Should there be access to a judicial process? This would only be suitable for the most complex situations, where intervention or the lack of intervention would lead to death/irreversible harm and there is significant disagreement between key parties as to what is in the best interest of the person concerned.

Chapter 7: Reduction of Coercion

1. **Please share your views on how the Review understands coercion**

Overall, the Review indicates that it has sought the opinions of people who use services and looked to local, national and international models. The Review gives examples of coercion referencing direct and indirect coercion that include use of force through detention, restraint and seclusion, feeling coerced, interference with personal communication, limited to social contacts and surveillance without informed consent (p.89). The Review also makes reference to the requirements of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and indicates the need for further clarity by the UN on 'disability discrimination' (p.90). This overview does suggest complexity in defining coercion. The Review notes '*...in many situations, some use of coercion can be necessary and proportionate as part of promoting and protecting all of a person's relevant human rights*', referencing this as a model in many places worldwide. Whilst this looks to current practice 'necessary and proportionate' is unclear, may be subjective and may not define coercion, but potentially a service or individual response.

Whilst the Review discusses racism in relation to coercion, this could go further to look at direct and indirect racism across a range of interventions and could include consideration of all Protected Characteristics. The Forensic Network is of the view that coercion is distinct from compulsion, and that the description of coercion by the Review does not reflect this. Coercion implies negative motivation, which most practitioners would reject as the purpose of the measures outlined. Compulsory treatment and restrictive practices take place to preserve health and life, both of the person concerned and of others. The Forensic Network fully supports measures to reduce the need for compulsory measures wherever possible,

recognising that at times these are necessary in order to preserve rights overall. The Review should use the term “compulsion” except when referring to an intent with ill will, and then “coercion” is appropriate.

2. What do you think about the Review’s proposed approach to reducing coercion, including reducing the use of involuntary treatment?

The Forensic Network support the reduction of coercion and the promotion of a person-centred and least restrictive approach to patient care and broadly agree with the proposed ‘full spectrum’ approach across law, policy and practice as outlined within the Review.

The five concrete actions listed would benefit from further detail as to how they would be achieved and associated timescales. Additionally, the Review highlights that earlier intervention may avoid the need for compulsion; however, it is unclear at what stage this would be most beneficial and whether it will support an integrated care response that addresses mental health, physical and social care needs whilst establishing early safeguarding to any risk of coercion.

3. Do you think that “coercion” or some other word(s) should be used to describe the use of force, the possible use of force and the experience of coercion?

Agree – it needs to remain explicit wherever coercion does occur. However, further definition would be beneficial to allow all to recognise and have an understanding of coercion, as distinct from compulsion and restrictive practices. Having clear standards and safeguards helps services to provide the necessary care in the least restrictive way. The Review talks to authentically describing lived and professional experience of coercion in mental health and social care services. Would it be possible to further explore the experience of a point in time and look at the wider context of environment, culture and society?

4. Please share your views on whether law reform could drive changes which could reduce the use of coercion.

Law reform would place a legal obligation on services to change, but a minimum standard may result in services being delivered at this minimum level if there is not the investment in staffing and training across all agencies involved in caring for people. We would agree with the Review that a change will require time and oversight. A national register of restraint across settings (education, residential setting, nursing homes, hospitals and mental health settings) would help to quantify and clarify the issues relevant to restraint. This would enable data driven improvements to physical environments, staffing and training to reduce the need for restraint and other restrictive practices.

5. Do you think that safeguards for medical treatment in Part 16 of the Mental Health Act should be strengthened?

Yes. The Forensic Network supports that the current part 16 safeguards be extended to include a broader range of interventions that are given under compulsion. Having external DMP or equivalent scrutiny of care plans (beyond the narrow focus on medication) would be of benefit.

6. We seek your views on whether the Mental Welfare Commission should have stronger powers to oversee the use of coercive interventions and to identify areas for action.

The Forensic Network broadly support the Mental Welfare Commission having stronger powers to oversee the use of coercive interventions and to identify areas for action, if used proportionately. The remit of the MWC would potentially be significantly increased and consideration would need to be given to whether ‘coercion’ would become part of visits with published results. We also note the recent consultation on all Deaths in Detention being potentially reported to the MWC and the potential impact this may have on the remit of the Commission. These changes will require resource to implement and staff working across mental health services may require support to engage effectively with such expanded scrutiny. Collaborative approaches to addressing issues, which is currently the general approach taken by the MWC, is valued and the Forensic Network would support this being retained (in preference for a model of inspection and direction).

7. Please share any suggestions you have for the Review’s ongoing work on understanding rising rates of detention and community-based Compulsory Treatment Orders.

Rising rates of Community-based CTOs may be linked to efforts to maintain people at home and to reduce hospital admissions. This may be linked to the overall reduction in beds with a move to supporting people in the community. The thresholds for admission to hospital are higher than in the past and this will increase the use of community options. In individual cases community-based Compulsory Treatment Orders are found to be helpful in avoiding ‘revolving door’ admissions in patients with chronic mental health conditions.

Chapter 8: Accountability

1. What do you think about our proposals to give the Mental Health Tribunal increased powers to order that specific care and/or support be provided for a person?

We would highlight caution in this approach. Many Clinical Teams and practitioners work as effectively as they can to identify appropriate care and treatment for patients and to ensure that treatment is delivered in a timely manner that respects the human rights of the patient. However, there are occasions where resources are limited and despite best efforts, there is little that practitioners or services can do to provide specific care and/or support for patients; increasing powers within legislation will not solve issues relating to resource and service provision in the short-term. In addition, whilst it is acknowledged that the Review would not intend this power to be used to require professionals and practitioners to deliver care which they do not believe can be clinically justified, we would strongly caution against a position where the Mental Health Tribunal could instruct specific care and treatment for individuals.

2. What do you think about the ways we want to extend current excessive security appeals to anyone who feels they are being subjected to unjustified levels of restriction?

The Forensic Network broadly support the extension of these appeals to include all individuals who feel they are being held in conditions which they believe are unnecessarily restrictive. We note the recommendation by the Independent Review into the Delivery of Forensic Mental Health Services (2021) that patients within low secure settings should have the right to appeal against the level of security they are being held in and support this recommendation. However, we would caution that this may create a significant caseload initially, as with the introduction of excessive security appeals for patients in high/medium secure forensic settings. Furthermore, consideration would need to be given to how the outcome of such appeals would be monitored and managed to ensure action is taken.

Excessive security appeals brought in with the 2003 Act led to the development of two medium secure units (the third was already built) in Scotland. This was a successful mechanism that should never have been required. The extension of the excessive security appeal from medium to low secure has not yet resulted in new provision in health or community settings. Capacity across the Forensic Estate remains in excess of 90% and patient flow is very difficult. Clinical decisions on excessive security are guided by the Forensic Network’s Security Matrix. The high secure hospitals Board was the first NHS Board to introduce a human rights based approach such that individual needs are considered in all decisions (*Scottish Human Rights Commission, Human Rights in a Health Care Setting: Making it work for everyone, SHRC 2011*). There is always a balance in any setting between the rights of one and the rights and safety of all. Responsibilities for the latter are set out in legislation.

3. What do you think about our ideas for reforming the ways a person can raise a concern or complaint about their care and treatment? Do you have any other ideas to make this process more effective and equitable?

We would agree that ways for individuals to challenge their care and treatment need to be more equitable, accessible, coordinated and effective and that more meaningful monitoring and reporting on complaints is

needed. However, we would query the inclusion of this within this legislation as there are other clearly detailed and established processes for this within other legislation (including complaints legislation in the NHS). Given the complexity of current complaints processes across agencies and organisations, we do not think it would be helpful to add yet another process to these. Strengthening and improving current complaints processes would be preferable. Central data collection would have merit, in order to identify repeated complaints about the same issue in a particular setting or area. This would allow more systematic consideration of the issues causing concern, rather than the current process of focusing on a single individual's experience.

4. What are your thoughts on collective advocacy groups raising court actions? Should these proposals also cover individual advocacy organisations?

Broadly supportive of this, however more detail would be required as to how this would work in practice. It may be helpful for collective advocacy groups to challenge services where there are consistent failures to provide; however, the definition of a collective advocacy group would need more detail. For example, how many people count as collective advocacy? How do you weigh up different groups who have contrasting perspectives on the same issue? This could be fraught and cause significant difficulties unless a clear framework is produced to guide the process.

5. What are your views on why and how we think collective advocacy should be strengthened?

As above, for the proposals relating to strengthening collective advocacy to work, there will require to be a national framework with clear oversight and provision of infrastructure to ensure consistency in practice.

6. Do you have any suggestions to make the scrutiny landscape for mental health services more effective?

We recognise the challenges presented by the current scrutiny landscape within mental health services in Scotland and the provisional recommendation for Scottish Government to develop a comprehensive and effective improvement and assurance framework for mental health services. We would support further consideration of proposals relating to data collection in order to provide clear evidence for service improvements and to fully understand how different groups may be affected by practices within mental health settings (e.g. protected characteristics – racism, gender inequality) or the role that social determinants of mental health play.

7. What do you think about the ways in which we think the role of the Mental Welfare Commission should be extended? Do you have any other ideas?

This seems sensible in line with the other proposals contained within this chapter; however, we would again highlight the required increase in the MWC's size and budget if it is to effectively fulfil this extended remit. A level of accountability directly to Scottish Parliament would be beneficial in ensuring that recommendations are followed through.

Chapter 9: Children and Young People

1. Do you think the current 2003 Act principle for children is still needed?

Yes; it is strongly felt a principle around meeting the needs of the child was still essential. Regardless of what that principle was, it was felt to draw particular attention to the needs of children and young people. The application of mental health law to children and young people was in a very specific confine of care and treatment and, while recognising the broadening out of its application generally, there were fears that without a core principle recognising the child's welfare in accessing care and treatment, that population would lose out on additional safeguards they can and should be able to call on.

The implications of the UNCRC and how this would be considered in clinical situations is extremely important. There will need to be a balancing of rights. This is in several contexts such as balancing the rights

of the child and the rights of the parent. Balancing competing rights such as the right to life and right to private life and decision making. Addressing conflicting and competing rights will require guidance. The Human Right enablement assessments need to add to care rather than be a tick box exercise. It is not clear how this would impact on or complement GIRFEC and the child's plan.

2. What do you think about having a statutory duty on Scottish Ministers and health and care agencies to provide for children the minimum standards needed to secure the human rights set out in international treaties such as the UNCRC?

For Children and young people's mental health the minimum standard is set by the CAMHS service specification and the Neurodevelopmental service specification. This has clear roles and responsibilities. There are the principles of care that are in line with Human rights and the UNCHRC. Getting it right for every child (GIRFEC) already has the requirements for the planning and coordination of care. The review is aspirational in discussing the social determinants of health. It should be clear which level of governance has responsibility for impacting change (e.g. individual clinicians cannot impact on child poverty and this responsibility lies with policy makers).

3. What are your views on reforming crisis services for children and young people experiencing acute mental distress? What are your views on the safeguards for emergency detention?

A Review in 24 hours: this could disadvantage young people who are admitted in crisis and may require more time for the crisis to pass. It is not clear who will make these reviews in the document. It is also not clear that the professional doing the review will be able to secure the resources needed to support the young person in the community effectively. There was a suggestion it would not need to be medical staff who make these review; MHOs were suggested. This is not practical and an MHO would require support to discharge distressed patients from hospital. There has been a suggestion that this review could involve a Tribunal. This has the potential of being traumatic for a young person having to tell their story again. The idea that MHO could confirm an EDC in 24 hours or conduct reviews is highly unrealistic with the current provision of MHOs.

4. What do you think about law reform to ensure access to CAMH services up to at least the person's 18th birthday to ensure age appropriate services more generally?

Transitions remain a difficult area of clinical practice. The transition of a young person with mental health difficulties should not be based on legislation or an arbitrary age range. Transition should be based on which service is best able to meet the young person's needs. This would be a rights based approach and would avoid any potential discrimination on the basis of age. Rather than a change in legislation a change in culture to a needs based transition would be more in keeping with the human rights approach.

5. What are your views on our ideas about relatives and families?

This links to the section on balancing the rights of the child and the rights of the parent. Some young people do not wish to have parents involved in their care and this would be a barrier to them receiving care. There could be issues with parents not being their child's named person could not attend tribunals, it was noted children's hearings could still see the parent request to attend regardless. The notion a parent would be denied the ability to participate in a legal process around the care of their child was a major concern, in particular around decisions such as a young person's residence. At present there is discrimination in the current Mental Health Act in that adults can choose their Named Person but children with capacity cannot.

6. What are your thoughts on how supported decision making, human rights enablement and the autonomous decision making test in chapters 3, 5 and 6 might apply to children and young people?

A much clearer definition of these tests is required and what they add in addition to current tests. The impact on children and young people with capacity (as currently defined) is not clear. It was not clear how this new test would be affected by developmental maturity. These tests were much more explicitly drawn

towards adults rather than children and young people was highlighted. In doing so, these tests would go against ICD 11 and the 'lifelong' nature of support it calls for those with a mental health condition.

7. What do you think about our proposals on advocacy and on accountability?

The proposed additional authorisations and monitoring of restraint and seclusion is appropriate and welcomed. This monitoring should cover all settings not just mental health settings. If seclusion is care-planned for a young person then this could be authorised by a second opinion such as medication and NG feeding. Additional monitoring and safeguards may not address the fundamental issues in providing care (particularly around staffing) that led to restrictive practices due to the lack of an alternative option.

8. What are your views on autism, learning disability and neurodiversity and the possible law reforms for children and young people?

There are already legislative provisions for this support in other acts such as the additional support for learning. It is not clear how these addition plans would add to the care that young people receive in and above the Child's plan and Additional Support for Learning plans. There is not a need for an additional coordinated support plan - the existing provisions should be implemented.

9. What do you think about our proposals on safeguards for treatment and services and safeguards to protect the relationships between children and parents?

As above.

10. At this time, Scotland's mental health law applies to compulsory mental health treatment at all ages. Do you have views on the idea of moving mental health law for children to connect it with other law for children, to apply across health, education and social care?

There have been efforts to provide support and care for mental health conditions across the lifespan universally, while recognising the different needs of age groups. This should be enhanced rather than dismantled. Disenfranchising children and young people from the specific protections of the mental health act would severely disadvantage our most vulnerable children and young people from the protections and safeguards of the mental health legislation. It is not clear if any new child's legislation would have all the same powers; if not this could be discrimination in terms of age. This is relevant for orders that are rarely used in young people but are required such as orders under the Criminal Procedures Act. The reason many children and young people required the protections under mental health legislation was as a result of failures to enforce the other pieces of legislation, and there was no real sense that bringing the different pieces of legislation together would change this.

Transitions an already difficult area could be even more difficult due to having to change legislation with proposal. This could be difficult for care experienced young people who have rights up to 23-25 years of age is against The Promise. If these two separate pieces of legislation were developed, children and young people could be left 'in limbo' while mental health legislation for adults proceeded. It was added that bringing to together all these pieces of legislation would be an incredibly complex work and leave children and young people waiting on legislative change for years. In pursuing children's legislation, that would not reflect the particular needs of children and young people with a mental health condition.

Chapter 10: Adults with Incapacity Proposals: Part 1 Guardianship

1. We seek your views on the new model (advantages, drawbacks and adjustments needed) Specifically, what are your views on the role of co-decision making and its omission from the model?

The Forensic Network agrees that co-decision making should be omitted from the model. The lack of clarity around oversight, dispute resolution and role mean that there is unlikely to be benefit in having this role.

2. Will the proposed change address the issues currently experienced with guardianship?

If the Decision Making Representative application is heard by the Tribunal rather than the Court, in a timelier fashion, there would be clear benefits to this.

3. What are your views about the proposed streamlined application process?

Further detail is required on how the process would work in practice.

4. Does the proposed emergency provision in the model address the concerns about the current system?

Disagree – greater clarity on timescales and process is necessary in order to be able to comment.

5. Should the reframed model allow for the grant of a specific or one-off order (currently called an intervention order)?

Disagree – we do not see any need for retaining a one-off order, such as the current intervention order.

6. Should the current access to funds process be subsumed within the new guardianship model?

Only if this results in a less bureaucratic and complex system than is currently in place.

7. Should the current management of residents finances process be subsumed within the new guardianship model?

Please see above.

8. What are your views on a system of supervision?

We support having one agency overseeing both financial and welfare Power of Attorney/Decision Maker Representative roles. Overall a less bureaucratic process would be welcome. Given the potential for a Local Authority Decision Representative to have a conflict of interest, we agree that the MWC could have a role in overseeing these.

Chapter 10: Adults with Incapacity Proposals: Part 2 Power of Attorney

1. What are the key points of guidance that need to be given to attorneys?

The main issue of concern in relation to power of attorney is their inability to consent to deprivation of liberty (eg when a person needs to be placed in a nursing home from which they would be prevented from leaving). This is often not understood by those holding Powers of Attorney or those applying for them. Otherwise we are not aware of any significant issues with the current guidance.

2. What support should be given to attorneys – by whom, when?

Clear guidance and signposting to additional support when required would be of assistance. Access to subsidised legal advice and possible peer support could be considered.

3. What are your thoughts on the reporting structure for someone with concerns?

Powers of attorney are not scrutinised closely, making it difficult to know whether there are consistent areas of concern that need to be addressed. Raising concerns about an attorney can be difficult, with the Office of the Public Guardian having limited capacity to investigate concerns raised. A process similar to ASP referrals may be appropriate, if additional resourcing to support this is available.

4. What are your thoughts on the investigations structure?

See above.

5. What are your thoughts on authorities being able to supervise an attorney, on cause shown, following a statutory inquiry?

The Forensic Network does not have any specific views on this.

6. What are your thoughts on attorneys having power to authorise a deprivation of liberty (assuming this power has been granted in the power of attorney)?

The Forensic Network has concerns about adding this power, and greater detail on scrutiny and safeguards would be required to be able to give an informed view. There is discomfort that an individual can grant a Power of Attorney which then results, possibly many years later, in them being placed in a setting they are not permitted to leave, against their will. Robust oversight and safeguards would be required to ensure their human rights are protected.

7. What measures should be taken to increase the awareness of a PoA?

No comments to add.

Chapter 10: Adults with Incapacity Proposals: Part 3 Medical Treatment and Research

1. We seek your views on the recommendations we are proposing, please share.

It would be helpful to 'stress test' the proposals against clinical case scenarios to identify issues that may arise in practice.

2. What are your thoughts on the provisions within s47(7) on the use within the AWIA of force, detention and the relationship with the 2003 Act?

The Forensic Network recognises that there are currently inconsistencies in the use of Sec 47 of the AWI and EDCs, particularly in physical health care settings. We support the need for greater scrutiny of the range of care provided under Sec 47, and support improved safeguards and the right of appeal to more closely align with those in mental health legislation. Mental Health Officers could offer an additional safeguard for Sec 47 in this regards, acknowledging the significant resource implications this may have.

3. Is any change needed to the list of special treatments requiring additional safeguards, (section 48) or the procedures by which they are authorised?

No view on this. If the addition of any specific treatments is being considered (for example TMS), we are of the view that the evidence base would need to be carefully considered before doing so.

4. Is any change needed to the dispute resolution procedure in section 50?

We are not aware of any need for change to this procedure.

Chapter 11: Deprivation of Liberty

1. Please share your views on our proposals

The Forensic Network disagrees with the proposal that "where a person cannot make an autonomous decision but we are satisfied that with support they have expressed a will and preference to remain in their current living arrangements, **even if these arrangements would otherwise constitute a deprivation of liberty**, we do not think there is any need for further judicial oversight." As the Review will be aware, the purpose of the deprivation of liberty (eg as mentioned in the proposals, for the person's safety and wellbeing), is not considered relevant when considering whether a legal framework is necessary for the measures that are in place (*P v Cheshire West*). The ECHR makes it clear that deprivation of liberty in a democratic society requires lawful authorisation in order to be compliant with Article 5 (the right to liberty). Passive acceptance of a situation should not be considered consent, as noted in the *Bournemouth* judgement.

The Review will be aware of the substantive and procedural requirements that are needed in order for Deprivation of Liberty to be lawful in terms of Article 5 of the ECHR. The current proposals, focusing largely on a mechanism for review, would appear not to meet the substantive and procedural requirements. The

overall proposal to avoid diagnosis, with the associated lack of clarity to whom the legislation will apply, poses further challenges in meeting the requirements of ECHR.

The Forensic Network disagrees that “it is disproportionate to suggest that in the absence of concerns, the adult in such situations should be treated as being deprived of their liberty and the family subject to monitoring by the State”. It is difficult to reconcile this statement with the principals of mental health and incapacity legislation, which are largely focused on protecting rights and providing safeguards for individuals deprived of their liberty. Relying on concerns being raised (which is unlikely for someone lacking autonomous decision making) risks placing a vulnerable group in the population unnecessarily at risk.

It is our view that a legal framework authorising deprivation of liberty is required in all settings where individuals are subject to continuous supervision and would not be free to leave. Such a legal framework should clearly outline the criteria under which someone is deprived of their liberty, and how the deprivation can be challenged, with reviews of the deprivation being a legal requirement. In the absence of such a framework, we are of the view that there would not be a real and effective ability to challenge the lawfulness of a deprivation of liberty. Although there are clear resourcing issues to achieve a suitable framework, we are of the view that this should not result in proposals that will weaken the protection of human rights for individuals of any age. It is noteworthy that less robust scrutiny and review seem to be being considered for the elderly than would be considered suitable for younger age groups.

The Forensic Network do not support a Deprivation of Liberty/Liberty protection scheme (as in England), and would prefer a judicial process.

2. Please share your views on the proposed standard and urgent deprivation of liberty orders and the suggested process. Who do you think should be able to apply for a deprivation of liberty order?

It is our view that the Incapacity legislation should be amended to allow for short-term guardianship but in the absence of this we support the development of deprivation of liberty orders. This would appear to be most suitable for the Chief Social Work Officer (delegating authority to MHOs) to undertake. In practice, as with current AWI applications, a MHO would make the application, with supporting reports from other relevant professionals (which could include psychiatrists, psychologists, speech and language therapists, etc).

What are your views on the safeguards in the process?

The time limits proposed would not reflect the situations of many individual requiring these orders, who are likely to have long term impairments and ongoing lack of autonomous decision making ability. Authority lasting only six months would place unsustainable pressure on available specialist resources, for little purpose. Given the lengthy delays in accessing a Court, and the likelihood that authority will need to be extended, an application to renew the authority would need to be made as soon as it was granted, in practice, for a significant number of people. We support a right of appeal.

For the urgent orders, application to a Court or Tribunal may take too long if a person’s life is at risk. It would be helpful to have the option of an ‘interim’ order in extreme situations, pending a hearing being arranged for formal judicial review. 28 days for an initial order may allow sufficient time to progress to a standard order. Initial authority for a three-month period may better suit the situations likely to require an urgent order.

3. How can we ensure that there is real, effective and accessible ability for the adult and/or their representative to challenge the lawfulness of a deprivation of liberty order?

Please see response to the first question. In summary, having a legal framework with clear criteria, statutory reviews and clear appeal mechanisms will ensure the adult and other interested parties can effectively challenge the lawfulness of a deprivation of liberty order.

4. What do you see as potential barriers to the operation of deprivation of liberty orders? Anything else you would like to see included?

For deprivation of liberty orders, as outlined in the proposal, the timely access to the Courts/Tribunal will be a significant barrier. Access to suitably qualified professionals to undertake assessments or to provide independent reviews on request may also present challenges.

It would be useful to include clear criteria outlining who may be made subject to deprivation of liberty orders, and what criteria need to be met. This will allow clear grounds on which an order could be legally challenged (or upheld). Social Work colleagues would also like to see more robust guidance around the use of Section 13 (z). Deprivation of liberty should apply across the population, with no age criteria. This will ensure children and young people receive the same safeguards.

Chapter 12: Mental Disorder

1. Should there be a gateway to mental health and capacity law which reflects a diagnostic criterion? – what terminology should we use?

Agree - The proposal is for legislation to enable people's rights. It is the view of the Forensic Network that to be able to do this effectively, especially for those individuals with the most complex needs, diagnosis needs to form part of the gateway to mental health (in addition to other criteria). Unless there is clarity as to whom the legislation applies, there may be significant unintended consequences. For entitlement to rights (and services), if this applies to everyone it will in effect apply to no-one – becoming a platitude about what citizens can expect from the State.

Although the focus is on enabling rights, there is recognition that compulsion will remain part of mental health and incapacity legislation where necessary. For the group of individuals who may require care and treatment against their will, being clear to whom this legal authority applies becomes of greater importance. Current mental health legislation explicitly excludes certain conditions as falling within the definition of mental disorder (such as dependence on alcohol or sexual deviance). In circumstances where individuals will be detained, and thereby deprived of their liberty, the EHCR requires identification of a mental disorder. It is difficult to see how compliance with EHCR could be achieved without an identified mental disorder being stated. UNCRPD requires that disability not be grounds for detention. Even within current legislation, a diagnosis in and of itself does not authorise detention – a series of other criteria also need to be met. There is undoubtedly tension between UNCRPD and the EHCR, however it is our view that UNCRPD Treaty does not explicitly require that diagnosis should not form part of criteria when considering compulsory measures. It is the Treaty rather than the general comment which was ratified by the UK Government.

If diagnosis is not part of delineating to whom legislation applies, there is the potential for a significantly larger proportion of the population to come within the scope of mental health and incapacity legislation. Some may consider this desirable. The Forensic Network's view is that resources should be focused on those with the greatest need, who are often unable to advocate for themselves or challenge the lack of service provision. Clarity on diagnosis will prevent unnecessary (and potentially unlawful) deprivation of liberty on a wider group, and will provide a clear point on which legal challenge is possible – both in terms of enabling rights as well as challenging compulsory measures.

The Forensic Network advocates for all mental disorders (as currently defined) to remain within mental health and incapacity legislation. As per our response to the Rome Review, we do not think there is any benefit in having separate legislation applying only to two specific diagnoses (namely learning disability and autism) and are of the view that both physical and mental health outcomes would be worse for people with

learning disability or autism if such an approach is taken. This is supported by evidence from New Zealand after the removal of learning disability and autism from their mental health legislation. This led to serious public protection concerns (as individuals detained under ‘civil sections’ could no longer be detained in forensic settings), an increase in the number of people with learning disability in prisons and the loss of specialist mental health care settings. It is worth noting that a significant proportion of people with learning disability currently in forensic settings in Scotland are detained under ‘civil sections’.

What terminology should we use?

The Forensic Network would propose a gateway that includes diagnosis, autonomous decision making ability, treatability (in the widest sense, including rehabilitation and prevention of deterioration), consideration of risk of harm to health, welfare, self and/or others, and the necessity for legal measures.

In terms of terminology, it may be helpful to consider the ‘euphemism treadmill’, whereby words that are used to replace terms that are considered offensive over time become offensive themselves. As an example, the word “retarded” was considered a ‘kinder’ alternative to the previous term “imbecile”. Both terms are now considered grossly offensive. This happens when stigma is attached to the underlying condition, which is the case for both learning disability and serious mental illness. Whatever terminology the Review team decides to adopt; in time it will come to have negative connotations due to the underlying stigma. The UNCRPD reference to psychosocial and intellectual disabilities fails to reflect that many people with mental disorders do not consider themselves disabled. It is far from clear that ‘mental disturbance’ is more acceptable than mental disorder.

The World Health Organisation International Classification of Diseases (ICD 11) now refers to Mental, Behavioural or Neurodevelopmental Disorders. Scotland is a pilot site for implementing ICD 11 across the health service, with Scottish Government supporting implementation. As this is the globally agreed terminology, it may be helpful to use this terminology to help delineate the range of conditions relevant to mental health and incapacity legislation. We would also support the use of ‘defined mental health condition’, to encompass the conditions currently comprising ‘mental disorder’ in existing legislation.

Chapter 13: Fusion or alignment?

1. **Given the changes being proposed by the Review, do you think a single piece of legislation for mental health, incapacity and adult protection law is the best way forward?** Disagree.

Do you consider that 2 or 3 pieces of law would be preferred, each dealing with specific issues across mental health, incapacity and adult protection law?

Agree - There are significant challenges in achieving fused legislation, including complexity around legislation pertaining to children and young people and ensuring the legislation can equally apply in forensic contexts. For these reasons, the Network prefers an alignment of principles, criteria and safeguards across mental health and incapacity legislation rather than formal fusion of the Acts.

2. **What do you think about our suggestion of aligned legislation? Which aspects should be aligned and which should be left within standalone law?**

There is a logic to legislation being aligned as this allows for a consistent approach for those who would be impacted by it. As it may be overambitious to attempt fusion at this stage, the Forensic Network supports alignment of principles, criteria and safeguards across both mental health and incapacity legislation.

3. **Please tell us if you consider a single judicial forum should deal with all mental health, incapacity and adult protection cases (Y/N).**

We support a single judicial forum for mental health and incapacity legislation. Very few aspects of Adult Support and Protection legislation require a legal decision. The role of the Tribunal in ASP cases would therefore be very small.

- **Should that forum be the sheriff court?** Disagree
- **Should that forum be a tribunal?** Agree
- **Should there be a single forum only in the event of fused legislation?** Disagree. We support the Tribunal dealing with incapacity legislation as well as mental health legislation. This would require adequate resourcing of the Tribunal.
- **Is a single forum your preferred way forward regardless of wider changes to the legislation?** Yes
- **If you consider aligned legislation is preferred, should a single judicial forum be a part of that alignment?** Yes - Tribunals more suited to this than Sheriff Courts.