



Scottish Independent Advocacy Alliance
(SIAA) Response to Consultation on
Updates to the Code of Practice for the
Mental Health (Care and Treatment)
(Scotland) Act 2003

September 2026



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Background to the Scottish Government Consultation

The Scottish Government consulted on proposed updates to parts of volume 1 of the Code of Practice made under section 274 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") in 2026. The Code of Practice was first published in October 2005 and had not been updated since. Scottish Government said that this update was deliberately a limited, targeted update rather than a full revision: the Government has said it expects further and more comprehensive revisions to all three volumes of the Code as part of wider mental health law reform.

The consultation covers a new chapter on restraint and seclusion in hospital, including clear definitions of restraint and seclusion; the lawful limits of restraint and the safeguards required to comply with human rights obligations; the use of restraint and seclusion with children and young people, grounded in UNCRC principles; the use of restraint with people with learning disabilities and autistic people, in line with non-discrimination principles in the Act, the UNCRPD and the UNCRC; and the use of restraint in the context of nasogastric tube feeding.

About this response

SIAA is the national intermediary organisation for independent advocacy in Scotland and does not provide independent advocacy itself. The evidence below is drawn from our thirty-two member organisations. These organisations provide independent advocacy in settings relevant to this consultation like hospitals and forensic settings across Scotland.

SIAA welcomes the opportunity to respond to these proposed updates to the Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice. Our response is informed by the experiences and concerns of our members who work directly with those experiencing restraint and seclusion in Scotland. We believe further guidance in this area is vital to protect the rights of the people our members work with and that independent advocacy plays a key role in realising these rights.

Introduction to independent advocacy

What is independent advocacy?

Independent advocacy is about speaking up for, and standing alongside individuals or groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice: addressing barriers and imbalances of power, and ensuring that an individual's human rights are recognised, respected, and secured. Independent advocacy supports people to navigate public services/systems and acts as a catalyst for change in a situation.

Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves.

There are two types or models of independent advocacy – individual and collective. Individual advocacy supports an individual to represent their own interests or represents the views of an individual if the person is unable to do so. Collective advocacy supports groups to speak up about their experiences and influence change. More information on independent advocacy and the types of independent advocacy is available on the [SIAA website](#).

Independent Advocacy in the Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 gives anyone with a 'mental disorder' the right to access independent advocacy. In the law 'mental disorder' is defined as anyone with mental illness, dementia, personality disorder, learning disability and/ or autism.

The Act placed a duty on local authorities and health boards to ensure the availability of advocacy services in their area. The Code of Practice for the act clarified this is a right to choose the model of independent advocacy they can access (therefore including individual and collective advocacy).

Independent Advocacy in the Scottish Mental Health Law Review (SMHLR)

Despite the clear right of access to independent advocacy set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 the 2022 Scottish Mental Health Law Review found that only around 5% of those with a right to independent advocacy accessed it. The review made a number of recommendations around independent advocacy in their final report including;

- that Scottish Government should consolidate policy and legislation to ensure a consistent definition of independent advocacy, rights to access Independent Advocacy and reconsider how it is commissioned and funded
- an opt-out system for independent advocacy

This update to the Code of practice represents, in particular, an opportunity to build on the recommendations of the SMHLR in relation to consolidating policy.

Independent Advocacy and Human Rights

We welcome the right-based focus of this new chapter of the code of practice. Independent advocates are human rights defenders, and independent advocacy protects human rights in several ways:

- through enabling better understanding of rights
- enabling routes to remedy and access to justice
- enabling the right to participation
- empowering rights holders¹

In instances of restraint and/or seclusion, where rights are at an acute risk of being violated independent advocacy must be considered as a vital safeguard.

Independent advocacy and restraint and seclusion

Independent advocates often work with those in society most likely to experience restraint and seclusion, including those in inpatient mental health settings and those detained under mental health law. We would like to draw attention to VOX Scotland's response to this consultation which provides examples of the lived experience of restraint and seclusion directly from individuals working with independent advocates. Their response illustrates the trauma and detrimental impact these practices can have.

Key messages

- Given the fundamental role independent advocacy plays in the mental health and human rights landscape in Scotland, we believe independent advocacy should have a clearer role in the new chapter on restraint and seclusion. Independent advocacy should be recognised within this new chapter as a right under the mental health act, an essential safeguard in any use of restraint and seclusion, and a practical mechanism for rights-based decision-making. To do this independent advocacy's role should be embedded throughout the new chapter, within each section where relevant, explaining the value of individual and collective advocacy and affirm the right of access to both.
- As the Scottish Government takes forward the recommendations of the Scottish Mental Health Law Review to increase access to independent advocacy any updates to the code of practice should consider how they can support these actions. For example, by setting out that independent advocacy is consistently offered and considered at every stage of any restraint and seclusion incident. Embedding independent advocacy throughout this chapter will go some way in future proofing the code of practice.
- It must be clear in the wording and throughout the updated code, where it references independent advocacy, that the presence of independent advocacy is not evidence that

¹[SIAA Independent Advocacy and the Human Rights Bill 2023](#)

a restrictive practice was properly applied. Access to independent advocacy is a clear right under the Mental Health Act and should be routinely offered, however its' independence should not be compromised.

- In order to recognise that independence is core to advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003, all references to advocacy within the new chapter should be updated to state '**independent advocacy**'.
- Our members are often working with those directly experiencing restraint and seclusion. They identified multiple ways patients are restricted beyond the guidance's current definitions of restraint and seclusion. We recommend that the current definitions are reviewed and broadened to encompass a wider range of restrictive practices.
- While monitoring and recording instances of restraint and seclusion remains inconsistent, we will be unable to fully understand the extent and impact of these practices on individuals across Scotland. Clear and detailed guidance on monitoring and recording, with direct consideration of the impact on individuals' human rights is required. We call for independent advocacy referrals, including model (individual or collective) requested, acceptance rates for referrals, reasons for declined referrals and waiting list time to be included within this monitoring. This is particularly important as we know independent advocacy organisations are underfunded and we must have a better picture of where rights to independent advocacy are not being upheld.
- Staff training should include developing an understanding of the role independent advocacy.
- Although we welcome this further guidance, we echo the Scottish Human Rights Commission's concerns that stronger safeguards in law, through reform of the 2003 are urgently required to protect human rights of those experiencing restrictive practices.² The need for changes to legislation recommended in the 2022 Scottish Mental Health Law Review and Learning Disability and Autism in the Mental Health Act 2019 should remain at the forefront of work in this area. SIAA are concerned that progress on moving forward recommendations from the reviews has stalled significantly and urge the Scottish Government to increase resource and focus on implementing the recommendations from both reviews. A first step must be providing a clear timetable on implementation of review recommendations.

The issues in numbers

² Restrictive practices in Scottish adult mental healthcare - gaps in human rights protection

100%	uptake of independent advocacy in the State Hospital, where it is offered on an opt-out basis, evidence that access is a matter of system design, not demand.
£12 saved	for every £1 invested in independent advocacy (£7 NHS, £5 local authority). (Social Finance, Independent Advocacy for Independent Lives)
71%	of independent advocacy organisations reported unmet need in 2023, many now operate waiting lists for the first time. (SIAA Advocacy Map)

Consultation on Updates to the Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 Question Responses

Question 1: Do you agree with the general principles and the purpose of restraint and seclusion, as described in the draft update?

SIAA recommends that the general principles give deeper consideration to how "best interests" is framed, and in particular to how it relates to article 12.

The Committee on the Rights of the Child has published a series of general comments explaining how the UNCRC works in practice. General Comment 14³ addresses article 3, the right of the child to have their best interests taken as a primary consideration, and paragraphs 43 to 45 focus on how that right links to article 12, the right to be heard. Article 12 ("I have the right to be listened to and taken seriously") is one of the four general principles of the UNCRC, alongside best interests.

SIAA and our member organisations have a particular interest in the right to be heard, and we would draw the Scottish Government's attention to the Committee's statement that "as the child matures, his or her views shall have increasing weight in the assessment of his or her best interests". SIAA considers this significant and would like to see it reflected more fully in both the general principles. The revised code should make clear that a child's views carry increasing weight as the child matures, and that best interests cannot be used as a reason to set those views aside.

³ [United Nations, General Comment 14, \(\(CRC/C/GC/14, 2013\)](#)

Question 2: How clear, accurate and useful do you find the section on United Nations Convention on the Rights of the Child?

SIAA welcomes this guidance's explanation of the UNCRC requirements, particularly the reference to advocacy. However, we advise that this chapter should specifically set out a right of access to *independent* advocacy. For advocates to effectively represent the views of those they work with without any conflict of interest it is vital that advocacy organisations are structurally, financially and psychologically independent.

This section is particularly clear in its explanation of rights, advocacy and the need for patients to understand the complaints processes. We suggest much of the clarity and information in this section could also be replicated in other sections of this chapter.

Question 3: Do you agree with our definitions of restraint and seclusion?

SIAA and its members support the development of clearer definitions of restraint and seclusion and believe these definitions go some of the way in addressing the lack of clarity within our current system.

However, some of our members felt that the definitions would benefit from further development to encompass wider forms of restriction. They suggested that the current definitions mainly focused on physical restrictions, where there are in fact multiple forms of restrictions that impact the human rights of those they work with. This includes:

- Restrictions on contact with family and friends.
- Restrictions on access to fresh air or outdoor space.
- Access to personal electronics.

These examples from our members align with the broader description of 'what restrictive practices look like' set out in the Scottish Human Rights Commission's 2026 Briefing Paper '[Restrictive practices in Scottish adult mental healthcare - gaps in human rights protection](#)'. This paper also highlighted that restrictive practices are not well recognised or understood by practitioners. This supports the suggestion of our members that real life examples from across the sector are incorporated into this section or further guidance.

We also know that multiple forms of restrictions can have a cumulative impact on patients' and their human rights. This should be explained within this section of the guidance.

An SIAA member organisation also raised issues around informal coercion that they witness in hospitals: "Alongside wider definitions of formal restriction, we'd like the response to recognise informal coercion – leverage around time out, leave or privileges, the implied threat of detention for informal patients, and the language used in records, ward rounds etc. to describe people who disagree with their treatment. Independent advocates witness much of this, and very little of it is currently recorded or open to challenge."

Question 4: Do you agree with our guidance on the lawful limits of restraint and seclusion?

We welcome the lawful limit guidance being framed clearly within the European Convention on Human Rights (ECHR).

We recommend that ‘informing the patient of their right to access independent advocacy’ is included within each example list of procedural safeguards. We also suggest this section details the individual’s right to independent advocacy and the vital role it plays in these circumstances.

Question 5: Do you agree with our recommendations around future care planning?

Many people require support to understand future care planning and complete advance statements. Independent advocacy plays a key role in supporting individuals to understand, contribute and make decisions for their future care planning. Not only does getting future care planning right improve care, but it could also prevent many instances of restraint and seclusion. Therefore, in this section we recommend that there is clear reference to a patient’s independent advocate being involved in care planning. As VOX Scotland’s response highlights it is important that individuals care plans are continually reviewed for the best chance to avoid restraint and seclusion. An individual having a long-term relationship with a trusted independent advocate can be valuable in making sure communication works between staff and patient.

We advise that this part of the guidance should be linked directly to relevant human rights principles including Article 12 in the UN Convention of Rights of Persons with Disabilities (UNCRPD) to have equal recognition before the law. This is particularly important in future proofing this current update as the Scottish Government has committed to incorporating the UNCRPD into Scot’s Law through a Scottish Human Rights Bill, expected to be part of the legislative programme for year 2 of the current parliamentary term.

Our members also highlighted that there are positive practices around advance statements that could be recognised within this guidance. For example, advance statements are being used to record personal triggers, identifying de-escalation approaches and recording preferences about interventions they find helpful.

Question 6: Do you agree with our guidance for using restraint and seclusion with children and young people?

We support this chapter making specific reference to the United Convention on the Rights of the Child (UNCRC). Our members stressed the importance of ensuring children’s views and wishes are actively sought and heard, and that this is important regardless of whether any final decision aligns with those wishes. Independent advocacy is key in supporting children and young people to have their views heard and understand the decisions made about their care.

Therefore, we advise that a clearer and more robust reference to the right to independent advocacy should be given in this section. We recommend an additional step should be added to the 'what 'practitioners should do' section setting out that practitioners must make sure that children and young people understand their right to independent advocacy and how to access it.

Question 7: Do you agree with our guidance for using restraint and seclusion with autistic people and people with learning disabilities?

It is important to note here that the ways that autistic people and people with intellectual disabilities are included in the 2003 Act is controversial and that the Learning Disability and Autism in the Mental Health Act, 2019, (the 'Rome review') calls for changes in the law to align with the UNCRPD. The Rome review also made recommendations on the provision of independent advocacy, these include:

- that independent advocacy be offered on an opt-out basis to autistic people and people with intellectual disability
- non-instructed advocates are allocated to all persons who are not able to instruct an advocate due to the limits of their communication abilities
- duties are placed on Scottish Government and local public services to provide resources for independent advocacy to meet the need
- Independent advocates should have powers to be able to support all people through the whole process of decision making and giving effect to those decisions.

These recommendations again highlight the role independent advocacy has in ensuring autistic people and people with learning disabilities rights are protected when restraint and seclusion is used. Therefore, we advise that a clearer and more robust reference to the right to independent advocacy, and explanation of the benefits it can have in supporting those with learning disabilities and autistic people, should be set out in this section.

Question 8: Do you agree with our recommendations for using restraint and seclusion in the context of nasogastric tube feeding?

Independent advocacy should be considered and offered before and after the use of restraint and seclusion nasogastric (NG) feeding. Currently this section does not make any reference to advocacy so we advise that a clearer and more robust reference to the right to independent advocacy should be given in this section.

Question 9: Do you agree with our recommendations for monitoring and recording the use of restraint and seclusion?

SIAA shares The Scottish Human Rights Commission's concerns about what remains hidden by the absence of robust monitoring and recording in the use of restrictive practices in adult mental health inpatient care and believe this applies to our wider mental healthcare system.

We urge the Scottish Government to recognise that this update to the Codes of Practice is a temporary measure, and that full-scale law reform is required if it is to meet its human rights obligations to people covered by mental health law.

The Scottish Mental Health Law Review made several recommendations on restraint and on how it should be monitored and scrutinised, including that:

- the Mental Welfare Commission should monitor and report on the use of restraint, seclusion and covert medication; and
- the Scottish Government should propose legislation for a national register of restraint, to be set up and maintained by a central public authority capable of hosting the exchange of data between multiple public authorities and of reporting publicly on trends in data from all of those authorities.

We believe getting a clearer, more consistent picture of when and how restraint and seclusion is used is a key step in safeguarding patients' human rights. However, it is not the end of the road and full law reform is still required.

We agree with the recommendations set out in this new chapter. We suggest, however, that they go further with more detailed recording requirements. In particular, we suggest including requirements to record access to independent advocacy and the human rights impacts. These recommendations are explained in more detail below.

Given that independent advocacy is a key safeguard, a right under the 2003 Act and supports right-based decision making, recording whether a person's right to independent advocacy is accessible to them when restraint and seclusion is used is an essential component of the monitoring and recording process. We recommend that services using restraint and seclusion should be required to record whether:

- the person was informed of their right to independent advocacy;
- the person accessed independent advocacy, on their own terms;
- any referral or re-referral to independent advocacy was made at the person's request,
- the person experienced any barriers to accessing independent advocacy support.

The last point is particularly important in understanding independent advocacy resourcing. If significant waiting lists are in place due to underfunding this points to an issue in the health boards and local authorities discharging their legal duty to 'ensure availability' to independent advocacy under the Act.

We make these recommendations whilst urging careful consideration of how they are written and applied. Independent advocacy should not become a procedural step in the incident process. Guidance should state clearly that independent advocacy providers hold no responsibility for the authorisation, administration or review of restrictive practice, and that the involvement of independent advocacy cannot be used as evidence of compliance.

SIAA and our members would welcome the opportunity to comment on specific drafting on independent advocacy in the code, as independent advocacy can be strengthened or drawn into the administration of restrictive practice depending on how it is framed.

We also recommend that whenever restraint and seclusion is used that the human rights impacts are recorded and monitored. Explicitly capturing which rights have been restricted and where this is cumulative would have a range of benefits, including:

- Supporting practitioner awareness of rights implications.
- Improving transparency.
- Strengthening accountability.
- Enabling more meaningful review of decisions.

Our members suggested that collective advocacy could be a valuable tool in monitoring and reporting. It is the route that captures what individual incident recording cannot, and it must be resourced and expected as part of the response to this chapter, not left as something services may choose to use. Collective advocacy could:

- capture group experiences and systemic issues
- offer less traumatising ways for people to share experiences because concerns can be raised collectively
- reduce the burden placed on individuals recounting experiences.
- inform service improvement through shared learning.

We suggest this is also the strongest route by which independent advocacy evidence enters monitoring. Aggregate, thematic evidence generated through collective advocacy can inform inspection and improvement without advocacy organisations becoming a case-level data source within incident or inspection processes. Where individual advocacy information is shared, this should be at the person's request or with their consent, and should not compromise the independence or confidentiality of the advocacy relationship.

Access to all models of independent advocacy

The Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 already confirms people's right of access to all types of independent advocacy. The guidance should reiterate that right explicitly, so that no setting reads "access to advocacy" as meaning one model only, and so that collective advocacy is recognised as part of a person's entitlement rather than a discretionary add-on.

This matters particularly in the context of restraint and seclusion, because collective advocacy is not yet well understood across Scotland and commissioning practice for it is patchy: whether a person can access it depends on where they live rather than on what they need. It is also worth restating the scale of the gap. The Scottish Mental Health Law Review found that only around 5% of people with a right to independent advocacy access it.

Collective advocacy groups, supported by independent advocacy organisations, should be supported in all hospitals. Increased collective advocacy provision is a key feature of the

Scottish Mental Health Law Review, and this guidance is the natural place to say so for inpatient mental health settings. Without an expectation set here, the monitoring route we recommend in this response will exist only in the areas that already invest in it.

Although we agree with the recommendations, we feel the guidance could go further in offering consistent procedures across and clear pathways to redress.

Question 10: Do you agree with our recommendations for staff planning, training and welfare?

SIAA welcome this new chapter's focus on training for staff in accordance with human rights principles. As discussed earlier in our response, independent advocacy plays an essential part in safeguarding patients' rights. However, we are aware from our experiences and those of our members that the role of independent advocacy is not always understood within services. Without an understanding of independent advocacy practitioners are unable to support patients to understand their right of access. When people are supported to understand independent advocacy and their right to access it we have evidence from our membership that uptake is high. As highlighted earlier in the paper, in the State Hospital, which has a dedicated independent advocacy organisation, uptake is regularly at 100% of patients. This is in essence an example of "opt-out" provision that is enabled through the specific high-secure forensic setting with limited number of residents, the independent advocacy organisations themselves are able to provide timely and high-quality information about independent advocacy to patients new to the hospital.

With this in mind, we therefore recommend that this updated part of the Code of Practice explicitly advises health boards to train their staff in independent advocacy including patients' rights to independent advocacy and the local referral process. This training could be included within wider human-rights training and should include collective advocacy. SIAA suggest that any training information developed on independent advocacy should be co designed by SIAA and our member organisations. SIAA have developed a national learning platform for independent advocacy so have extensive expertise to contribute.

SIAA also support VOX Scotland's recommendations surrounding more detailed training being included in this guidance. They suggested mandatory training and support for staff on several areas including:

- Care planning
- De-escalation and trauma-informed care
- The trauma that use of restraint and seclusion can cause
- Recording of incidences

Question 12c. Please tell us more about your answer (e.g. what should the guidance include, who should it apply to).

Our members felt there was a need for detailed practical guidance for staff to support consistent implementation. This included possible guidance on how to meet basic needs during seclusion, and how to maintain rights and dignity during seclusion or restraint.

Question 13a. Do you have any other comments on the proposed changes to the Code of Practice Volume 1?

As detailed earlier in our response Independent Advocacy plays a key role in protecting the rights of those who may be experiencing restraint and seclusion. We call for this guidance to be more explicit on the role of independent advocacy and champion its use. However, it is important to note that independent advocacy needs to be adequately and sustainably commissioned and resourced to allow access to those who need it. Despite the current lack of uptake in advocacy of those with the right of access, many of our members are still overstretched and operating waiting lists. In order for the intention of the Mental Health (Care and Treatment) (Scotland) Act 2003 and this Code of Practice to be realised consideration and action needs to be taken by commissioners around the resourcing of independent advocacy.

Independent advocacy can support individuals to address power imbalances and hold those accountable to their actions when things have gone wrong. However, this is not possible without there being mechanisms for redress. A clear framework of accountability and redress is missing from this chapter. It must be clear where patients and their supporters can go to challenge decisions when they feel they have experienced improper restraint and seclusion. As the Scottish Human Rights Commission set out in their briefing paper 'neither professionals nor people with lived experience felt confident that there was accountability, or remedies when restrictive practices were used improperly'⁴. The Code of Practice should explain the mechanisms for raising concerns and seeking redress.

About SIAA

The Scottish Independent Advocacy Alliance (SIAA) is the national intermediary organisation for independent advocacy in Scotland, with 33 member organisations providing independent collective and individual advocacy across communities, hospitals, and prisons. SIAA's role is to promote, support and advocate for independent advocacy.

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⁴ Scottish Human Rights Commission [Briefing paper on restrictive practices in adult mental healthcare](#) Page 10

