Law Society of Scotland

Written Evidence

Views and experiences of Mental Health Law in Scotland

May 2020

Introduction

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We have a statutory duty to work in the public interest, a duty which we are strongly committed to achieving through our work to promote a strong, varied and effective solicitor profession working in the interests of the public and protecting and promoting the rule of law. We seek to influence the creation of a fairer and more just society through our active engagement with the Scottish and United Kingdom Governments, Parliaments, wider stakeholders and our membership.

Our Mental Health and Disability sub-committee and Criminal Law Committee welcome the opportunity to consider and respond to the Independent Review of Mental Health Law in Scotland's call for evidence: Views and experiences of Mental Health Law in Scotland.[1] The committees have the following comments to put forward for consideration.

General Comments

Previous Consultations

We have had the benefit of ongoing engagement with the Scottish Government on issues relating to mental health law in Scotland over the course of many years. In April 2018, we responded to the Scottish Government's consultation on Adults with Incapacity Reform. That response is available on our website.[2] Rather than repeat at length the content of that response, for the purposes of this response we confirm that it continues to represent our views on Adults with Incapacity Reform. Notwithstanding the current review, we would emphasise the need to continue to carry forward all aspects of the existing review which commenced as a review of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"), including those addressed in the 2018 and preceding consultations, and in our response of April 2018. It remains important to proceed without unnecessary delay with the full range of reforms within the scope of the 2018 consultation and our response to it, and to make effective changes to relevant legislation, including in particular the 2000 Act.

In view of the ambiguity that has arisen internationally over the term "incapacity", we use it in the normal Scots law sense as derived from "incapable", as provided in section 1(6) of the 2000 Act.

1 https://mentalhealthlawreview.scot/

2 https://www.lawscot.org.uk/media/360115/18-04-30-mhd-consultation-awi-reform.pdf

Unified Tribunal

We continue to support the creation of a new unified tribunal with jurisdiction in respect of the 2000 Act, the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") and the Adult Support and Protection (Scotland) Act 2007 ("the 2007 Act"). Such a tribunal would facilitate the development of expertise, and improve efficiency by allowing administrative processes to be split from judicial processes. It would provide an opportunity to build upon the good practice developed within some Sheriffdoms, and we would hope that some Sheriffs with particular expertise in this area would seek to transfer this expertise to the new tribunal, following the example of shrieval participation in the current mental health tribunal system. A tribunal setting is more appropriate for Adults/patients and their families. A new tribunal empowered to look at remedies under all three pieces of legislation could ultimately allow individual cases to be dealt with more efficiently and holistically. Except where otherwise indicated, our response to this consultation is made in the context of this overarching proposal, and references to a tribunal or tribunal member are references to this proposed unified tribunal.

Publication of Judgements

We also renew our calls for more judgements to be published, particularly in relation to proceedings under the 2000 Act. At present, judgments were often only published following personal requests by practitioners. It would be helpful to have access to a body of reported cases. It is noted that a much higher proportion of cases is reported under the equivalent jurisdiction exercised by the Court of Protection in England & Wales.

The Criminal Justice System

We are aware that a high proportion of the people who become involved in the Scottish criminal justice system may have or have experienced mental health issues, or temporary or long-lasting impairments of capacity for other reasons, or even more broadly issues within the scope of the concept of "vulnerability", addressed below. This includes the victims, witnesses and the accused but this should also include those undertaking official roles such as the prosecutor, defence, court service staff and the judiciary.

Much of our recent work has focused on the vulnerable accused person. We published a Report in April 2019[3] following a roundtable event on how to achieve effective stakeholder communication of information for vulnerable persons across the Scottish criminal justice system. That highlighted a number of recommendations, including three where we would suggest that our work is of relevance to this Review. These are:

- the development of a framework of understanding to be shared across the Scottish criminal justice system following a multi-agency review of definitions and interpretations of vulnerability
- a review of existing legislation measures and practices including ongoing consultations in relation to vulnerable persons leading to the development of a central portal of knowledge and information

3 https://www.lawscot.org.uk/media/362501/vulnerable-accused-persons-report-final.pdf

- a review of groups for whom there is limited support and representation within the Scottish criminal justice system

Our work is continuing in relation to “Ensuring Fairness: A Review of the existing legislation measures and practices concerning vulnerable persons accused of criminal offences in Scotland.” That considers in part the definition of what “vulnerable” means in the criminal context. We recognise that the definition of “vulnerability” has a meaning across the broader context of the Review, which includes, for example being “at risk” for purposes of the 2007 Act. A number of definitions appear in statute, regulations and guidance. They tend to be many and varied, and may sometimes appear to be inconsistently so. Achieving a broadly satisfactory definition of “vulnerability” may be a useful objective of the Review.

The vulnerable accused may enter the criminal justice system at a number of points, but most commonly following their detention/suspicion/arrest at the police station. We have concerns that too often vulnerability is not picked up there through lack of identification of any issue, for a number of reasons. Consequently, the vulnerable accused will suffer through a lack of support or understanding appropriate to their needs (see our comments below regarding the need for comprehensive and holistic education and training).

Custody at the police station is then followed by difficulties in ensuring effective assessment, and thereafter communication of the relevant information regarding their needs and condition to the Crown for consideration as to whether to prosecute.

That may result in potential prosecution and /or a lack of support/attention/help or alternative signposting to the appropriate health or other support organisations. These issues will continue to arise within the court forum, where there is a need for the person not only to understand the process but to instruct solicitors and give evidence. There is no specific provision for a supporter under Scots Law though, if identified, a psychologist and psychiatrist’s assessment could be carried out where appropriate. Other specialist assessment across a wide range of relevant skills might be required.

There is then the possibility that a conviction- with the stigma this presents- is followed by a prison sentence. The prison context is unlikely to be the best place for help to be given.

It is important too at this stage to touch on the impact of the COVID-19 pandemic emergency. We are aware that the COVID-19 is impacting significantly on mental health issues for many physically, emotionally, socially and psychologically. Just how that impact will pan out is not known at this stage, and will not be known until the relevant information can be in-gathered and evaluated. How that will interact with the commission/incidence of criminal offending behaviour remains to be seen. We would be interested in hearing how the Review intends to handle the issues that we understand are arising from COVID-19 and the lessons to be learned for the longer term.

The health services within the Scottish criminal justice system are now delivered by the NHS, where there is recognition that custody and prison are not the appropriate place for someone who is suffering from a

mental health issue. This has been identified as a matter of importance by the Scottish Government in their "Justice in Scotland: vision and priorities"[4] which stated that:

"the population in contact with the criminal justice system is a vulnerable one in health and wellbeing terms, with people experiencing high levels of mental health problems, trauma, learning difficulties (sometimes undiagnosed) and challenges with problem alcohol and substance use. These commonly co-exist with long term social disadvantages that are now well understood as the wider determinants of our health. Addressing the health and social needs of this population can contribute to reducing health inequalities and strengthen a human rights approach to health."

We recognise that a number of organisations are committed to developing an awareness of the issues and providing an evidence base by producing case reports, while working with criminal justice partners in seeking to educate in better recognition of mental health issues, the need for support and the type of support which is to be given.[5]

Language

We consider that close attention should be paid to terminology. "Mental disorder" is the language of deficit. A less pejorative term that values diversity and respects differences should be used and should be the subject of consultation. This ties in with our observations above about how to define vulnerability. The Review's call for evidence refers to where the law means "someone with "a mental disorder", it means someone who has a mental illness, a personality disorder or a learning disability. This can include people experiencing dementia, depression or autistic people." Autism, for instance, is a very wide term which affects many in different ways but importantly it is a "lifelong developmental condition that affects the way a person communicates, interacts, and processes information."[6]

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

We have identified several areas where we believe the 2003 Act is not currently working well:

1. There is an issue with the named person provisions for those who cannot nominate a named person. In particular Adults who have serious impairments of capacity from birth or childhood such that they are not going to be in a position to ever be able to nominate a named person should have the right to have a named person. We believe these Adults should have a default named person from a defined list such as their parents, if alive, siblings if any, or their welfare guardian if one is appointed. If there are any issues regarding the appointment of such a named person we think the powers currently available to Mental Health Officers (MHOs) to object or ask for the removal of the named person should protect the Adult from any unsuitable relatives

4 https://www.gov.scot/publications/justice-scotland-vision-priorities/pages/4/

5 See for example: https://www.supportinmindscotland.org.uk/criminal-justice-and-mental-illness

6 Scottish Autism, https://www.scottishautism.org/about-autism

being a named person. In addition we believe that for other Adults who have lost relevant capacity through for example dementia, again leading to the position where they are unlikely to be able to nominate a named person, but who have appointed a welfare power of attorney or have a welfare guardian appointed, then that attorney or guardian should- in the absence of a nominated named person- be accorded the status of named person until or unless the Adult nominates another person. For clarification, if the welfare guardian is the local authority they should not be the named person as they are already involved in the process through the actings of the MHO, and the Tribunal can ask for any other reports they may wish from a social worker if helpful.

2. There are difficulties where individuals are detained suddenly, and immediate practical steps need to be taken to safeguard their property. Some sort of fast-track guardianship may address this issue, and this could be facilitated by a unified tribunal.
3. The issue of the status of attorneys and guardians in tribunal proceedings should be addressed. See above in terms of affording such attorneys or guardians named person status.
4. The key concept of reciprocity in the 2003 Act is not necessarily being recognised in front of the Tribunal. Ensuring that a patient subject to 2003 Act proceedings gets the right care, treatment and support is key. Again, a unified tribunal empowered to look at the full range of remedies under all three pieces of legislation could address this issue by ensuring the minimum intervention necessary to secure the right care, treatment and support.
5. The limited scope of recorded matters should be reviewed, especially the current inability of the tribunal to apply sanctions if the provider of medical treatment, community care or relevant services, unreasonably fails to obtemper a recorded matter. Recorded matters are of particular benefit to patients who are subject to community orders and their carers for the “talking treatments”, eg psychology and addiction services. Recorded matters ensure that the principle of reciprocity (section 1 of the 2003 Act) is carried forward into a patient’s care plan and tailored to a patient’s needs and circumstances. It is of concern that recorded matters are not available for patients subject to compulsion orders, which might well be considered to be discriminatorily in breach of Article 25 (which provides for the right to health) of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). A unified tribunal should be empowered to seek further evidence in appropriate cases (as is often done in Sheriff Court cases relating to the 2000 Act, under powers conferred by section 3 of the 2000 Act), and should be able to take an overarching guiding role in relation to the individual care plan.
6. More generally, although we support the principle-based model of the legislation, we consider that further changes to the deprivation of liberty aspects of the legislation would provide more robust protection of the patient’s human rights under the 2003 Act. For example, detention is specifically authorised in the Act but the community measures of care require only a requirement to reside at a specified place, when often the place is one where a deprivation of liberty occurs. We consider a unified tribunal would also provide further and longstanding protection by the ability to consider all the relevant legislation, especially for those individuals receiving community treatment in one forum, as appropriate to an individual’s circumstances.
7. In addition, the charging policies and guidance given to Local Authorities require to be consistent when considering measures that require an Adult to reside at a specific place.

Currently there are different practices amongst local authorities and the guidance is not clear on charging for care fees when an Adult is placed in a care home under a community-based Compulsory Treatment Order, and where an Adult is placed by their attorney or guardian under the 2000 Act. In the former, Local Authorities are encouraged not to charge but in the latter all Adults will be charged on a means tested basis in terms of the National Assistance Regulations 1992 and the CRAG guidance.[7] This leads to inconsistencies and unequal consequences where the same care and treatment may be given, but under two different Acts. Again, if there is a unified tribunal this would be able to be dealt with more consistently and in a way that utilises, in the least restrictive way for the patient, the necessary and relevant powers of each piece of legislation. Further, clear and consistent guidance could be given as to when and how charging is to be applied.

Looking to the Scottish criminal justice system, we would suggest that consideration is given to:

1. Community treatment provisions, as the Criminal Procedure (Scotland) Act 1995 covers the hospitalised accused only and therefore does not capture those who are at liberty but in need of treatment.
2. Community Payback Orders and whether those can be extended to include treatment requirement for mental health.

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

There are a number of factors which prevent the Act from working effectively. These include:

- Lack of resources
- Lack of suitable 'safe places' for those experiencing crisis- a continuum of resources is required that can respond immediately to need, ranging from community-based services to hospital and residential care. Safe, secure, comfortable, relaxing, homely, warm, properly resourced and staffed 'safe places' are needed for those experiencing crises due to mental illness since it is not appropriate to hold mentally distressed people in custody who have not committed a crime.[8]
- Poor or inconsistent access to psychiatric and other specialist supports.
- Appropriate specialist support services may be difficult to access in rural & island communities, leading to a piecemeal approach.

We have already referred to vulnerability within the criminal justice system and the link to mental health, which also ties into homelessness. We refer to the Scottish Government's "Health and homelessness in Scotland" Report in 2018[9] where the findings included:

7 Charging for Residential Accommodation Guidance: https://www.sehd.scot.nhs.uk/publications/CC2019_02.pdf

8 See "A safe place to be: the experiences of people in custody in mental distress", Support in Mind Scotland, 2014 https://www.supportinmindscotland.org.uk/Handlers/Download.ashx?IDMF=311944a1-7cb8-43ec-8983-0e2d2890ca70

9 https://www.gov.scot/publications/health-homelessness-scotland/

- at least 8% of the Scottish population (as at 30 June 2015) had experienced homelessness
- around 30% of the Scottish population had evidence of a mental health problem (with no evidence of drug or alcohol-related conditions)
- around 6% of people experiencing homelessness had evidence of a mental health condition, a drug-related condition and an alcohol-related condition (although not necessarily at the same time). This figure was higher at 11% for those with repeat homelessness.

People who go on to become homeless, generally, have poorer health than others and those with mental health and other health issues are using health services. This may suggest that the 2003 Act is not meeting the needs of these particularly vulnerable communities, and that may be contributing to an escalation into homelessness.

Any link between care and treatment under the 2003 Act, criminal justice and homelessness needs to be explored further.

We recognise that housing people with mental health conditions who require significant support is an area of potential difficulty. This requires collaborative working among health, housing providers, social work services and other specialist support services. Focusing on developing and improving that multiagency approach is essential.

The role of Curators under the 2003 Act should be carefully reviewed. In particular, Curators are not currently able to appeal decisions of the Tribunal and we believe that this hinders the operation of the 2003 Act.

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

We would suggest that the needs of those with learning disabilities are not well served by the current legislation. In particular, we believe that a unified tribunal empowered to take an overarching guiding role in relation to the care plan for an individual with a learning disability could adopt a more holistic approach, thus avoiding those who require supportive measures being subject to unnecessarily restrictive orders under mental health legislation, while also ensuring appropriate care and treatment.

We refer to our November 2018 response to the Independent Review of Learning Disability and Autism in the Mental Health Act.[10]

10 https://www.lawscot.org.uk/media/361485/18-11-22-mhd-consultation-review-of-mental-health-act-autism-learning-disabilty.pdf

Other groups we would suggest are not being well served by the current legislation include:

- Persons who are at risk of suicide:

  There have been year-to-year fluctuations in probable suicides in Scotland but with a general downward trend from about the beginning of the 21st century. However, the 2018 figure was higher, leading National Records of Scotland[11] to speculate that the downward trend had ended. Approximately three-quarters of all probable suicides are men (74% in 2018 and between 70% and 77% every year from 1986).

  The rates vary with age. In 2018, the largest number of probable suicides was in the 45 – 49 age range. The Mental Health Foundation state that around 70% of people who die by suicide are known to health services in the year prior to death.[12] More needs to be done to develop and raise awareness of the services and supports, particularly supports which are targeted at men. There is a need to address the root causes of suicide. We have referred earlier to the impact of COVID-19, which may also need to be considered as time goes on.

- Young people

  There is enormous pressure on the Child and Adolescent Mental Health Services. We understand that is contributing to an increase in rejected referrals. There are few alternative support services to meet these needs. Following the review in 2018, SAMH has highlighted concerns that young people were still being rejected.[13] It was described as an urgent situation. During the quarter January-March 2019, 9,748 children and young people were referred to CAMHS[14] with 21.2% rejected.

- Those experiencing social deprivation

  Socially disadvantaged people have an increased risk of developing mental health issues to the extent that adults living in the most deprived areas are approximately twice as likely to have common mental health problems as those in the least deprived areas (22% versus 11%).[15]

11 https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/suicides

12 https://www.mentalhealth.org.uk/news/success-scottish-government-establishes-new-body-tackle-suicide

13 https://www.samh.org.uk/about-us/news-and-blogs/samh-comment-on-latest-camhs-figures

14 https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2019-06-04/2019-06-04-CAMHS-WaitingTimes-Report.pdf?

15 http://www.healthscotland.scot/health-topics/mental-health-and-wellbeing/overview-of-mental-health-and-wellbeing

- BAME communities

  In England and Wales nearly a fifth of people come from a BAME background where the mental health of such groups is important because they face individual and societal challenges affecting access to healthcare and health issues.[16]

- People who have been part of the care system

  There is a stigma around mental health, particularly in relation to males which should be specifically addressed.

- People with dementia & challenging behaviour

Investment is needed to develop specialist resources targeting specific groups which would allow for appropriately trained staff in the relevant support services.

The health, local authority, voluntary and third sector services all need to work collaboratively to address the identified needs of these specific groups, and this should underpin policy development and inform future legislation.

Consideration could be given to how to respect citizens' rights and human rights further. This could include the development of joint training programmes to contribute to local plans for developing services to serve the needs of the groups identified above.

The See Me programme[17] should continue to be developed and the provision of workplace mental health and social care programmes should be mandatory.

Finally, we would also suggest that those who require compulsory treatment for shorter periods of time, particularly on first admission, are not well served by the range of orders available under current legislation. The 2003 Act prescribes arrangements for the detention of patients in hospital involving (the possible use of) an Emergency Detention Certificate (EDC) followed by a Short Term Detention Certificate (STDC) and a Compulsory Treatment Order (CTO). We propose that a further detention order be considered, if required, at the end of an STDC to be known as an 'Intermediate Detention Certificate' (IDC), lasting up to 6 weeks. The effect of such an order would be to bridge the gap that currently exists between the maximum 28 day duration of a STDC and the potential duration of 6 months for a CTO. There is anecdotal evidence within the Health and Social Care Partnerships that the current arrangements for detention of patients in Scotland would significantly benefit from the greater flexibility offered by an IDC.

Stigma in society and in the perception of patients subject to hospital detention (notably CTOs) can cast a shadow over the detention process. Stigma was an intractable problem for patients subject to earlier legislation and retains its foothold particularly for patients being detained for the first time. Being made the

16 https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

17 https://www.seemescotland.org/

subject of a CTO application whist receiving treatment in hospital following a short-term detention is a traumatic experience for many patients who are not always receptive to the possibility of CTOs lasting for less than their maximum duration. The introduction of an IDC would allow clinicians a realistic opportunity of treating detained patients within a window of around 70 days (medications for depression and psychosis generally need more time to reach a therapeutic dose than the current timetable for orders permits) and in so doing potentially limit the number of CTO applications subsequently required. An IDC application would arguably help to foster good relationships between patients and members of the care team who at the end of a STDC might be discussing a further 6-week period of detention rather than 6 months. At the same time an IDC would uphold the principles of the least restrictive alternative, maximisation of benefit to the patient and be more respectful of deprivation of liberty issues. It would also allow for a better use of mental health resources by reallocating MHOs and clinicians otherwise involved in the more lengthy process of preparing applications for CTOs.

In order to ensure compliance with ECHR under the Human Rights Act 1998, IDC applications would require to call before a tribunal for consideration. Legal criteria will have to be devised appropriate to an IDC.

It is acknowledged that CTO applications will continue to be necessary for those in need of longer term care arrangements and those with a significant history of non-compliance with treatment on a voluntary basis. However recent evidence in the Annual Report of MHTS 2018/2019[18] suggests that a significant number of CTO applications once granted are revoked or allowed to lapse. An IDC in such circumstances may be all that is required

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

We have no comments to make.

The Act requires a local authority to provide services for people with a mental disorder who are not in hospital, which should be designed to minimise the effect of mental disorder on people and enable them to live as full a life as possible (sections 25 and 26 of the Act).

Do you think this requirement is currently met? Does more need to be done to help people recover from mental disorder? You may wish to provide an example or examples.

We believe that there are very few cases where local authorities act in specific discharge of their duties under these sections. These sections should be used more to ensure appropriate care and support. It appears that local authorities often fail to view these as separate, additional duties towards people with mental disorders, over and above their general social work duties. Consequently, these sections are not

18 https://www.mhtscotland.gov.uk/mhts/files/Annual_Report_2018_2019.pdf

currently achieving what they were intended to achieve and more should be done to ensure that they are implemented effectively, perhaps including the provision of additional guidance.

We also consider that there is an access to justice issue in enforcing these rights. The 2003 Act does not provide that the Mental Health Tribunal for Scotland can determine any disputes or issue arising under these provisions. Consideration could be given to providing the unified tribunal with the ability to do so, which we believe will assist to achieve the aim that these duties exist to help recovery specifically for those with mental health problems.

We can provide examples to illustrate the current issues:

A university student in her 20s witnessed the death of her best friend in a tragic accident. She fitted many of the diagnostic criteria for an ASD but had never been assessed. She was suicidal and was waiting months for a psychiatric appointment. Her supports rely on her family who live a long distance from her, her GP who has unsuccessfully tried to speed-up the referral process, friends, and the university she attends. She continues to struggle daily to cope with her traumatic experience.

A young woman had a bi-polar disorder and experienced psychosis and psychotic delusions who, while dealing with an "episode", went to a nightclub and was actively "looking to get raped". She phoned the police and said that she was going to hurt someone and needed arrested. She described her experience of being arrested by police officers with dogs, treated "like a criminal" by police officers, police station nurse, police "medical person" and then taken to court on the Monday morning in handcuffs where "the judge was baffled as to why I was there". Her case was dismissed, and she was discharged with no aftercare.[19]

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?

We agree that the law needs to focus more on economic, cultural and social rights, and on entrenching duties as regards these rights. Individuals should not be made subject to orders only because suitable support for their housing, education, work and standards of living and health is not available timeously.

Law forms part of society and reflects it. It needs to collaborate with the vulnerable groups that we have highlighted and with communities through existing mechanisms such as legislation and being proactive in seeking the inclusion and involvement of these groups. This could be achieved through:

- Addressing stigma & raising awareness about mental health problems.

  The Mental Health Foundation's (MHF) evaluation of See Me programmes in Scotland[20] notes that there have been several policy and practice developments that have contributed to changes in the way that people think, talk, seek help and share experiences about mental health. However, an

19 "A safe place to be: the experiences of people in custody in mental distress", Support in Mind Scotland, 2014 https://www.supportinmindscotland.org.uk/Handlers/Download.ashx?IDMF=311944a1-7cb8-43ec-8983-0e2d2890ca70

20 https://seemescotland.org/media/9723/sm-cross-cutting.pdf

increase in profile does not necessarily equate to a reduction in stigma. They identified three recommendations around:

  - Consolidating the national commitment to tackling mental health stigma and discrimination
  - Positively framing mental health messages
  - Growing a peer leadership approach within See Me

- Joint campaigning with other agencies & organisations

- Promotion and the adoption of education and training

  This includes all organisations as well as those involved with those with mental health issues. This could include media promotions (including first-hand account interviews with people who have experienced mental health problems).

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

Yes. See above.

Training within the legal profession is an important element in encouraging respect for the rights and dignity of people with mental health needs. Within the context of the criminal justice system, we have identified the need to provide training for all members of the profession including staff involved with the criminal justice organisations and the judiciary so that they can identify relevant conditions/disorders and support can be put in place to assist and deal with them across the criminal justice system. Such training should be delivered jointly with specialists representing the respective fields.

The Review is also looking at the way people with a mental disorder are affected by the Adults with Incapacity (Scotland) Act 2003, and the Adult Support and Protection (Scotland) Act 2007.

Based on your experience, are there any difficulties with the way the 3 pieces of legislation work separately or the way they work together? What improvements might be made to overcome those difficulties?

We refer to our comments above on the need for a new, unified tribunal empowered to look at remedies available under all three pieces of legislation. We believe that this would address current difficulties outlined above, and make the system more efficient and effective for individuals and their families.

Is there anything else you wish to tell the Review?

We have no further comments to make.

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