Consultation on proposals for a Mental Health (Scotland) Bill

An analysis of responses

The Scottish Government
Riaghaltas na h-Alba

About this report

1. This report provides an analysis of responses to the Scottish Government's recent *Consultation on proposals for a Mental Health (Scotland) Bill*[1]. This consultation dealt with the issues described in the background section below.

Background to the consultation

2. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the "2003 Act") came into force in October 2005. In the two years following commencement of the 2003 Act, there were many bodies monitoring the situation, from user and carer groups, service providers, the Tribunal Service and the Mental Welfare Commission ("the Commission"). Each had kept the Scottish Government informed of areas which did not appear to be functioning as well as had been anticipated. Although there was no strong feeling that there was anything fundamentally wrong with the 2003 Act, the Scottish Government decided that a "light touch" review should be undertaken.

3. In 2008, the Scottish Government instituted a limited review of the civil provisions of the 2003 Act under the chairmanship of Professor Jim McManus and the Review Group reported back on March 2009[2]. The Scottish Government response[3] to the McManus Review noted some recommendations would require primary legislation to amend the 2003 Act before they could be implemented.

4. Additionally, a number of matters relating to how the mental health legislation is working in practice have been brought to the Scottish Government's attention by service users and practitioners. Primary legislation is required to give effect to these changes. Following a public consultation in 2010[4] the Scottish Government indicated that it intended to introduce a statutory scheme for victims of mentally disordered offenders but that primary legislation would be necessary to implement such a scheme.

Overview of Responses

5. A total of 110 written responses[5] were received. Annex B contains a list of respondents. Table 1 below shows the distribution of responses. A number of respondents were happy for their responses to published on the Scottish Government website but not their names. 1 respondent requested that neither their name nor their response be published on the Scottish Government website. The content of all these responses have been taken into account in this analysis. Circa 23% of responses were submitted by individuals and circa 77% by organisations.

7. A number of respondents endorsed comments made by other respondents (e.g. ACUMEN endorsed the Scottish Independent Advocacy Alliance response). A number of respondents appear to have discussed their responses with other

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[1] Link to SG website http://www.scotland.gov.uk/Publications/2013/12/1962
[2] Link to SG website http://www.scotland.gov.uk/Publications/2009/08/07143830/0
[3] Link to SG website http://www.scotland.gov.uk/Resource/Doc/1094/0105288.pdf
[4] Link to SG website http://www.scotland.gov.uk/Publications/2010/08/27104119/0
[5] Link to SG website http://www.scotland.gov.uk/Publications/2014/04/7902

respondents within their sector as in a number of instances identical comments have been made to some of the questions.

8. The majority of respondents did not answer every question in the consultation paper but rather responded to questions relating to their own life experiences or areas of expertise. The proposals outlined in Chapter 2 Mental Health (Care and Treatment) (Scotland) Act 2003 received the most comments and in particular the proposals around advance statements, named persons, medical matters, and suspension of detention although far fewer respondents commented on the rest of the proposals in this chapter. These proposals were of a more minor and technical nature. The proposals outlined in Chapter 3 Criminal cases were commented on by the fewest number of respondents.

Table 1: Distribution of responses

Respondent Category	Total Received	% of Responses
Academic institutions	1	0.91
Advocacy organisations	11	10.00
Anonymous/Confidential	7	6.36
Children and young people	5	4.55
Conjoined health and local authority	4	3.64
Health	10	9.09
Individual	18	16.36
Local authority	21	19.10
Other professional organisations	7	6.36
Professional representative organisations	8	7.27
Service users and carers organisations	11	10.00
Voluntary and charitable organisations	7	6.36
Total	**110**	**100.00**

Summary

9. An analysis of responses can be found at Annex A. Broadly speaking, respondents welcomed the majority of the proposals set out in the consultation paper. The one exception relates to the Scottish Government's proposals with regard to medical matters in Chapter 2. The majority of respondents were strongly opposed to these proposals. Whilst a majority of respondents supported the proposals in Chapter 4 in relation to victims' rights, many commented that this would require sensitive and careful handling to ensure the correct balance between the needs of mentally disordered offenders and the rights of victims. Some respondents also commented that mentally disordered offenders subject to compulsion orders should not be included within this scheme.

Next Steps

10. The Scottish Ministers have carefully reflected on the written consultation responses. Feedback provided to the Bill Team at various stakeholder meetings and events subsequent to the issue of the consultation paper has also been fed into the Ministerial decision making process. The policy memorandum accompanying the Mental Health (Scotland) Bill – introduced to the Scottish Parliament on 19 June – sets out the Scottish Government's policy in regard to the Bill's provisions.

Chapter 2 Mental Health (Care and Treatment) (Scotland) Act 2003

1. This chapter covers amendments to the 2003 Act the Scottish Government said it would bring forward as a result of the McManus Review along with minor technical and drafting amendments drawn to the Scottish Government's attention by stakeholders.

Advance Statements

2. A significant majority of those who commented on these proposals were supportive. Two common threads across the sectors related to the need for 24 hour access to the advance statements and that there should be a section within each statement which says the document must be regularly reviewed. The time period favoured by respondents for this "regular review" ranged from annually to once every three years. A number of respondents (from the service users and carers organisations and voluntary and charitable organisations sectors) said there should be a duty placed on Health Boards to promote advance statements. Respondents from the professional representative organisations and other professional organisations sectors commented that a statutory duty should be placed on the responsible medical officer to discuss the making of an advance statement and explain its effectiveness as part of a patient's after care plan.

3. A respondent from the service user and carers organisation sector commented that "the witnessing of an advance statement was highly medicalised and it should be broadened out to include peer support workers". A respondent from the professional representative organisations sector commented that "the range of person who can witness an advance statement should be broader and include Independent Advocates and all staff."

4. A number of respondents from the advocacy organisations sector whilst welcoming the proposals also expressed concern: at advance statements being overridden if an individual was really unwell; and about the legal status of advance statements under the 2003 Act. One respondent commented that "accountability and justification needs to be strengthened".

5. A respondent in the other professional organisations sector expressed concern that the Tribunal would be expected to check, in every case, whether or not an advance statement had been lodged with the Commission. The respondent also commented that "the duty to ensure advance statements were placed before the Tribunal rests entirely with the professionals involved in the care and treatment of the individual".

Named Person

6. Those who responded to the proposed changes to the named person provisions all agreed that an individual should only have a named person if they wished to have one. A respondent from the service users and carers organisations sector and a respondent from the voluntary and charitable organisations sector suggested an individual could have 2 named persons to share the responsibility.

One or two respondents suggested that a register of named persons might be a good idea. A number of respondents suggested that an individual should “opt in“ to having a named person as opposed to the Scottish Government’s proposal that an individual should “opt out” of having a named person. The rationale being that the revised approach would remove the need for the “default named person provision” whereby, the Tribunal can appoint a named person (on receipt of an appropriate application).

7. There were mixed views on the proposal that a named person should give their written/witnessed consent to taking on this role. One respondent from the local authority sector commented “this will ensure the mental health officer fully discusses what is required” and a respondent from the conjoined health and local authority sector commented that “the witnessing of individual agreeing to act as a named person should prevent coercion”. Another respondent from this sector was not in favour and commented “this is bureaucratic and may be a barrier to people agreeing to take on role of named person”.

8. The proposals around the interaction of the named person with the Tribunal were not welcomed by a number of respondents across the sectors. Respondents commented these proposals would result in the role of the named person being diluted and safeguards being removed. There were varying views amongst and within sectors regarding the proposal that mental health officers should provide information to assist the Tribunal in coming to a decision regarding the appointment of a named person under section 257 of the 2003 Act. For example some respondents within the service users and carers organisations sector were in favour of this proposal but others were not. A similar position pertained within the local authority sector.

Medical Matters

9. Whilst a small number of respondents agreed with these proposals, the majority of respondents did not. A common thread running through responses from across all sectors was that the Tribunal should not be making decisions to take someone’s liberty away based on one medical report. Whilst it was acknowledged that the Tribunal could request an independent medical report many respondents felt that this could result in the Tribunal’s independence being called into question. There was an acknowledgement that the role of the GP has changed over time with a move away from family GPs to large GP practices but a number of respondents commented that where an individual did have strong links with their GP then that this could result in the provision of important information about the individual being fed into the decision making process. Respondents from the children and young people sector commented that as children and young people are the “most vulnerable group then they need all the protection they can get”.

Suspension of Detention

10. The majority of those who commented agreed that that in case the case of assessment orders, treatment orders, interim compulsion orders and temporary compulsion orders the prior consent of the Scottish Ministers should no longer be required to suspend an individual’s detention to enable attendance at a court hearing

or a necessary medical (including dental) appointment. One respondent within the conjoined health and local authority sector was not in favour of this proposal, as they considered the “existing proposals are robust and ensure a practitioner with extensive forensic experience is involved”.

11. Respondents had more varied views on the proposal to remove the rule that an individual’s detention cannot be suspended for any more than 9 months in a 12 month period. A number of respondents from a variety of sectors (local authority, service users and carers organisations, and health) welcomed the proposals. Comments made by these respondents were “a pragmatic approach”, “accords with least restrictive treatment alternative” and “provides the opportunity to properly test out care plans within a supportive statutory context”.

12. Whilst recognising that there were difficulties with the current system, the majority of those who commented on this proposal were against it. A number of respondents commented that the proposals were reversing the protection and safeguards introduced by the 2003 Act and potentially recreating difficulties that had been in existence under the Mental Health (Scotland) Act 1984. Another common concern expressed by respondents was that the new proposals could result in an individual’s case being reviewed less frequently resulting in an individual being detained for longer than might actually be required on a compulsory treatment order before other options are considered.

13. Some respondents highlighted the fact that a responsible medical officer can add more restrictive conditions during the period an individual’s detention is suspended than originally approved by the Tribunal. Other respondents highlighted that an individual, subject to a hospital based compulsory treatment order could have their detention suspended for a lengthy period of time under the proposals yet they would be likely to be under more restrictions than an individual who was on a community based compulsory treatment order.

Information about extending a compulsory treatment order

14. A significant number of respondents offered no comment on this proposal. A number of respondents from the local authority sector commented that this proposal was already standard practice in their area. Other respondents (local authority, other professional organisations and professional representative organisations sectors) commented that whilst this proposal was undoubtedly good practice it had the potential to significantly increase a mental health officer’s workload and a suggestion was made that the mental health officer should only be required to write a report in those cases where the Tribunal actually held hearing.

15. To enable mental health officers to comply with this proposal, a number of respondents from the local authority sector said responsible medical officers would need to ensure they notified the mental health officer much earlier, than currently happens, of their intention to extend a compulsory treatment order. One local authority respondent commented that rather than metal health officers writing a separate report, might it not be possible for a section to be added to the responsible medical officer’s report and the mental health officer could simply complete this section as required.

Emergency, short term and temporary steps
Suspension of certain orders

16. Significantly fewer respondents commented on the emergency, short term and temporary steps proposals. The majority of those who did supported the proposals. The majority of the relatively few of those who responded (other professional organisations, local authorities and voluntary and charitable organisation sectors) to the suspension of certain orders welcomed the proposals.

Removal of detention provisions

17. Significantly fewer respondents commented on these proposals. The majority of those who commented welcomed the proposal that where a removal order is made a duty should be placed on a mental health officer to notify the Commission. Two respondents from within the local authority sector disagreed with this proposal and commented that it would be more appropriate for the Sheriff Clerk to notify the Commission when the order was made. A respondent from the children and young people sector expressed concern about the potential impact the removal provisions could have on young people over 16 who often had no family or close friends around them to provide support.

18. More comments were made with regard to the proposal to increase a nurse's power to detain pending a medical examination (under section 299 of the 2003 Act) to "up to three hours". Overall a majority of those who responded agreed with this proposal. Respondents from the conjoined health and local government and professional representative organisations sectors commented that this would allow for the involvement of a mental health officer and a respondent from the local authority sector commented the proposal should result in a decrease in the number of emergency detention certificates in hospital settings. A number of respondents who supported the proposal commented that it would be important that the nursing staff contacted the medical staff and the mental health officer at the very beginning of the period of detention to minimise the amount of time an individual was held.

19. A number of respondents (professional representative organisations, local authority and other professional organisations sectors) were not in favour of the proposal on the grounds this would restrict an individual's liberty. A respondent from the service users and carers organisations sector expressed concern that the rationale behind the proposal was "more to do with availability of staff rather than what was best for the individual concerned".

Timescales for referrals and disposals

20. Significantly fewer respondents offered any response to these proposals. The majority of respondents who did comment on the proposal regarding when a case should be referred to the Tribunal supported the proposal on the grounds the proposal clarified the position and this was helpful. The proposal regarding timescales for the Tribunal to hear certain cases generated a little more comment. A number of respondents supported the proposals albeit a number of these respondents also commented that they were unclear as to exactly what the issue was here. A number of respondents from the professional representative

organisations sector commented that the Tribunal was well aware of its obligations under Articles 5 and 6 ECHR and so these respondents were not convinced the proposals added much. One of these respondents went on to say that the proposals could give rise to appeals on the grounds of procedural impropriety (section 324 of the 2003 Act).

Support and service provisions

21. These proposals were welcomed by all the respondents who offered comments. A respondent within the children and young person sector commented that the proposal to provide services for certain mothers with post natal depression should be extended to cover any child in a mother's care not just a child under the age of 1 year. Two respondents within the voluntary and charitable organisations sector commented that fathers are parents too so the scope of section 24 of the 2003 Act should be widened to include fathers who may require this service as well. A respondent in the other professional organisations sector commented that in addition to the section 24 proposal, a duty should be placed on local authorities to support individuals with a mental disorder who are parents.

Arrangements for treatment of prisoners

22. The proposed technical amendments relating to provisions around a transfer for treatment direction were not commented on by many respondents. Those who did comment broadly welcomed the proposals. A respondent from the professional representative organisations sector commented that removing the requirement to have either the Tribunal President or a member of the shrieval panel may result in small cost savings and increased flexibility with regard to the scheduling of hearings.

23. A number of respondents within the local authority sector commented that local authorities would need to put back up arrangements in place to cover certain scenarios. A mental health officer is appointed from the local authority area where the prisoner normally resides which is not necessarily the local authority area within which the prison is situated. As time is likely to be of the essence and to obviate the need for a mental health officer having to travel long distances (e.g. from Dumfries say to the north of Scotland to visit a prisoner in prison) then it may be more practical for a mental health officer from the local authority area in which the prison is located to visit the prisoner instead and report back to their fellow mental health officer.

Cross border patients and absconding patients

24. The relatively few respondents who commented on these proposals were broadly content. One respondent from the individual sector queried "why are we taking in persons from EU states". A respondent from the other professional organisations sector welcomed the proposals but expressed concern that the proposals could potentially render patients from outwith Scotland vulnerable to treatment without safeguards that they would not normally be able to receive in the jurisdiction from which they came.

Additional matters raised by respondents

25. A number of respondents submitted material they had submitted to the Scottish Parliament's Public Petition Committee (petition PEO1494 Mental Health Legislation). The Public Petitions Committee agreed to close this petition on 4 March 2014 "on the basis that there is broad agreement from the organisations that responded (to a request for information from the Committee) that the Mental Health (Care and Treatment) (Scotland) 2003 Act is compliant with human rights legislation and does not require amending in the way sought in the petition". Further details about this petition can be found on the Scottish Parliament's website.

26. A number of other matters were raised by respondents and a selection of these is listed below:

- section 268 appeals against excessive security
- use of covert medication and restraint
- deaths of psychiatric patients
- Tribunal recorded matters
- Multiple Tribunal Hearings
- S244 and treatment of certain informal patients in relation to artificial nutrition

Further information on all the specific comments raised by respondents can be found by reviewing the consultation responses published on the Scottish Government website.

Chapter 3 Criminal Cases

27. This chapter dealt with mainly technical and drafting amendments. A significant number of respondents did not offer any comments on these proposals.

28. Those who did comment broadly welcomed the proposals. A general observation made by respondents from a number of sectors (conjoined health & local authority; professional representative organisations; local authority) was that the proposed changes may assist court operations but may initially be confusing for responsible medical officers and mental health officers.

29. The proposal to allow the Court to extend an assessment order for a period of up to 21 days rather than 7 days generated the most comments. The majority of respondents from the local authority sector supported this proposal and commented that this would allow for a more robust and informed assessment. A number of these respondents also commented that the extra time “would need to be justified”. One respondent commented that “the proposal would need to be monitored to ensure the end result of this amendment was not that a 28 day assessment order just became a 49 day assessment order”.

30. More of the other professional organisations sector who responded supported this proposal than opposed it. The common comment being that this would allow medical practitioners more time to carry out assessments. A respondent from the individual sector commented “this will help get all the paperwork together, reduce delays and be less stressful for the individual”

31. A number of respondents (from individuals, advocacy organisations, and voluntary and charitable organisations sectors) commented that the increase from 7 to 21 days was too big a jump and that if an increase was required then 14 days would be more appropriate. Some of these respondents commented that the courts needed to improve the way they dealt with mental health cases. A respondent from the other professional organisations sector commented that no justification had been provided for extending an assessment order from up to 7 days to up to 21 days.

Chapter 4 Victims' Rights

32. This chapter sets out the Scottish Government's proposals for a victim notification scheme for victims of mentally disordered offenders.

33. The majority of those who offered comments on this chapter agreed in principle to the introduction of a victim notification scheme, although a number of respondents (from within the local authority, professional representative organisations, other professional organisations, anonymous/confidential sectors) commented that the scheme should only apply to patients subject to a compulsion order and restriction order (CORO).

34. A common thread running through the responses was that the introduction of a victim notification scheme was a complex and sensitive issue and care would require to be taken to get the balance right between the needs of the mentally disordered offender and the rights of the victim.

35. One respondent from the voluntary and charitable organisations sector was in favour of the proposals but wanted an "opt out" rather than "opt in" scheme. This respondent was against written representations and commented that "all representations should be given orally in person or by pre-recording in relation to every key decision about the defender". A respondent from the individual sector commented "restrictions on the ability of victims to make representations are crucial" and further commented that "victims should be allowed to have their say but any decision made should not be fully swayed by victims' views".

36. A respondent from the other professional organisations sector was not in favour of the procedure outlined with regard to the Tribunal dealing with oral representations and suggested that the Tribunal's existing procedure for dealing with such representations should be followed here as these had been found to work well.

37. A number of respondents (from the service users and carers, voluntary and charitable organisations, anonymous/confidential, individuals, and advocacy organisations sectors) were not in favour of the proposals. A number of respondents were concerned that the introduction of such a scheme would increase the stigma attached to mental illness. One respondent commented that linking mental illness with the criminal justice victim notification scheme would criminalise mental illness.

38. Some respondents commented that "a number of safeguards are already in place around MAPPA[6], VISOR[7] etc. and that this is enough". A number of respondents expressed concern that the inclusion of mentally disordered offenders

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[6] Multi Agency Public Protection Arrangements http://www.scotland.gov.uk/Topics/Justice/policies/reducing-reoffending/sex-offender-management/protection

[7] MAPPA is supported by the Violent and Sex Offender Register (ViSOR)

subject to compulsion orders within the scope of the scheme would mean that individuals who have committed only minor offences – such as people with learning disability – will be discriminated against. Other respondents commented that allowing victims to make representations could undermine the recovery and rehabilitation of a mentally disordered offender.

Chapter 5 Assessing Impact

Equality

39. The majority of respondents from the local authority sector who offered comments considered that the consultation proposals reflected good practice and a strengthening of protective and supportive functions within the 2003 Act. Some local authority respondents commented they did not consider the proposals adversely impacted on any of the protected characteristics. Other respondents (local authority, conjoined health and local authority and health sectors) expressed some concern that the named person provisions may impact on those individuals who lack capacity.

40. A number of respondents (local authority, professional representative organisations, and other professional organisations) commented that if the victim notification scheme proposals are implemented as set out as in the consultation paper (i.e. the scheme will apply to victims of mentally disordered offenders subject to compulsion orders) then persons with learning disabilities may be discriminated against.

41. A number of respondents from the service user and carers organisation sector commented that the proposals have positive impacts in relation to the maintenance of a central register of advance statements and the fact an individual can choose whether or not they wish to have a named person but a negative impact in relation to the proposals for a victim notification scheme and the proposal that only one medical report will require to be submitted with a compulsory treatment order application.

42. One respondent from the service user and carer organisations sector commented that people with learning disability were discriminated against as a result of mental health legislation applying to them. This respondent considered people who have a learning disability should be excluded from the mental health legislation and an entirely separate piece of legislation should be written solely for people with a learning disability. A respondent from the voluntary and charitable organisation sector and a respondent from the individual sector commented that the mental health act should not apply to people with autism spectrum disorder. The respondent from the voluntary and charitable organisation sector also commented that including people with autism spectrum disorder within the definition of “mental disorder” is a cost saving exercise.

43. Some respondents from the health sector thought the proposals relating to the suspension of detention provisions could potentially reduce costs through being less complex to operate and that the additional flexibility provided could save costs as a result of there being less need to recall patients undertaking rehabilitation in the community back to hospital.

Business and Regulation

44. A number of respondents (academic institution, other professional organisations sector) commented that if it was to become routine practice for the Tribunal to seek an independent medical report in cases where they were considering an extension to a compulsory treatment order then this could result in increased costs for the Tribunal.

45. If the Commission intended to maintain copies of the advance statements forwarded to them on a central database then a respondent from the academic institution sector thought this could result in increased IT costs for the Commission. [The Commission indicated in their response that on the basis of the current draft Bill proposals they estimated “one off” IT capital costs in the region of £250,000.]

46. A number of respondents (local authority, professional representative organisations and other professional organisations sectors) commented that if the Bill remained as currently drafted then mental health officers would be facing an increased workload and taken together with the other statutory duties placed on mental health officers in relation to adults with incapacity and adult support and protection legislation this could result in mental health officers being overloaded.

47. A respondent from the other professional representative organisations sector commented that if the Tribunal was to determine case “with utmost speed” this could lead to an increase in appeals and a consequent increase in costs for the Tribunal and the Scottish Legal Aid Board (legal aid).

48. A respondent from the individual sector commented that the proposals relating to cross border transfers in situations other than emergencies could result in increased health costs and valuable resources being used up on people from outside Scotland.

Academic Institutions
Robert Gordon University – School of Applied Social Studies

Advocacy Organisations
ACUMEN
Advocacy Project
Angus Independent Advocacy
Circles Network
Dumfries and Galloway Advocacy Service
Dundee Independent Advocacy
East Ayrshire Advocacy Service
Independent Advocacy
Partners in Advocacy
Patients Advocacy Service
Scottish Independent Advocacy Alliance

Anonymous/Confidential
7 respondents

Children and young people
Centre for Excellence for Looked After Children in Scotland – Strathclyde University
Faculty of Child and Adolescent Psychiatry – Yorkhill Hospital
NSPCC Scotland
Together
Wave Trust

Conjoined Health and Local Authority
Dumfries and Galloway Council Social Work & NHS Dumfries and Galloway
Inverclyde Council and Inverclyde Community Health Partnership
North Lanarkshire Mental Health and Learning Disability Partnership Board[8]
West Dunbartonshire Health and Community Care Partnership

Health
Argyll and Bute Community Health Partnership
Mental Health Nursing Forum
NHS Forth Valley
NHS Grampian – Royal Cornhill Hospital, Aberdeen
NHS Greater Glasgow and Clyde, Glasgow City Community Health Partnership
NHS Greater Glasgow and Clyde. Skye House, Stobhill Hospital
NHS Health Scotland

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[8] North Lanarkshire Council, NHS Lanarkshire, Lanarkshire Links, The Advocacy Project, Lanarkshire Association for Mental Health

NHS Highland Mental Health Operations Group
NHS National Services Scotland
Royal Scottish Ambulance Service

Individuals
Mr W Buchannan
Dr Derek Chiswick
Dr James A T Dyer
Mr Maurice Frank
Miss Angela Geddes
Mrs Judith Gilliland
Ms Anne Greig
Mr William Hunter Watson
Mr Graeme Kelly
Dr Bartholomeus Lakeman
Dr Thomas Leonard
Mr Andrew Muir
Mrs Chrys Muirhead
Mr Alan Richardson
Helen Richardson
Dr Jill Stavert
Mrs Louise Whitehill-Smith
Mr Tom Wightman

Local Authority
Aberdeen City
Aberdeenshire
Angus
City of Edinburgh
Dundee City
East Ayrshire
East Dunbartonshire
East Lothian
Fife
Falkirk
Glasgow City
Highland
Midlothian
North Ayrshire
Perth and Kinross
Renfrewshire
Scottish Borders
South Ayrshire
South Lanarkshire

Stirling Council
West Lothian

Other Professional Organisations

Care Inspectorate
General Medical Council in Scotland
Legal Services Agency
Mental Health Tribunal for Scotland
Mental Welfare Commission
Scottish Courts Service
Scottish Human Rights Commission

Professional Representative Organisations

Association of Directors of Social Work
British Psychological Society
Law Society of Scotland
Faculty of Advocates
Royal College of General Practitioners Scotland
Royal College of Psychiatrists in Scotland
Scottish Council on Deafness
Scottish Independent Hospitals Association

Service users and carers organisations

Addressing the Balance
Edinburgh Carers Council
Health and Social Care Alliance Scotland
HUG
Inclusion Scotland
People First (Scotland)
Scottish Disability Equality Forum
Skye & Lochalsh Mental Health Association
Support in Mind
User and Carer Involvement
VOX (Voices of Experience)

Voluntary and charitable organisations

Alzheimer Scotland
Autism Rights
Marie Curie Cancer Care
Mental Health Foundation
Scottish Association for Mental Health
Scottish Recovery Network
Victim Support Scotland

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